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**Applying Large-Scale Subsidies for Low-Income  
Populations to Health Insurance Coverage  
through Small Employers**

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## **Contents**

NOTE: Normally, we would provide an Executive Summary for a paper of this length. However, a shorter version of this paper appeared as a *Health Affairs* “Web Exclusive” on May 21, 2003, under the title, “Use Of Subsidies To Low-Income People For Coverage Through Small Employers.” Because an Executive Summary here would essentially duplicate the content of the copyrighted *Health Affairs* piece, it has been omitted. The *Health Affairs* paper may be accessed at [www.healthaffairs.org/WebExclusives/Neuschler Web Excl 052103.htm](http://www.healthaffairs.org/WebExclusives/Neuschler%20Web%20Excl%20052103.htm).

Acknowledgements.....	iv
<b>I. INTRODUCTION.....</b>	<b>1</b>
<b>II. SLIDING-SCALE PUBLIC SUBSIDIES FOR EMPLOYMENT-BASED HEALTH INSURANCE COVERAGE: GENERAL CONCEPT AND REQUIREMENTS.....</b>	<b>4</b>
<b>III. ILLUSTRATIONS OF HOW ALTERNATIVE SUBSIDY STRUCTURES FOR EMPLOYMENT-BASED COVERAGE COULD WORK.....</b>	<b>11</b>
A. Basic Assumptions.....	12
B. Income-Based Worker Contribution Approach: A Possible Application of Public Program Dollars through Premium Assistance.....	13
C. Income-Based Public Subsidy Contribution Approach: A Modified Version of the Bush Administration’s Tax Credit Proposal.....	17
D. A Hybrid Subsidy Approach: Combining Resources from Existing SCHIP and Medicaid Programs for Children with Tax Credits for Adults and Employer Contributions.....	22
E. Comparing Total Costs of Alternative Approaches by Funding Source.....	25
<b>IV. SUMMARY AND CONCLUSION.....</b>	<b>28</b>
<b>APPENDIX A: PILOT PROGRAMS THAT OFFER SUBSIDIES FOR SMALL-FIRM EMPLOYMENT-BASED COVERAGE.....</b>	<b>31</b>
<b>APPENDIX B: PREMIUM LEVELS USED FOR ILLUSTRATIVE COMPARISONS....</b>	<b>34</b>
<b>NOTES.....</b>	<b>35</b>

## List of Tables and Figures

<b>Table 1: Percent of Private-Sector Establishments that Offer Health Insurance, United States, 2000.....</b>	<b>8</b>
<b>Figure 1: Prevalence of Own-Employer Coverage, by Wage (Earnings) and by Family Income Relative to Poverty, 1999.....</b>	<b>9</b>
<b>Table 2: Total Monthly Premium Amounts Used in Illustrations.....</b>	<b>13</b>
<b>Table 3: Target Worker Contributions under the Income-Based Worker Contribution Approach.....</b>	<b>14</b>
<b>Table 4: Pre- and Post-Tax Monthly Worker Contributions in Dollar Amounts under the Income-Based Worker Contribution Approach.....</b>	<b>15</b>
<b>Table 5: Post-Tax Worker Contributions as a Percent of Income under the Income-Based Worker Contribution Approach .....</b>	<b>16</b>
<b>Table 6: Monthly Tax Credit Amounts under the Bush Administration’s Health Insurance Tax Credit Proposal .....</b>	<b>18</b>
<b>Table 7: Post-Tax Worker Contributions for Employment-Based Coverage as a Percent of Income under the Bush Administration’s Health Insurance Tax Credit Proposal.....</b>	<b>20</b>
<b>Table 8: Post-Tax Worker Contributions for Employment-Based Coverage as a Percent of Income under a Modified Version of the Bush Administration’s Health Insurance Tax Credit Proposal with Higher Maximum Tax Credit Amounts.....</b>	<b>21</b>
<b>Table 9: Post-Tax Worker Contributions as a Percent of Income under the Hybrid Subsidy Approach.....</b>	<b>24</b>
<b>Table 10a: Lower-Cost Health Plan Case: Illustrative Annual Costs of Covering 10,000 Subsidized Workers and Dependents through Alternative Subsidy Approaches .....</b>	<b>26</b>
<b>Table 10b: Standard-Cost Health Plan Case: Illustrative Annual Costs of Covering 10,000 Subsidized Workers and Dependents through Alternative Subsidy Approaches .....</b>	<b>27</b>
<b>Table B-1: Total Monthly Premium Amounts Used in Illustrations.....</b>	<b>34</b>

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The ideas and proposals in this paper were presented and discussed, in preliminary form, at a roundtable discussion convened by IHPS in Washington, D.C., on May 3, 2002, under the title, “Subsidy Structures to Reach Uninsured Workers and Families through Low-Wage (Small) Firms.” The discussion was moderated by IHPS President Rick Curtis, and the various approaches to subsidy structures for employment-based coverage of low-wage, uninsured, small-firm workers were outlined by IHPS Senior Program Officer Ed Neuschler.

The authors of this paper extend their appreciation to the roundtable participants for taking the time to share their valuable insights and expertise on the approaches presented. All participants were invited for their personal analytical, research or programmatic expertise, and were not asked to represent any official position of their organizations on the approaches discussed. In alphabetical order, roundtable participants were as follows:

- Robert S. DiPrete, Director, Oregon Health Council
- Lynn Etheredge, Independent Health Policy Consultant
- Gillian Hunter, Financial Economist, Office of Tax Analysis, U.S. Department of the Treasury
- Chuck Kiskaden, Director of Marketing and Sales, PacAdvantage (California)
- Kathlyn Mead, CEO, Sharp Health Plan, San Diego (FOCUS Project)
- Christina Moylan, Division of State Children’s Health Insurance, Centers for Medicare and Medicaid Services
- Len Nichols, Vice President, Center for Studying Health System Change
- David Parrella, Director, Medical Care Administration, Connecticut Department of Social Services
- Vondie Moore Woodbury, Director, Muskegon Community Health Project (Access Health)

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It is important to note that the views expressed here are those of the authors. No official endorsement by The David and Lucile Packard Foundation or its trustees or the California HealthCare Foundation or its trustees is intended or should be inferred.

# Applying Large-Scale Subsidies for Low-Income Populations to Health Insurance Coverage through Small Employers

## I. Introduction

To expand health insurance coverage to the uninsured, policy makers are now considering several proposals. Most of the proposals—from expanding eligibility for existing public programs such as Medicaid and the State Children’s Health Insurance Program (SCHIP) to making available tax credits or vouchers to purchase private health insurance—would provide subsidies for health insurance coverage to populations based on personal (family) income. Almost three-quarters (74%) of the 38.4 million uninsured people under age 65 are in families with incomes below 250% of the federal poverty level.<sup>4</sup>

Most uninsured people do not have access to employment-based coverage,<sup>5</sup> but it is well known that a substantial majority of uninsured people are in working families. More than 70% of uninsured people under age 65 live in families with at least one full-time worker.<sup>6</sup> But workers with meager compensation often do not have access to employer-sponsored coverage and, given their low income-tax rates, such workers typically would receive little benefit for employment-based coverage from current tax preferences. Thus, significant additional subsidies, in one form or another, will be needed if large numbers of low-income workers and families are to become insured.

With some exceptions, most current proposals to assist low-income workers and families obtain health insurance do not attempt to work with or through employers.<sup>7</sup> The Bush administration’s proposal for health insurance tax credits, for example, would not allow tax credits to be used toward the worker’s cost for employer-sponsored coverage. (Other proposals include ideas for direct subsidies to small firms in an effort to encourage the firms to offer coverage to their employees.<sup>8</sup> But these proposals are not promoted actively by leading policy makers and are difficult to target in a way that efficiently helps the uninsured low-income working population.<sup>9</sup> Further, these separate subsidy structures aimed at employers are not designed to work in concert with tax credits or premium assistance programs directed at low-income workers and families, who are often employed by small firms that do not offer coverage to their employees.)

There is a considerable risk that major coverage-expansion approaches that bypass employers entirely would create incentives to drop employer coverage that could undermine the foundation of health insurance coverage for most working families.<sup>10</sup> Over 40% of non-elderly individuals are in families with incomes below 250% of the federal poverty level, as are about one-quarter of all individuals with employment-based health coverage.<sup>11</sup> A program that offers either direct public coverage or significant tax credits or vouchers exclusively for non-employment-based coverage to such a large segment of the working-age population could lead some employers to drop coverage. In response, succeeding waves of employers might eliminate or reduce their contributions. Most experts agree that small firms with a significant proportion of low-income workers would be most likely to initiate such shifts,<sup>12</sup> especially in a weak economy with rapidly rising health insurance premiums. Such employers would be far more likely to sustain or add coverage if they were given an option that allowed them to make health insurance contributions for their workers at a sustainable level.

## ***Using Subsidies for Low-Income Populations for Health Coverage through Small Employers***

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Nothing is sacrosanct about our employment-based health care coverage system per se, but major erosion of the system's financial foundation would cause major increases in the uninsured population and make future coverage expansions that much more difficult. Two-thirds of the non-elderly population already get their health coverage through an employer, directly or indirectly. Even among the low-income non-poor (i.e., individuals with incomes between 100% and 200% of the federal poverty level), almost half (46.6%) have employer coverage.<sup>13</sup> As a practical budgetary matter, neither federal nor state governments are likely to replace the contributions employers now make toward health coverage for their low-income workers. And, if workers were asked to pay the entire premium themselves—even if their wages were increased by the amount their employers previously paid toward health insurance—some number of them would choose not to do so and would become uninsured.<sup>14</sup>

For these reasons, it would seem sensible to explore how public programs or subsidies aimed at expanding coverage of low-income adults and children might be designed to reinforce, rather than undermine, employment-based coverage. In particular, since most uninsured workers work for firms that do not now offer health coverage,<sup>15</sup> it seems useful to explore how coverage of low-income workers and families might be expanded through such employers.

- Non-offering employers are overwhelmingly small businesses with 50 or fewer employees. About six of seven jobs in firms that do not offer health coverage are in small firms.<sup>16</sup>
- Small firms with primarily low-wage workforces are much less likely to offer health coverage than are other small firms (see Table 1 in the next section), so allowing subsidies for low-wage workers to be used for employment-based coverage would have strong potential to add new coverage with minimal risk of replacing existing employer coverage.

There are other reasons, too, for using the workplace, where possible, as one means of reaching uninsured people whose employers do not now offer coverage. Compared to direct public coverage, employment-based coverage may attract greater participation from previously uninsured workers because it is easier to sign up for—workers don't have to take time off from work to apply—there's less welfare stigma because it's the way everybody else gets their health insurance, and the whole family can enroll through the same health plan easily.<sup>17</sup> Also, payroll deduction is the easiest, least painful, and most reliable method of collecting any amount the worker may be required to contribute toward the cost of coverage.<sup>18</sup>

Clearly, not all uninsured people have a stable enough job to make reaching them through the workplace sensible. But where an employment-based approach can be used, it often will be possible to reduce public subsidy costs by obtaining some contribution toward health coverage from the employer, although that contribution will be smaller than the contribution employers who already offer coverage typically make. Further, compared to individually purchased private health insurance (which the Bush administration has proposed to subsidize through refundable income tax credits), employment-based insurance has lower administrative overhead, cannot refuse coverage based on health status, usually has more comprehensive coverage (lower deductibles and copayments or coinsurance), and does a better job of pooling risk across workers of different ages and health risk levels.

## ***Using Subsidies for Low-Income Populations for Health Coverage through Small Employers***

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Some policy makers might object to allowing new subsidies to be used for employment-based coverage because many employers, especially small employers, do not offer workers a choice of competing health plans. To address this concern, subsidies could be made available only when the employer agreed to use a coverage venue that affords choice of health plan.

Experience from several local pilot programs suggests that many uninsured employers with low-wage workforces are willing to contribute toward coverage for their workers, if the contribution is modest and predictable, and if their workers can afford what they are asked to contribute. These employers do not offer coverage now because neither they nor their workers can contribute enough to meet insurance carriers' typical requirements for commercial group coverage.

- The FOCUS (Financially Obtainable Coverage for Uninsured San Diegans) project asked small employers in San Diego that previously had not offered health insurance to their workers to pay only about \$30 to \$60 per worker per month (depending on the extent of dependent coverage); it asked workers to contribute on a sliding scale, from 1% to 4% of their income. The project filled its 2,000 available slots very quickly. (Additional details about the FOCUS project, which was discussed at the May 3<sup>rd</sup> roundtable, appear in Appendix A.)
- Two projects in Michigan—Access Health in Muskegon County and HealthChoice in Wayne County—have also had success in covering workers in previously uninsured small businesses (with mostly low-wage workers<sup>19</sup>) by asking employers and workers each to pay about one-third (or a little less) of the cost of coverage through a network of local providers. Together, the two projects have more than 23,000 enrollees.<sup>20</sup> Employers currently pay about \$42 per month per worker in Muskegon County and about \$45 in Wayne County.<sup>21</sup> (More information about the Access Health project, which was discussed at the May 3<sup>rd</sup> roundtable, appears in Appendix A.)

Currently, a somewhat similar program is being pursued in New Mexico, which recently received federal waiver approval to offer a coverage program for low-income adults (only) through previously uninsured employers.<sup>22</sup> Furthermore, effective November 1, 2002, Sacramento County began using \$1 million in tobacco-litigation settlement money to subsidize insurance premiums for up to 500 low-wage workers and dependents at firms with fewer than 50 employees.<sup>23</sup>

## **II. Sliding-Scale Public Subsidies for Employment-Based Health Insurance Coverage: General Concept and Requirements**

The apparent success of local pilot projects, though limited in scope, suggests expanding coverage to workers in small firms with low-wage workforces has the potential to reach an important segment of uninsured workers and families. Although the pilot projects have been limited by availability of funds for the necessary subsidies, variations on current proposals and existing public programs could make more public funding for expanding coverage available.

The Bush administration's budget for fiscal 2003, for example, called for spending \$89 billion over 10 years on tax credits to help the low-income uninsured buy non-employment-based private health insurance. The administration's tax credit proposal was not enacted, but its inclusion in the President's budget suggests a willingness on the part of key policy makers to seriously consider allocating substantial sums to extend coverage to the uninsured.

In addition, a number of states (including New Mexico, as noted above) continue to pursue ways to extend employment-based coverage to complement public program expansions, using federal waivers of Medicaid and SCHIP program rules. Connecticut and Oregon have been discussing their approaches for some time and have developed plans.<sup>24</sup> Similar initiatives are being pursued at the county level in California.

In seeking to broaden access to health insurance coverage, an important question is: How can a public subsidy based on workers' incomes be structured to allow applications that build on, rather than "crowd out," employment-based health insurance coverage for low-income workers; reach uninsured workers through their small employers effectively and efficiently; and provide working-family-friendly, one-stop shopping for coverage? We believe a sensible approach would be to build on the existing base of employment-based insurance coverage by including alternatives that allow individuals to apply individual tax credits and/or public program expansions toward purchasing employment-based coverage.

Our approach, narrowly targeted to workers and families in small firms that have a mostly low-wage workforce and/or that did not offer coverage previously, would combine public subsidies directed to low-income individuals and families with modest employer and worker contributions to parlay the key advantages of job-based insurance—simplicity of enrollment, premium payment through payroll withholding, and risk pooling—to maximize the net increase in coverage. This general approach is intended to be flexible enough to work with any large-scale public subsidy program, including tax credits to purchase health insurance and premium assistance from means-tested public programs like Medicaid and SCHIP.

**“What we need is a mechanism for bringing additional resources to subsidies for coverage in exactly the target population our legislature is concerned about—which is workers with relatively low wages where all or part of the family is uninsured because of problems with affordability.”**

—Robert DiPrete,  
*Oregon Health Council*

Experience from local pilot projects and available research findings suggest that to be effective on a broad scale, a subsidy approach that focuses on reaching low-income workers through small firms with low-wage workforces would have to include the key characteristics described below.

**(1) Employer contribution requirements are modest, defined, and predictable over time.** Small employers with many low-wage workers simply cannot afford the amount typically required to obtain group coverage.<sup>25</sup> The minimum amount employers normally would have to contribute toward health coverage of a worker—half of the worker-only premium—would represent 14% of wages for a minimum-wage worker.<sup>26</sup> (Nationwide, private-sector employer contributions for health insurance represent, on average, about 7.4% of wages and salaries.<sup>27</sup>) That amount is too large to expect small employers with mostly low-wage workers to pay out of their usually marginal profits, and low-wage workers, not surprising, are less willing than other workers are to trade reduced wages for increased benefits. The local pilot program experience, however, suggests that many small employers with mostly low-wage workers will offer health insurance if they feel the amount they are required to contribute is manageable and predictable and will remain so for some period of time.

An additional consideration is that employers are unlikely to contribute toward health coverage unless they feel their contribution will make their workers better off. It would not be reasonable, for example, to expect employers to pay to enroll their workers in a public program if all or most of the workers could enroll directly without charge.

**(2) Subsidies (or tax credits) are directed to workers based on the worker's family income and/or individual wage, and not to employers.** To be sustainable over time, government subsidies need to be targeted to individual workers and families who cannot otherwise afford coverage rather than to their employers. Direct subsidies to employers, or subsidies to all of an uninsured firm's workers, based on characteristics of the employer (e.g., low wage profile and/or previously uninsured) are not likely to be adoptable or sustainable on a broad scale. Opponents will ask, rightly, why government is subsidizing higher-income proprietors and employees within the group. Indirectly, of course, employers will benefit from a subsidy to their workers, in that it will enable them to offer employment-based coverage for a lower employer contribution than otherwise would be required of them. But basing the subsidy amount on the worker's income means that, where the proprietor and any higher-income employees can afford to pay for their own coverage, they would have to do so if they want to be covered.

Another reason for suggesting that subsidies be focused on low-income or low-wage workers is that available evidence suggests that subsidies need to cover a substantial portion of the premium to be effective in encouraging the uninsured to enroll. And there seems to be little political support for subsidies directed at employers that would be large enough to be effective, for reasons similar to those already noted.

- Only about 20% of the smallest firms—those with fewer than 10 workers—currently offer health coverage. And, although those firms might be expected to be more responsive to price than larger firms, the highest estimate of their price responsiveness that can be found in the research literature is that a 10% premium subsidy would engender about a 20% increase in the probability of offer (i.e., from 20% offering to about 24% offering).<sup>28</sup>

- States such as Kansas and Oregon, which have offered modest, time-limited tax credits to small employers to encourage them to begin offering health insurance, have found such subsidies to be ineffective.

These observations are reinforced by a recent study published by the Center for Studying Health System Change (HSC) that suggests that “premium subsidies paid directly to small firms are unlikely to significantly reduce the number of uninsured.” The authors note the following:

Direct subsidies of employer-sponsored insurance premiums suffer from two fundamental problems. First, their success in extending health insurance to additional workers is hindered by small employers’ relatively low responsiveness to premium subsidies. Subsidies would have to be very large to have a significant effect on the number of uninsured workers who gain access to employer-sponsored health benefits. Second, because subsidies are given to the employer—rather than directly to employees—it is difficult to target the subsidies to those most in need: low-income, uninsured persons.<sup>29</sup>

Note that this HSC study did not examine a subsidy structure that targets relatively large subsidies to low-income workers.

**(3) Coverage is offered to the whole employer group through approaches acceptable to providers.** Coverage should be made available at least to all full-time permanent employees in the group, both those who are eligible for subsidies and those who are not. Employers will be more willing to participate if they can offer group coverage to their higher-income workers (including themselves) as well as to their low-income workers. Further, whole-group coverage would allow individual workers to maintain their coverage source and provider relationships if their subsidy status changes due to increased or decreased earnings at that job.

Non-subsidy-eligible workers would have to pay the difference between the total premium and the modest employer contribution, but they could qualify either for current-law tax advantages (by making their premium contribution through a section 125 flexible spending account or premium-only plan, POP) or perhaps, under a tax credit scenario, for a modest tax credit in lieu of current tax preferences. (To avoid adverse selection problems, high participation standards would need to be established for non-subsidized workers, as is done routinely in the normal small-group market.)

At least one local pilot project reduced its direct subsidy costs by coaxing providers into accepting low payment rates for project enrollees—rates similar to those paid under Medicaid. While providers have been willing to accept low rates for relatively small, time-limited pilot projects, they likely will refuse to participate—for fully understandable reasons—in a broad-scale, permanent program paying Medicaid-level rates for care of working families. One way to avoid this problem is to provide coverage through private-sector health plans that serve the commercial employer market.

**(4) Worker-friendly “one-stop shopping” for family coverage is offered.** Signing up at work is the easiest way to enroll in health coverage, and work-based coverage traditionally allows all family members to be covered by a single health plan. While this may seem commonplace, its importance should not be overlooked. Family coverage is especially important for children, who are more likely to get needed care if they are enrolled in the same health plan as their parent.<sup>30</sup>

By contrast, the expansion of public coverage that took place during the 1990s often did not include parents in the public program and permitted but did not facilitate premium assistance toward employment-based family coverage. Thus, children typically were covered by separate health plans from their parents (as, for example, when a low-income working parent had fully paid employer coverage for herself but could not afford the contribution required to cover her children through her employer plan). Further compounding this problem in a number of states, children of different ages in the same family might be covered by different health plans, even though all were eligible for public coverage.<sup>31</sup> And the Bush administration's health insurance tax credit specifically envisions the possibility that low-income parents might buy tax credit-financed individual coverage for themselves while their children remain enrolled in Medicaid or SCHIP.<sup>32</sup>

We believe any reasonable policy design should permit any and all public funds available to low-income workers and family members to be applied toward single-point-of-enrollment family coverage.<sup>33</sup> Implementing this kind of design will require the administrative capability to combine contributions from multiple sources on behalf of a single worker and family and direct those funds to the worker's chosen health plan. If desired, an organization with such capability also could provide worker choice of health plan. As reflected in the design of both current public programs and proposed individual tax credits, many policy makers believe that large-scale subsidy programs should afford recipients a choice of competing health plans. And some oppose providing subsidies for low-income people to participate in employment-based coverage specifically because small-employer groups typically do not offer a choice of competing health plans.<sup>34</sup> This concern could be addressed by making subsidies available only when the employer agrees to use a coverage venue that affords choice of health plan, such as a private consumer-choice purchasing group, a clearinghouse for health plans with functions similar to those described by Etheredge,<sup>35</sup> or access to plans serving state or federal employees through an enrollment-broker function.

**“One-stop shopping for family coverage just makes common sense. And the ability to piece the money together on behalf of the family, as opposed to having to send the family members all over the place to follow the money, is, again, common sense.”**

—Rick Curtis,  
*Institute for Health Policy Solutions*

**(5) Sliding-scale subsidies are made available *only* to workers in businesses whose size and wage composition make it highly unlikely that they would offer work-based health insurance under normal market conditions.** Compared to the small pilot programs undertaken to date, under a broad-scale program, the question of which employers qualify to participate becomes much more important.

To maximize the “bang for the subsidy buck,” sliding-scale subsidies to supplement a modest employer contribution could be made available *only* to workers in businesses whose size and wage composition make them highly unlikely to offer work-based health insurance under normal market conditions. Targeting these businesses accurately, so that new public subsidies are focused on covering the uninsured, rather than largely replacing existing private spending for health coverage, would be a critical budget issue.

Since the likelihood that a business will offer health coverage (at least to some workers) increases with firm size (as measured by number of employees)—see Table 1—firm size is one obvious

## ***Using Subsidies for Low-Income Populations for Health Coverage through Small Employers***

criterion. There seems to be no reason to allow firms with more than 50 workers to qualify for below-market employer-contribution requirements. But a lower size threshold may be desirable, perhaps at 25 or even 10 employees.

The wage profile of the firm is also a relevant consideration. As seen in Table 1, across all firm sizes, businesses with a high proportion of low-wage workers are less likely than are other firms to offer health coverage, but this is especially true for small firms. It also seems obvious that firms with mostly low-wage workers are likely to have a high proportion of workers who would qualify for subsidies based on individual wages or family income.

**Table 1: Percent of Private-Sector Establishments that Offer Health Insurance, United States, 2000**

<b>Number of Employees in Firm</b>	<b>&lt; 10</b>	<b>10-24</b>	<b>25-99</b>	<b>100-999</b>	<b>1,000+</b>	<b>&lt; 50</b>	<b>50 +</b>
Low-wage firm*	25.4%	46.3%	73.5%	94.2%	96.4%	31.4%	92.7%
Non-low-wage firm	50.2%	83.4%	92.4%	96.9%	99.4%	58.7%	97.4%

\* A low-wage firm is defined as one in which 50% or more of employees earn less than \$9.50 per hour (approximately the lowest quartile of wages nationally).

SOURCE: U.S. Agency for Healthcare Research and Quality, *2000 Employer-Sponsored Health Insurance Data. Private-Sector Data by Firm Size, Industry Group, Ownership, Age of Firm, and Other Characteristics*, Rockville, MD: August 2002. Table I.A.2 (<http://www.meps.ahrq.gov/mepsdata/ic/2000/index100.htm>).

Limiting eligibility (for a lower-than-market employer contribution) to firms that have not offered health coverage to any of their workers for some period of time, usually 12 months, is a standard way of attempting to focus public resources on workers who otherwise would be uninsured, and may be useful or even necessary in some situations, particularly in relatively small pilot projects. But, in the context of a new, broad-scale federal or state program, there are equity issues and longer-term effects to consider as well.

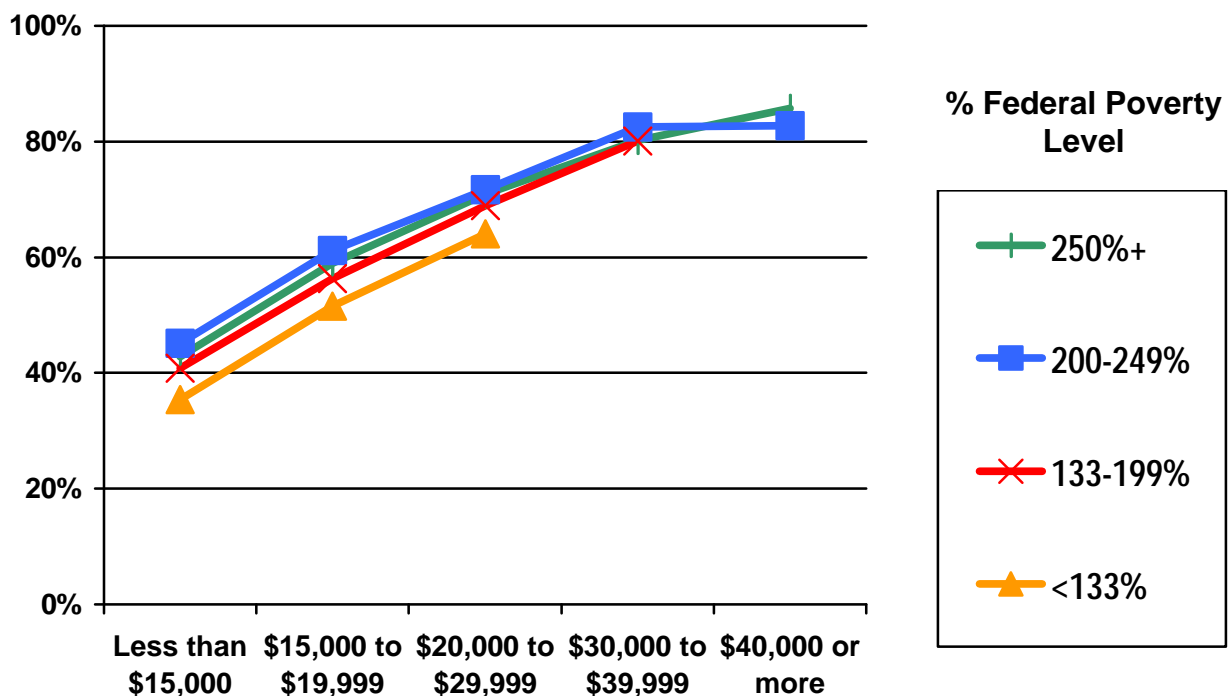
About one-quarter of the smallest firms (those with fewer than 10 workers) with mostly low-wage workforces do offer health coverage to their workers. But, in the regular insurance market (unsubsidized except for normal federal tax advantages), these firms very rarely are able to sustain that coverage. Regardless of wage profile, very small firms drop coverage much more frequently than do other businesses. And businesses with mostly low-wage workers drop coverage at a rate three times faster than other businesses.<sup>36</sup> There is no doubt that the cost to these firms, relative to total worker compensation and business revenues, is high. Should such employer groups be excluded from a public subsidy program available to otherwise similarly situated workers and firms simply because they previously attempted to “do the right thing” and offer their workers health coverage? And should their workers, who have often accepted lower wages in exchange for a job with health benefits, have to forego a subsidy that would now be available to those who previously chose higher (though still low) wages instead of health coverage?<sup>37</sup>

## Using Subsidies for Low-Income Populations for Health Coverage through Small Employers

Using an employer's wage profile as a criterion in defining qualifying employers is also compatible with the well-established relationship between wage level and employee benefits such as health insurance. Put simply, higher-wage workers are more likely to be offered employer-paid benefits of various sorts, including health coverage.

This relationship is displayed graphically in Figure 1, which shows the percentage of full-time, full-year workers<sup>38</sup> at various earnings (wage) and family income levels who have health coverage through their own employer. (The four lines on the chart represent four different family-income levels, from less than 133% of the federal poverty level to 250% of the federal poverty level and over.) It is particularly striking that the relationship between wage level and own-employer coverage holds true regardless of the wage earner's total family income relative to the federal poverty level.

**Figure 1: Prevalence of Own-Employer Coverage, by Wage (Earnings) and by Family Income Relative to Poverty, 1999\***



\* Percent of full-time, full-year adult wage-and-salary workers with employment-based insurance through their own employer, by earnings at longest job and by family income as a percent of the federal poverty level, United States, 1999.

SOURCE: IHPS analysis of the March 2000 Current Population Survey. Data points with large relative standard errors have been omitted.

## ***Using Subsidies for Low-Income Populations for Health Coverage through Small Employers***

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A final argument for allowing public subsidies to be applied toward employment-based coverage by workers in small firms with majority low-wage workforces, even if the firm already offers health coverage, is that such firms would be highly likely to stop contributing and to drop coverage if most of their workers became eligible for larger public subsidies for public or non-employment-based coverage.<sup>39</sup> Particularly in a weak economy with rapidly rising health insurance premiums, such employers are far more likely to continue offering coverage if they are given an option that allows them to make health insurance contributions at a sustainable level.

In light of these considerations, and consistent with the goals of providing stable coverage and encouraging employers to “do the right thing,” it seems sensible to us to make small firms with mostly low-wage workforces eligible to participate in the work-based, sliding-scale-subsidy approach, whether or not they have offered coverage to their workers previously. In this paper, we do not specify a fixed definition for “small firm with a mostly low-wage workforce.” (For purposes of elucidation, however, it may be useful to think in terms of firms with fewer than 25 workers and a median wage of \$10 per hour or less. Nationwide, there are about 5 million workers in such firms; roughly half of them are uninsured.) Taking into account the considerations noted here, a specific definition will have to be developed to fit the budget of the body interested in pursuing this approach to expanding health insurance coverage and the circumstances of the small-employer market in that agency’s jurisdiction.

### **III. Illustrations of How Alternative Subsidy Structures for Employment-Based Coverage Could Work**

Traditional public health insurance programs such as Medicaid typically use a fixed income standard for eligibility, based on family income relative to the federal poverty level. Applicants whose incomes are below the standard get full benefits; applicants whose income exceeds the standard get no assistance.<sup>40</sup> An all-or-nothing approach works reasonably well when income standards are low, and applicants are very unlikely to have access to other sources of health coverage. But when policy makers want to provide assistance to working families at higher income levels, using a sliding scale based on family income has a number of advantages.

- First, it provides assistance, albeit at more modest levels, to higher-income families who would not qualify for assistance under traditional public programs but who cannot afford the entire cost of health insurance on their own.
- Second, because the public subsidy is reduced but not eliminated as income increases, there is a smaller disincentive for workers to take a better-paying job when one becomes available.
- Third, providing free or very low-cost public coverage (to adults above the federal poverty level) discourages workers from accepting employment-based coverage that may become available to them and, thus, tends to “crowd out” employer coverage over time.<sup>41</sup> Asking workers to contribute more as their income increases makes it less likely that they will turn down an employer’s offer of health insurance if the contribution required is reasonable.

In the remainder of this paper, we illustrate how sliding-scale public subsidies to individuals could be applied toward the purchase of employment-based health insurance coverage.

- **Illustration of the “income-based worker contribution approach”: a possible application of public program dollars through premium assistance.** Under this approach, a worker’s contribution to the premium cost is determined by the worker’s income (or, possibly, wage) and the worker’s contribution increases as his or her income increases up to a specified level. The public subsidy pays the remaining premium cost (net of the employer’s contribution). We illustrate a sliding-scale arrangement under which the public subsidy decreases as the worker’s income increases up to 300% of the federal poverty level; above that level there is no subsidy. This approach could use existing or expanded public programs, such as SCHIP or Medicaid, that, in addition to providing direct public coverage, are authorized to offer premium assistance to enable individuals to purchase employment-based coverage. (At present, however, these programs generally do not provide assistance on a sliding scale.)
- **Illustration of the “income-based public subsidy contribution approach”: a modification of the Bush administration’s tax credit proposal.** As noted earlier, the Bush administration recently proposed tax credits to purchase health insurance. The approach examined in this paper would require modifying the administration’s proposal to allow individuals to use tax credits to purchase qualified employment-based coverage. In this approach, the government specifies a maximum subsidy amount it is willing to provide, and decreases that amount on a sliding scale as the family’s income increases, up to a specified level. The worker then pays the difference between the subsidy amount and the insurance premium

(net of the employer's contribution). The maximum subsidy amount could be specified either in dollar terms or as a percentage of the premium. Following the administration's proposal, we illustrate a sliding-scale arrangement under which the public subsidy (tax credit) decreases as the worker's income increases, up to \$30,000 in the case of a single worker without children and \$60,000 for most other workers.

In addition, we illustrate a "hybrid subsidy approach" that would combine resources from existing SCHIP and Medicaid programs for children and tax credits for adults to make employment-based coverage affordable for low-wage, uninsured, small-firm workers and their families. Such a hybrid approach to public subsidies for employment-based family coverage may be of particular interest to states in the event federal tax credits for health insurance are enacted.

## **A. Basic Assumptions**

Before illustrating how sliding-scale subsidies for employment-based health insurance coverage would work, we briefly discuss several basic assumptions about the employer's contribution and the premium levels to be used in our comparisons.

**Employers' Contribution to Coverage.** As discussed earlier, participating employers would not receive a subsidy per se, but the contribution they are asked to make toward their workers' coverage would be fixed at an amount considerably lower than what is typically required in the commercial market. For purposes of these illustrations, we assume employers would be required to contribute a flat \$50 per covered worker per month, regardless of the worker's age or the plan or coverage tier the worker selects. We believe \$50 is low enough, and far enough below current market requirements, to attract a significant number of small businesses that do not offer coverage now.<sup>42</sup>

**Premium Levels Used for Comparisons.** The impact of the different subsidy approaches on worker contribution levels and on public subsidy costs will vary, depending on the underlying premium cost for the coverage being provided. To illustrate a reasonable range of potential variation, we examine two illustrative cases: a *standard-cost case* and a *lower-cost case*, as shown in Table 2. The standard case is intended to reflect the typical cost of employer-sponsored, HMO-style, worker-only coverage in 2002. The lower-cost case can be thought of as representing current market rates for the lowest-cost HMO coverage available to young workers in a low-cost geographic area (or, alternatively, as reflecting rates for PPO coverage with higher cost-sharing amounts than are typically used now).<sup>43</sup> Additional background and comparative information on the illustrative rates is given in Appendix B.

**Table 2: Total Monthly Premium Amounts Used in Illustrations\***

<b>Coverage Tier</b>	<b>Standard Case</b>	<b>Lower-Cost Case</b>
Worker only	\$220	\$150
Worker plus children	\$484	\$330
Worker plus spouse and children	\$748	\$510

\* The standard case is intended to reflect the typical cost of employer-sponsored, HMO-style, worker-only coverage in 2002. The lower-cost case can be thought of as representing current market rates for the lowest-cost HMO coverage available to young workers in a low-cost geographic area. See Appendix B for further discussion.

SOURCE: IHPS analysis.

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## **B. Income-Based Worker Contribution Approach: A Possible Application of Public Program Dollars through Premium Assistance**

As noted earlier, in the income-based worker contribution approach to public subsidies for health insurance coverage, the amount a worker is required to contribute toward employment-based coverage is based on the worker's income and, perhaps, on the coverage tier the worker selects. Thus, for example, the worker's contribution might be calculated as a percentage of income (or, perhaps, wage), and the percentage might increase as income increases.

To avoid constant revision of the contribution amount based on small changes in income, contribution levels could be established for a limited number of income categories, as shown in Table 3.<sup>44</sup> The public subsidy would then equal the difference between the premium for the health plan chosen (net of the employer's contribution) and the worker's contribution. The worker would never have to pay more than the net premium cost (i.e., total premium cost less the employer's contribution). The concept of a fixed contribution from participants is most commonly associated with public programs, such as Medicaid or SCHIP, that offer premium assistance to individuals in addition to direct public coverage. Generally, however, required participant contributions increase with income only modestly under such programs, if at all.

**Table 3: Target Worker Contributions under the Income-Based Worker Contribution Approach**

<b>Worker's Income Category (% FPL<sup>#</sup>)</b>	<b>&lt;100%</b>	<b>100%- 149%</b>	<b>150%- 199%</b>	<b>200%- 249%</b>	<b>250%- 299%</b>	<b>300%+ (Not Eligible)</b>
<b>% FPL Used for Calculating Worker's Contribution<sup>†</sup></b>	<b>75%</b>	<b>125%</b>	<b>175%</b>	<b>225%</b>	<b>275%</b>	<b>400%</b>
Target Worker Contribution Percentage (Desired Percentage of Worker's Income)	<1.0%	<2.0%	<3.0%	<4.0%	<5.5%	N/A
Nominal Percentage of Income Used for Payroll Deduction <sup>*</sup>	1.0%	2.0%	3.5%	5.0%	7.0%	N/A

<sup>#</sup> FPL = federal poverty level.

<sup>†</sup> For purposes of illustration, worker contributions must be calculated at a specific income. This row shows the income levels used for the calculations within each income range, as a percent of the FPL.

<sup>\*</sup> The worker's gross payroll deduction for health insurance is calculated using these percentages. The actual cost to the worker, net of tax savings (discussed in text) will be less. Worker pays "net premium" (total premium less the employer's contribution) if it is lower than percent-of-income calculation.

SOURCE: IHPS analysis.

Table 3 includes several pieces of information. The first row shows the suggested income categories for workers; the second row shows, within each category, the specific income as a percent of the federal poverty level to be used to calculate worker contributions. The third row shows the target worker contribution percentage (i.e., worker contribution as a percentage of worker income the approach intends to achieve). The final row shows the nominal percentages of income to be used to calculate the worker's payroll deduction for health insurance.

The reason the target worker contribution percentage and the nominal percentage differ is that these calculations are based on the assumption that current tax law remains in place, and that employers and workers take full advantage of it. (Current tax advantages can be maximized by using a premium-only plan [POP] to reduce the worker's after-tax cost of health insurance. Under a POP—a form of section 125 flexible spending account—the amount deducted from a worker's paycheck for employment-based health coverage is excluded from taxable wages for both FICA taxes [Social Security and Medicare taxes] and income-tax purposes. The worker's savings equal 7.65% [FICA] plus the worker's marginal income-tax rate times the worker's payroll deduction amount. [And, because the exclusion applies to FICA taxes as well as income taxes, the employer also saves 7.65% of the amount the worker contributes.] A program aimed at expanding work-based coverage certainly would want to take advantage of all available subsidies, so we assume that any such program would make POP administration available to participating employers and would strongly encourage, if not require, its use.)

## ***Using Subsidies for Low-Income Populations for Health Coverage through Small Employers***

The target worker contribution percentages shown in Table 3 were developed to assure that coverage is affordable for the lowest-income working families and to provide for a smooth transition to non-subsidized coverage, i.e., to avoid a cliff effect—a significant increase in worker contribution—at 300% of the federal poverty level (where eligibility for any subsidy terminates in these illustrations). If these goals are not met, or if other goals are determined to be preferable, the percentages used for illustration can be adjusted easily.

The dollar contribution amounts that result from applying the percentages in Table 3 are shown in Table 4, both as gross or nominal amounts (pre-tax) and net of the tax advantages available by using a POP (post-tax). (With one exception, which is noted, contributions from those eligible for subsidies are identical under the lower-cost case and the standard case. Contributions from those not eligible for subsidized coverage differ depending on the total premium cost, so both cases are shown for that income level.)

**Table 4: Pre- and Post-Tax Monthly Worker Contributions in Dollar Amounts under the Income-Based Worker Contribution Approach**

Coverage Tier	Pre-/Post-* Tax Basis	Income (% FPL#)						
		75%**	125%	175%	225%	275%	400% (Lower-Cost Case)	400% (Standard Case)
Worker only	Pre-	\$7**	\$18	\$45	\$83	\$100†	\$100	\$170
	Post-	\$6**	\$15	\$35	\$64	\$77	\$77	\$131
Worker plus child(ren)	Pre-	\$9	\$31	\$77	\$141	\$241	\$280	\$434
	Post-	\$9	\$25	\$59	\$109	\$186	\$217	\$336
Full family	Pre-	\$11	\$38	\$92	\$170	\$290	\$460	\$698
	Post-	\$10	\$27	\$76	\$131	\$225	\$356	\$540

# FPL = federal poverty level.

\* The pre-tax line shows the (payroll deduction) dollar amount the worker would be required to contribute for coverage. The post-tax line shows the worker's actual outlay net of FICA and income-tax savings that would accrue from using a premium-only plan (POP) for health insurance contributions.

\*\* The income level used to calculate contributions for worker-only coverage in the "<100% FPL" range was 91% FPL, rather than 75% FPL. At minimum wage, a worker working 30 hours per week (a likely minimum standard to qualify for employer coverage) would earn 91% of the federal poverty level.

† This worker contribution equals the net premium for lower-cost coverage. Under the higher premiums of the standard-cost case, the income-based worker contribution would be \$142/\$110.

SOURCE: IHPS analysis.

## ***Using Subsidies for Low-Income Populations for Health Coverage through Small Employers***

Because marginal income tax rates vary across families in ways that cannot be captured completely in a simple model, post-tax worker contributions as a percent of income vary as well. As a result, the intended “target percentages” shown in Table 3 can only be approximated. Table 5 shows workers’ post-tax contributions as an estimated percent of income and also repeats the “target percentages” for easy comparison.

**Table 5: Post-Tax Worker Contributions as a Percent of Income under the Income-Based Worker Contribution Approach**

<b>Income (% FPL #)</b>	<b>75%*</b>	<b>125%</b>	<b>175%</b>	<b>225%</b>	<b>275%</b>	<b>400% (Lower Cost Case)</b>	<b>400% (Stan- dard Case)</b>
<b>Target Post- Tax Worker Contribution Percentage</b>	<b>&lt;1.0%</b>	<b>&lt;2.0%</b>	<b>&lt;3.0%</b>	<b>&lt;4.0%</b>	<b>&lt;5.5%</b>	<b>N/A</b>	<b>N/A</b>
Worker only	0.8%*	1.6%	2.7%	3.9%	3.8%†	2.6%	4.5%
Worker plus child(ren)	0.9%	1.6%	2.7%	3.9%	5.4%	4.3%	6.7%
Full family	0.9%	1.4%	2.9%	3.9%	5.4%	5.9%	8.9%

# FPL = federal poverty level.

\* The income level used to calculate contributions for worker-only coverage in the “<100% FPL” range was 91% FPL, rather than 75% FPL. At minimum wage, a worker working 30 hours per week (a likely minimum standard to qualify for employer coverage) would earn 91% of the federal poverty level.

† This worker contribution equals the net premium. Under the higher premiums of the standard-cost case, the post-tax income-based worker contribution would be 5.4% of income.

SOURCE: IHPS analysis.

In general, a percent-of-income approach provides good protection for workers and families—for example, all workers pay the same, regardless of their age, even if actual premium payments to plans are age-rated—but it also discourages employers from increasing their contributions and leaves government at risk for all premium increases. Because the public subsidy is open-ended under this approach, the actual purchaser will have to have strong incentives to keep premiums as low as possible. If most of a small employer’s workers qualify for a subsidy, as is expected to be the case, this incentive will be muted at best. Therefore, public agencies considering this kind of approach may wish to require employers of subsidy recipients to purchase coverage through a larger pool that includes many employers and workers who do not qualify for a subsidy. Also, because the subsidy amount will vary considerably across workers and plans under this approach, administering subsidy payments will prove to be very difficult unless the public agency works with an experienced

intermediary, such as a purchasing pool, to handle employer billing and apply employer and worker contributions and subsidy payments toward plan premiums.

Percent-of-income approaches also require adjustment when workers have a choice of plans, some of which cost more than others. In this situation, a determination must be made whether any part of the difference in premium between the lowest-cost plan available and the plan chosen by the worker should be paid by the public program and, if so, how much of that difference.<sup>45</sup>

Note also that the percentage-of-income approach may lead to a perception of inequity within employer groups. Because the federal poverty level varies by family size, a worker with dependents may pay less for family coverage than a childless worker earning the same wages would pay for worker-only coverage (assuming in each case that the worker's wages represent the family's total income). For example, under the contribution schedule used by the FOCUS project during 2001,<sup>46</sup> a worker earning \$1,750 per month (about \$10.10 per hour) paid \$61 per month for single coverage, but only \$20 per month to cover the worker and two dependents. While better reflecting families' relative ability to pay for coverage, this approach could lead some workers to feel discriminated against. (Note that no reports of complaints to this effect have been heard with respect to the FOCUS project. It is unclear whether this reflects self-selection among the employer groups that chose to participate or a true lack of any concern about the issue among employers and their workers.)<sup>47</sup>

This observation also calls attention to a more general problem of using poverty-based subsidies for low-wage, single workers without children. At minimum wage, a 40-hour-per-week worker earns 121% of the federal poverty level (158% in California, which has a higher minimum wage). A single, childless, full-time worker earning only \$10.00 per hour is already at 235% of the federal poverty level. Thus, a subsidy program with an eligibility cut-off at 200% of the federal poverty level could leave many low-wage, small-firm workers unable to afford coverage and could lead many eligible small firms to decline to participate. This is one reason we suggest that sliding-scale subsidies should be available up to 300% of the federal poverty level. Another important reason is to provide an adequate phase-down range for the subsidy. Under the Bush administration's tax credit proposal, for example, the full amount of the credit is available to single workers without children with up to \$15,000 in annual income (169% of the federal poverty level), and a gradually reduced credit is payable up to \$30,000 in annual income (338% of the federal poverty level). If extending eligibility to 300% of the federal poverty level is not feasible (even with reduced subsidies), then basing the eligibility standard on minimum wage in lieu of the poverty level might be a useful alternative. For example, the upper eligibility limit might be set at 200% of the minimum wage or 200% of the federal poverty level, whichever is higher.

### **C. Income-Based Public Subsidy Contribution Approach: A Modified Version of the Bush Administration's Tax Credit Proposal**

As noted earlier, in the income-based public subsidy contribution approach, the government specifies a maximum amount it is willing to provide, and then decreases that amount on a sliding scale as a family's income increases. The worker then pays the difference between the subsidy amount and the insurance premium (net of the employer's contribution). This public subsidy approach is most commonly thought of in conjunction with federal tax credits for individuals' purchase of health insurance coverage.

***Using Subsidies for Low-Income Populations for Health Coverage through Small Employers***

Under the Bush administration’s tax credit proposal, for example, individuals under age 65 would be eligible for a refundable credit that would pay up to 90% of their health insurance premium, up to a maximum annual credit of \$1,000 per adult and \$500 per child for up to two children. Thus, the maximum credit would be \$1,000 (about \$83 per month) for a single worker; \$2,000 (about \$167 per month) for a childless couple; \$1,500 (\$125 per month) for a single parent with one child; \$2,000 for a single parent with two or more children; and \$3,000 (\$250 per month) for a married couple with two or more children. (After 2003, these dollar amounts would be indexed to the growth in the Consumer Price Index for all urban consumers.)<sup>48</sup>

The maximum tax credit in the administration’s proposal would apply up to \$15,000 of adjusted gross income (AGI) for individuals with no dependents who file a single return, and up to \$25,000 of AGI for all other filers.<sup>49</sup> The subsidy percentage and credit amount would phase down above these income levels. The credit would phase out completely for single filers at \$30,000 and for other filers at \$60,000 (or \$40,000 if the policy covers only one adult). (The poverty-level equivalent of these dollar amounts varies, depending on family structure. For example, the maximum tax credit is available up to only 138% of the federal poverty level for a couple with two children, but up to 209% of the federal poverty level for a childless couple.)<sup>50</sup>

The tax credit amounts by family income and number of people covered are shown (in monthly terms) in Table 6.

**Table 6: Monthly Tax Credit Amounts\* under the Bush Administration’s Health Insurance Tax Credit Proposal**

<b>Adjusted Gross Income</b>	<b>\$15,000</b>	<b>\$20,000</b>	<b>\$25,000</b>	<b>\$30,000</b>	<b>\$40,000</b>	<b>\$50,000</b>	<b>\$60,000</b>
Single worker	\$83	\$46	\$23	\$0	\$0	\$0	\$0
Childless couple	\$167	\$167	\$167	\$143	\$95	\$48	\$0
Single parent with one child	\$125	\$125	\$125	\$107	\$71	\$36	\$0
Single parent with two children	\$167	\$167	\$167	\$143	\$95	\$48	\$0
Two parents with two children	\$250	\$250	\$250	\$214	\$143	\$71	\$0

\* Worker pays difference between tax credit subsidy amount shown here and the actual cost of the insurance premium (net of the employer contribution).

SOURCE: Based on descriptions and formulas given in Department of the Treasury, “General Explanations of the Administration’s Fiscal Year 2003 Revenue Proposals,” February 2002.

## ***Using Subsidies for Low-Income Populations for Health Coverage through Small Employers***

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Under the Bush administration's original tax credit proposal, tax credits for health insurance would not be available to people who have employer-based coverage or to people enrolled in public programs that provide coverage. In the illustration we discuss here, the administration's proposal would be modified to permit individuals to apply the tax credits toward employment-based health insurance coverage.

The idea that, under certain conditions, tax credits could be made available to workers and families in qualifying small firms, even though the employer was contributing toward coverage, is something we have suggested in another paper.<sup>51</sup> If it was necessary to limit additional tax expenditures for this variation, the conditions to be imposed would include the following:

- The option to use tax credits in conjunction with employer coverage would be available *only* to firms that qualify based on size and, if desired, wage profile (as discussed above). The option also might be made available to multi-employer (union) plans where most of the participating employers would meet the criteria if considered separately.
- All workers in the firm's health insurance plan, regardless of income, would have to switch to the new tax credit-based approach. (Or, in the case of union plans, it could be sufficient to have all workers in the bargaining unit switch to the new approach.)<sup>52</sup>
- While the employer's contribution toward health insurance would still be deductible as a business expense by the employer, it would be counted as income to the worker for income tax purposes (but not for FICA purposes), and the worker's tax credit would be based on the total premium.
- Employers' health insurance contributions would continue to be exempt from FICA taxes (for both employers and workers). This exemption would provide an incentive for employers to continue making contributions that are usable specifically (and only) for health insurance, rather than simply increasing workers' wages.

The Bush administration's tax credit proposal would allow refundable tax credits for health insurance coverage to simply be claimed on a worker's tax return at the end of the year, or to be claimed (and paid) in advance based on the worker's family income for the prior year; the Internal Revenue Service would issue eligibility statements (based on prior-year income) that could be used, in effect, as vouchers to pay insurance carriers. This same construct could be adapted easily to employment-based coverage. Workers would submit their eligibility notices (vouchers) to the administrative entity handling payroll for the employer, which in turn would adjust each worker's payroll deduction for health coverage accordingly and transmit the vouchers to the insurance carriers, along with the employer's regular premium payment.

Assuming that the tax credit amounts specified in the Bush administration's proposal could be applied toward employment-based coverage, as discussed, the worker contributions required under the standard and lower cost illustrative premium levels are shown, as a percentage of income, in Table 7.

**Table 7: Post-Tax Worker Contributions for Employment-Based Coverage as a Percent of Income under the Bush Administration’s Health Insurance Tax Credit Proposal**

Coverage Tier	Premium Level*	Income (% FPL <sup>#</sup> )					
		75%†	125%	175%	225%	275%	400%
Worker only	Lower-cost	2.5%†	1.8%	1.6%	3.2%	3.6%	3.4%
	Standard	12.9%†	9.4%	7.0%	7.4%	7.1%	5.8%
Worker plus child(ren)	Lower-cost	12.1%	7.2%	5.5%	5.5%	5.5%	5.6%
	Standard	28.5%	17.1%	12.5%	11.0%	10.0%	8.7%
Full family	Lower-cost	18.6%	11.1%	9.8%	9.5%	9.3%	7.6%
	Standard	39.6%	23.8%	18.8%	16.5%	15.1%	11.6%

# FPL = federal poverty level.

\* For specification of standard-cost and lower-cost premium levels, see Table 2.

† The income level used to calculate contributions for worker-only coverage in the “<100% FPL” range was 91% FPL, rather than 75% FPL. At minimum wage, a worker working 30 hours per week (a likely minimum standard to qualify for employer coverage) would earn 91% of the federal poverty level.

SOURCE: IHPS analysis based on descriptions and formulas given in Department of the Treasury, “General Explanations of the Administration’s Fiscal Year 2003 Revenue Proposals,” February 2002.

As shown in Table 7, lower-cost, worker-only coverage would be affordable, and some modest-income (non-poor) workers might be able to afford to cover their children. (Worker contributions for lower-cost, worker-plus-children coverage would range from \$113 per month to \$191 per month for tax credit recipients.)

It is readily apparent, however, that if (as we are assuming) only a modest employer contribution is available, the tax credit levels in the administration’s proposal are not sufficient to make typical employment-based coverage affordable for many low-income working parents with children, even with total premiums at the low-cost end of the “typical” range. Thus, application of the administration’s proposed tax credit, by itself, to work-based group coverage (with modest employer contributions) is unlikely to promote enrollment in plans with the kinds of benefits most policy makers agree low-income children should receive.<sup>53</sup>

This result is not surprising, since the President’s proposal appears to be aimed primarily at making high-deductible (non-group) coverage affordable for low-income, young, childless workers, who currently are least likely to be insured. But, while high-deductible coverage may be preferable to no coverage for low-income, childless workers, high out-of-pocket costs are known to deter low-income families from accessing preventive and primary care, which is critically important for their children’s health.

## ***Using Subsidies for Low-Income Populations for Health Coverage through Small Employers***

To make employment-based coverage affordable for whole-family coverage using a tax credit approach, the maximum credit amounts under the administration's health insurance tax credit proposal would have to be raised. The purpose would be to make the underlying percentage-credit structure effective and to cover a larger share of the premium. As noted earlier, the administration's proposal actually offers a very substantial tax credit (90% of the premium) for the lowest-income workers, reducing the size of the subsidy as the worker's family income increases. In the Bush administration's original proposal, however, the maximum dollar amounts for the health insurance tax credit are low compared to typical insurance premiums. Thus, as a practical matter, the administration's proposal specifies the subsidy in dollar terms.

For purposes of further illustration, we consider the effects of raising the maximum annual tax credit under the administration's proposal from \$1,000 per adult and \$500 per child (up to a maximum of two) to \$1,800 per adult and \$900 per child. (This kind of amendment might well result from serious congressional consideration of the administration's proposal. In addition, some adjustment of the credit amount by age might well be considered.<sup>54</sup>) These higher dollar caps would *not* limit the credit amounts under our lower-cost case, thus allowing the underlying percentage structure of the credit to determine the subsidy amount. The caps *would* limit the available credit amounts under the standard-cost case. With this modification, the resulting worker contributions, as a percentage of income, are shown in Table 8.

**Table 8: Post-Tax Worker Contributions for Employment-Based Coverage as a Percent of Income under a Modified Version of the Bush Administration's Health Insurance Tax Credit Proposal with Higher Maximum Tax Credit Amounts**

Coverage Tier	Premium Level*	Income (% FPL#)					
		75%†	125%	175%	225%	275%	400%
Worker only	Lower-cost	1.5%†	1.1%	1.1%	3.0%	3.5%	3.4%
	Standard	3.0%†	2.2%	2.1%	5.2%	6.1%	5.8%
Worker plus child(ren)	Lower-cost	3.0%	1.8%	1.7%	3.2%	4.2%	5.6%
	Standard	14.3%	8.6%	6.6%	7.4%	8.0%	8.7%
Full family	Lower-cost	4.1%	2.4%	4.7%	6.8%	8.2%	7.6%
	Standard	21.9%	13.2%	12.6%	13.3%	13.7%	11.6%

# FPL = federal poverty level.

\* For specification of standard and lower-cost premium levels, see Table 2. The maximum annual tax credit amounts applicable to this variant of the administration's proposal are \$1,800 per adult and \$900 per child (with a maximum of two children).

† The income level used to calculate contributions for worker-only coverage in the "<100% FPL" range was 91% FPL, rather than 75% FPL. At minimum wage, a worker working 30 hours per week (a likely minimum standard to qualify for employer coverage) would earn 91% of the federal poverty level.

SOURCE: IHPS analysis.

Increasing the maximum credit amount by \$800 per adult, while retaining all other parameters of the administration's tax credit proposal (except the prohibition against using it for employment-based coverage), produces worker-contribution requirements that appear to be generally affordable if lower-cost premiums are available. Worker contributions for worker-only coverage still seem relatively affordable even at standard premium rates, but coverage that includes children does not seem affordable at standard rates.

Unlike the income-based worker contribution approach, the tax credit approach produces worker contributions that are a greater percent of income for workers under the federal poverty level than for workers just above that level. Under the tax-credit approach, these workers pay the same percentage of premium (10%) and, therefore, the same dollar amount (in each coverage tier), which translates into a higher percentage of income for lower-income workers. But, as a practical matter, relatively few full-time workers have family incomes below the federal poverty level.

Imposing a maximum credit amount on top of a percentage-of-premium tax credit structure helps to control public outlays for subsidies and make public costs more predictable. But it leaves workers at risk for the full amount of any difference between the credit amount and the worker's share of the insurance premium. For example, if premiums are age-rated (as they are in the individual market and often are in the small-group market, including venues that offer workers a choice of competing health plans), then older workers would be considerably more disadvantaged than younger workers, unless the tax credit amount was adjusted by age as well.<sup>55</sup>

On the other hand, where plan choice is offered and a floor for benefits is established, it may well be seen as sensible to make workers bear the full additional cost if they choose a more expensive carrier or additional benefits. Also, a fixed-dollar subsidy amount maintains the greatest incentive for employers to increase their contributions, since their workers, not the government, will receive all the benefit of any employer contributions beyond the minimum required (at least until the worker contribution is reduced to the amount necessary to qualify for the maximum credit).

#### **D. A Hybrid Subsidy Approach: Combining Resources from Existing SCHIP and Medicaid Programs for Children with Tax Credits for Adults and Employer Contributions**

As mentioned earlier, a hybrid approach to public subsidies for employment-based coverage may be of particular interest to states. If the President's proposed tax credit proposal were modified to allow parents working for qualified small firms to use the tax credits for employment-based coverage, a state might be able to combine tax credits for adults purchasing employment-based coverage with employer contributions and premium assistance for the children under Medicaid or SCHIP to make employment-based family coverage affordable for low-wage, uninsured-small firm workers and their families.

Virtually all low-income children who are legal residents are now eligible for public coverage through Medicaid or SCHIP.<sup>56</sup> But, while several states have expanded public coverage of parents above the federal poverty level as well, most have not. And public coverage for working childless adults remains extremely rare. With most states now facing severe budget shortfalls, further expansion of traditional public coverage for adults seems highly unlikely in the near future. On the other hand, both Medicaid and SCHIP authorize the use of program funds to buy into employment-based

coverage on behalf of people eligible for those programs. This practice is referred to by the states as providing “premium assistance.”<sup>57</sup>

Meanwhile, the Bush administration’s proposal to provide tax credits to purchase health insurance remains on the table. As noted earlier (see Table 7), the maximum tax credits available under the administration’s proposal would not be sufficient to enable families to buy the more comprehensive coverage, including preventive and primary care, that is appropriate for low-income families with children. The administration’s proposal envisions that low-income working parents might choose to enroll their children in comprehensive coverage through Medicaid or SCHIP, while buying high-deductible individual coverage for themselves, using the tax credit. But children are more likely to receive needed care if they are enrolled in the same health plan as their parent(s). Parents will know better how to get care for their children if they are familiar with how the health plan works because they use it themselves. Available research documents that children are more likely to use care if their parents use care<sup>58</sup> and if their parents are insured.<sup>59</sup>

If the Bush administration’s health insurance tax credit proposal were modified to allow tax credits to be used toward purchase of employment-based coverage in certain circumstances (as discussed in the previous section), then it should be possible to combine federal tax credits for the working parent(s) with public-program premium assistance for the children to enable the family to pay the worker contribution required to enroll in the kind of work-based coverage approach under discussion. Under this hybrid approach:

- The employer would contribute \$50 per month per (participating) worker (as we have been suggesting).
- The state’s SCHIP and Medicaid programs would contribute the amount they normally would pay if the children in the family had been enrolled in public coverage.<sup>60</sup>
- The federal government would contribute the tax credit amount applicable to the parents alone (see Table 6), based on the family’s adjusted gross income and whether one or two parents are covered.<sup>61</sup>
- The worker would pay any remaining amount.

For purposes of illustrating this hybrid approach and comparing it to the other approaches, we assume that states pay about \$90 per month, on average, for public coverage of children under Medicaid or SCHIP, and that the average number of eligible children per family is two.<sup>62</sup> We also assume that the effective upper limit on SCHIP eligibility in most states is about 250% of the federal poverty level—after applying frequently used deductions from income—and that most states charge a premium of about \$25 per family to cover children above 150% of the federal poverty level.

Note that, for this alternative, we do *not* assume any increase in the maximum credit amount. Also, where children are eligible for public-program premium assistance, the tax credit is limited by the number of adults covered.<sup>63</sup>

With these assumptions, the worker contributions this hybrid approach would require are shown, as a percentage of income, in Table 9, for both illustrative premium levels.

## ***Using Subsidies for Low-Income Populations for Health Coverage through Small Employers***

Worker contributions for worker-only coverage under the hybrid approach are identical to worker contributions under the Bush administration's health insurance tax credit proposal, because no children are involved.

**Table 9: Post-Tax Worker Contributions as a Percent of Income under the Hybrid Subsidy Approach\***

Coverage Tier	Premium Level**	Income (% FPL #)					
		75%†	125%	175%	225%	275%	400%
Worker only	Lower-cost	2.5%†	1.8%	1.6%	3.2%	3.6%	3.4%
	Standard	12.9%†	9.4%	7.0%	7.4%	7.1%	5.8%
Worker plus child(ren)	Lower-cost	1.8%	1.1%	2.0%	2.2%	5.5%	5.6%
	Standard	18.2%	10.9%	9.1%	7.7%	10.0%	8.7%
Full family	Lower-cost	10.0%	6.0%	6.4%	6.3%	9.3%	7.6%
	Standard	31.1%	18.6%	15.5%	13.3%	15.1%	11.6%

\* The hybrid subsidy approach would combine tax credits for employment-based coverage for low-income adults with premium assistance for low-income children under Medicaid and SCHIP to broaden coverage for low-income families and their children.

# FPL = federal poverty level.

\*\* For specification of standard and lower cost premium levels, see Table 2.

† The income level used to calculate contributions for worker-only coverage in the "<100% FPL" range was 91% FPL, rather than 75% FPL. At minimum wage, a worker working 30 hours per week (a likely minimum standard to qualify for employer coverage) would earn 91% of the FPL.

SOURCE: IHPS analysis.

For single-parent families, given our \$90-per-child assumption about current Medicaid/SCHIP program costs, the hybrid approach produces relatively affordable worker contributions if lower-cost coverage is available, but not if it is not. (The jump in worker contribution amount for the 250% to 299%-of-poverty category is due to our assumption that children in these families would *not* be eligible for a contribution from Medicaid/SCHIP because they are not typically eligible for public coverage. However, the family would qualify for a larger tax credit, because the children would be included in that calculation.)

For full-family coverage under the lower-cost option, the hybrid approach would cost workers less than the tax-credit approach using the administration's proposed maximums, but more than the tax-credit approach using higher maximums. Whether the lower-cost coverage is affordable is doubtful, particularly for families below the federal poverty level. Workers in this situation would be likely to elect worker-plus-children coverage, leaving the spouse uncovered. At standard-cost levels, full-family coverage appears clearly unaffordable.

If the Bush administration's tax credit proposal were to be enacted with the higher maximum credit amounts suggested in the previous section, then lower-cost coverage would become affordable for entire families (i.e., including workers' spouses as well as children), and standard coverage would become somewhat less expensive for workers with children than under the tax-credit approach using higher maximums alone. The reason for this result is simple: under the hybrid approach, the assumed \$90-per-month Medicaid/SCHIP contribution per child is greater than the \$75-per-month tax credit per child under the higher-cap tax-credit approach.

### **E. Comparing Total Costs of Alternative Approaches by Funding Source**

A sophisticated comparison of likely total costs under alternative subsidy approaches would require a simulation model incorporating behavioral assumptions, because the extent of participation by workers will vary depending on a number of factors, including but not limited to their out-of-pocket premium contribution. In addition, the range of behavioral assumptions suggested by knowledgeable researchers varies widely.<sup>64</sup> For this and other reasons, a sophisticated simulation model is beyond the scope of this effort.

To provide some sense of the relative costs of subsidizing work-based coverage for low-income, small-firm workers and their families under the three alternative subsidy approaches presented above, however, we built a simple spreadsheet model. Our simple model calculates the costs of covering 10,000 subsidy recipients (both workers and their dependents) with a range of incomes and family structures typical of workers in low-wage, non-offering firms. The model uses the oversimplified assumption that the participation rate of workers by income and by family type (coverage tier) would be the same under all three alternatives. With this assumption, the results for the lower-cost health plan case are shown in Table 10a and for the standard-cost health plan case in Table 10b. As noted previously, the premium in the lower-cost plan reflects current market rates for the lowest-cost HMO coverage available to young workers in low-cost areas; the premium in the standard-cost plan reflects typical premiums nationally for employer-sponsored, HMO-style coverage in 2002. (For specification of standard and lower-cost premiums, see Table 2 or Appendix B.)

**Table 10a: Lower-Cost Health Plan Case\*: Illustrative Annual Costs of Covering 10,000 Subsidized Workers and Dependents through Alternative Subsidy Approaches\*\***

<b>(Dollar amounts shown in millions)</b>	<b>Income-Based Worker Contribution Approach</b>	<b>Higher-Cap Tax Credit Approach</b>	<b>Hybrid Approach (Bush Tax Credit for Adults Plus Medicaid/SCHIP Premium Assistance for Children)</b>
<b>TOTAL PREMIUM</b>	<b>\$15.8</b>	<b>\$15.8</b>	<b>\$15.8</b>
<b>Employer Payment (Net):<sup>a</sup></b>	<b>\$2.7<sup>a</sup></b>	<b>\$3.0</b>	<b>\$3.0</b>
<b>Worker Payment (Net of Tax Savings):<sup>a</sup></b>	<b>\$2.7<sup>a</sup></b>	<b>\$2.9</b>	<b>\$3.8</b>
Federal tax contribution: <sup>a</sup>	\$1.0 <sup>a</sup>	\$9.9	\$5.3
Federal Medicaid/SCHIP contribution: <sup>b</sup>	b	\$0	\$2.2 <sup>b,c</sup>
State Medicaid/SCHIP contribution: <sup>b</sup>	b	\$0	\$1.5 <sup>b,c</sup>
Public-program subsidy required (federal share) <sup>b,c</sup>	\$4.6 <sup>b,c</sup>	N/A	N/A
Public-program subsidy required (state share) <sup>b,c</sup>	\$4.8 <sup>b,c</sup>	N/A	N/A
<b>Total Public Contribution</b>	<b>\$10.4</b>	<b>\$9.9</b>	<b>\$9.0</b>

\* The premium in the lower-cost health plan case reflects current market rates for the lowest-cost HMO coverage available to young workers in low-cost areas. For specification of standard and lower-cost premiums, see Table 2 or Appendix B.

\*\*See notes at the end of Table 10b.

**Table 10b: Standard-Cost Health Plan Case\*: Illustrative Annual Costs of Covering 10,000 Subsidized Workers and Dependents through Alternative Subsidy Approaches**

(Dollar amounts shown in millions)	Income-Based Worker Contribution Approach	Higher-Cap Tax Credit Approach	Hybrid Approach (Bush Tax Credit for Adults Plus Medicaid/SCHIP Premium Assistance for Children)
<b>TOTAL PREMIUM</b>	<b>\$23.1</b>	<b>\$23.1</b>	<b>\$23.1</b>
<b>Employer Payment (Net)<sup>a</sup></b>	<b>\$2.7<sup>a</sup></b>	<b>\$3.0</b>	<b>\$3.0</b>
<b>Worker Payment (Net of Tax Savings)<sup>a</sup></b>	<b>\$2.8<sup>a</sup></b>	<b>\$7.6</b>	<b>\$11.1</b>
Federal tax contribution <sup>a</sup>	\$1.0 <sup>a</sup>	\$12.5	\$5.3
Federal Medicaid/SCHIP contribution <sup>b</sup>	b	\$0	\$2.2 <sup>b,c</sup>
State Medicaid/SCHIP contribution <sup>b</sup>	b	\$0	\$1.5 <sup>b,c</sup>
Public-program subsidy required (federal share) <sup>b,c</sup>	\$7.5 <sup>b,c</sup>	N/A	N/A
Public-program subsidy required (state share) <sup>b,c</sup>	\$9.1 <sup>b,c</sup>	N/A	N/A
<b>Total Public Contribution</b>	<b>\$17.6</b>	<b>\$12.5</b>	<b>\$9.0</b>

\* The premium in the standard-cost health plan case reflects typical premiums nationally for employer-sponsored HMO-style coverage in 2002. For specification of standard and lower cost premiums, see Table 2 or Appendix B.

*Notes:* Results include costs for only for subsidized workers and dependents. Non-subsidized workers and dependents could also participate. For a description of the alternative subsidy approaches, see text.

- (a) Under the “income-based worker contribution” approach, employer and worker contributions are shown net of the FICA and income-tax savings that would accrue from using a premium-only plan (POP) for health insurance contributions, under current tax law. (Under the other approaches, current health-insurance tax advantages for workers are replaced completely by tax credits.)
- (b) Some portion of the “public subsidy required” represents current public-program spending, particularly for Medicaid and SCHIP coverage of children in working families. Under the “income-based worker contribution” model, how much of the necessary subsidy might be derived from existing program spending cannot be determined precisely. The hybrid approach specifically uses existing Medicaid/SCHIP program funds available for eligible children. In either case, the cost of these subsidies typically would be shared between the state and federal governments under a matching formula. See note (c).
- (c) As a conservative approximation, the federal share is assumed to be 0% for subsidies to childless workers, 50% for parents and children under the federal poverty level, and 65% for parents and children above the federal poverty level.

SOURCE: IHPS analysis.

## **IV. Summary and Conclusion**

This report describes how public subsidies targeted to low-income workers and families—including both public-program subsidies and tax credits—might allow applications that broaden employment-based coverage for low-income workers and their families. The approach outlined in this report could work with a variety of subsidy mechanisms as a cost-effective way to make job-based enrollment and coverage work for more Americans. And by increasing total employer plus subsidy contributions while reducing the risk that such subsidies might precipitate cascading erosion in employment-based coverage, the approach could maximize the number of uninsured persons covered.

**Modest Contribution Requirements for Qualifying Small Employers.** A key observation of this report is that, by allowing employer contributions that are much less than those normally required in the regular commercial market, any public subsidies that are now or may become available for low-income workers and families could be more effective in expanding health insurance coverage if they were used to encourage small employers with largely low-wage workforces to offer and partially fund health coverage for their workers. To obtain broad participation of such employers in offering coverage for workers, it is important to bear in mind the following points:

- First, local pilot program experience indicates that many small employers with mostly low-wage workers will offer health insurance if they feel the amount they are required to contribute is affordable and predictable and will remain so over time; if their contribution reduces the costs their workers face; if their workers can afford what they are asked to contribute; and if the coverage source is reliable and sustainable and minimizes the employer's administrative burden.

Based in part on local pilot program experience, we suggest that such employers be required to contribute a flat \$50 per covered worker per month, regardless of the worker's age, the plan the worker selects, or whether dependents are covered.

- Second, employers will be more willing to participate if they can offer coverage to their entire employee group, both those who are eligible for subsidies and those who are not. This also will mean that workers can maintain their coverage source and provider relationships if their subsidy status changes due to increased or decreased earnings at that job.

**Sliding-Scale Public Subsidies for Coverage: Important Considerations.** A major question about alternative subsidy approaches is the trade-off between affordability for workers and families and cost to the government. If public subsidies for health insurance coverage for low-income workers and families are not large enough, the intended beneficiaries will not participate; yet, one must keep in mind that the larger the subsidies, the greater the costs to taxpayers.

The public subsidy level can be adjusted under any of the general approaches discussed in this paper, but the following dilemma still pertains:

- Public subsidy approaches that limit worker contributions to a relatively small percentage of income focus primarily on the affordability issue and, thus, are more likely to cover a significant number of uninsured low-income workers and families. Such approaches are expensive, however, and become more so as premiums for employment-based coverage rise. To counteract their inflationary tendencies, it will be important to assure that purchasers—whether individual employers or larger pools—have incentives to keep premiums as low as possible. Furthermore, approaches that require percent-of-income worker contributions are administratively cumbersome, because the subsidy amount required varies, depending on the plan chosen by the worker, and may require an experienced administrative agent to implement.

**“[We’ve] started to look at this kind of approach [subsidizing low-income workers in small firms] as an alternative way of dealing with what seems to be a tremendous demand on the state to maintain high levels of coverage.... We are proposing, basically, to move toward a subsidy program. Under an 1115 waiver ... we’re looking at starting an employer subsidy program that would initially be limited in terms of slots, because money is a concern ... initially to somewhere between 3,000 and 5,000 slots, based on an appropriation.”**

—David Parrella,  
*Connecticut Department of Social Services*

- Public subsidy approaches that limit the dollar amount of subsidy available to any particular worker and family limit government’s liability and are easier to administer than approaches that limit worker contributions to a percent of income. The drawback of these approaches, however, is that they are more likely to require worker contributions that are too high to be affordable, particularly as premiums rise, and, therefore, deter worker participation. Even if the health insurance tax credits under the Bush administration’s proposal were applicable toward employment-based coverage at certain small firms, as we propose, the credit amounts would be too small to make even lower-cost coverage affordable for most low-income working families with children. A tax-credit approach could be made affordable for working families, however, if the maximum credit amounts were increased.

**Possible Option for States: A Hybrid Subsidy Approach.** A hybrid approach to public subsidies for employment-based coverage may be of particular interest to states. If the President’s proposed tax-credit proposal were modified to allow parents working for qualified small firms to use the tax credits for employment-based coverage, a state might be able to combine tax credits for adults purchasing employment-based coverage with premium assistance for children under Medicaid or SCHIP to make employment-based family coverage affordable for low-wage, uninsured, small-firm workers and their families.

**Administrative Mechanisms for Combining Contributions from Multiple Sources.**

Applying any form of broad-scale public subsidy toward employment-based coverage for low-income workers presents important operational and administrative challenges. It requires the ability to combine contributions from multiple sources on behalf of a single worker and family and direct those funds to the worker's chosen health plan. Examples of organizations with such capabilities include consumer-choice purchasing pools like those now operating in several states, a clearinghouse and service bureau with functions similar to those described by Etheredge,<sup>65</sup> or a service-bureau adjunct to a state or federal employee health benefits program.

## **Appendix A: Pilot Programs that Offer Subsidies for Small-Firm Employment-Based Coverage**

### **A. The FOCUS Program in San Diego, California**

The FOCUS (Financially Obtainable Coverage for Uninsured San Diegans) program,<sup>66</sup> run by Sharp Health Plan, is a pilot program that offers heavily subsidized coverage to about 2,000 workers and dependents through previously uninsured small employers in San Diego County.<sup>67</sup> (Sharp Health Plan is a provider-system-based HMO that serves about 100,000 commercial, Medi-Cal [Medicaid] and Healthy Families [State Health Children's Insurance Program, SCHIP] enrollees.) Employers participating in FOCUS pay a flat dollar amount per month per worker that varies only by the coverage tier the worker selects, ranging from \$29.15 per month for worker-only coverage to \$58.44 per month for full-family coverage.<sup>68</sup> Employees and their families are eligible for coverage if they are uninsured and have family incomes below 300% of the federal poverty level. (Higher-income workers are not eligible for the program at all.) Employees pay premiums on a sliding scale, ranging from 1% to 4% of their monthly household income.

The difference between employer and employee contributions and the full cost of the plan is subsidized by a combination of foundation funds,<sup>69</sup> provider concessions on payment rates,<sup>70</sup> and donation of administrative services by Sharp Health Plan.<sup>71</sup> As of March 2000, foundation monies covered approximately 53% of the reduced premium cost,<sup>72</sup> with the remaining 47% coming from employer and employee contributions. The \$29.15-per-month employer contribution for worker-only coverage represents only slightly more than 20% of the estimated total premium. (To obtain group coverage in the regular commercial market, employers typically must pay at least 50% of the worker-only premium.)

The FOCUS program offers a rich commercial benefit design, including physician office visits for a \$5 copay, 100% hospitalization coverage, outpatient prescription drugs, and mental health coverage. The major coverage exclusions, relative to Sharp's regular commercial plans, are inpatient treatment for mental health and chemical dependency and aggressive treatment of infertility. The plan contracts with three Sharp-affiliated provider groups, an array of individual physicians, and 10 hospitals throughout San Diego County.

The project proved to be very attractive to small employers and had no difficulty in filling its 2,000 available subsidy slots. Despite a waiting list, enrollment had to be closed due to limited grant funds. (Coverage for in-force FOCUS companies continues for two years following a company's original effective date, and any new employees and/or new dependents have the opportunity to enroll during this period.)

Participating businesses are very small and have a high percentage of low-wage earners—80% have six or fewer full-time employees, and 60% of FOCUS-covered workers earn less than \$10 per hour. About 56% of full-time employees in FOCUS companies are enrolled in the program. (Many of the remaining employees have coverage from other sources, although some are either uninterested or have incomes too high to qualify for FOCUS.) Even before joining FOCUS, the businesses did not experience high turnover, and this has not changed.

Because additional grants or public funds have not been found to continue the FOCUS project, the earliest-enrolled companies began aging out of the subsidy program in April 2002. Sharp Health Plan is offering modest premium concessions in an effort to encourage them to maintain coverage, but workers will no longer be subsidized and will have to pay from 50% of the worker-only premium, up to 68% of the full-family premium.

## **B. The Access Health Project in Muskegon, Michigan**

Access Health of Muskegon offers community-based, affordable health coverage for about 1,300 uninsured working individuals and family members through about 330 small businesses.<sup>73</sup> Initiated by county government, the program is set up as an independent non-profit, tax-exempt (501[c][3]) organization and contracts directly with providers in the county, including two health systems and more than 200 physicians—97% of all providers in Muskegon County participate in the plan.

Businesses are eligible to participate if they are located in Muskegon County, have a median wage of \$10 per hour or less, and have not offered health insurance for the previous 12 months. The program is available to full- and part-time employees and dependents who do not have other health insurance coverage. (Individuals with pre-existing conditions are not excluded from coverage nor do they pay a different rate.)

Businesses, providers, and consumers worked together to develop Access Health's basic benefit plan, a relatively rich, mainstream plan that includes local physician services, inpatient hospitalization, outpatient services, ambulance, prescription drugs (formulary), diagnostic lab and x-rays, home health, hospice care, and behavioral health. Copayments are typically low (\$5 for a primary care visit, \$20 for a specialist) and structured to encourage primary care and wellness. Care provided outside Muskegon County is not covered (and tertiary hospital care is not available within the county). Claims processing is provided by two third-party administrators on a discounted basis.

Unlike the FOCUS experience in San Diego, high employee turnover is an important reason businesses are interested in offering health coverage. In a survey undertaken to inform the design of the program, small, low-wage businesses complained that churning of their workforce was costing them a lot of money. Uninsured businesses were found to be very small—most had 10 or fewer employees—and they were not members of the Chamber of Commerce (which offers insurance coverage through Blue Cross Blue Shield). Businesses in this niche also indicated they were willing to pay up to \$50 per worker per month for health insurance. Similarly, surveys of uninsured workers (mostly women under age 40 with children) showed that these workers could not afford to pay more than \$50 per month.

This survey information led to a three-share approach to financing the program. Employers, employees, and the community each cover a portion of the cost. The employer and employee each pay \$42 per month for coverage of an adult and \$22 per month for coverage of a child—a bit over 30% (each) of the total cost. The remaining approximately 40% of the cost is covered by the community. (Families with eligible children are encouraged to enroll them in the MICHild [SCHIP] program.) The community match portion of Access Health is a combination of federal, state, and local funds. All federal funding comes through Michigan's disproportionate-share hospital (DSH) allocation for the two local hospital systems.

## ***Using Subsidies for Low-Income Populations for Health Coverage through Small Employers***

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Within the niche of small, low-wage businesses that traditionally have not offered coverage, interest in the Access Health program has been very strong. There has also been considerable interest among larger businesses with classifications of employees who had never been eligible for coverage, such as part-timers. An important component of this success is that the coverage program “looks commercial.” Many participating businesses, while needing help, were not at all interested in being part of a government program. But “looking commercial” also costs more. The project’s major problem is that it has always been undercapitalized—DSH money for subsidies only goes so far.

## **Appendix B: Premium Levels Used for Illustrative Comparisons**

In comparing who pays how much under the alternative subsidy approaches discussed in this paper, we decided to examine two illustrative cases: a *standard-cost case* and a *lower-cost case*.

- **Standard-cost case.** The standard case is based on the actual employer-market national average premium for HMO-style, worker-only coverage, which is about \$230 per month in 2002 for firms of all sizes and about \$234 per month for firms with three to 199 workers.<sup>74</sup> However, we assume that newly insured workers will be somewhat less expensive than currently insured workers and will, therefore cost, on average, about 5%-6% less than current market rates, i.e., \$220 per month rather than \$230 or \$234 per month.
- **Lower-cost case.** Our lower-cost case assumes worker-only premiums that are about one-third less expensive than standard case premiums, or \$150 per month. These lower rates can be thought of as representing current market rates for the lowest-cost HMO coverage available to young workers<sup>75</sup> (on the assumption that most uninsured workers are relatively young<sup>76</sup>) in a low-cost geographic area (or, alternatively, as reflecting rates for PPO coverage with higher cost-sharing amounts than are typically used now).<sup>77</sup>

For each illustration, we assume that separate premiums are quoted for worker-only coverage, worker-plus (any number of)-children, and full-family coverage (worker plus spouse and any number of children).<sup>78</sup> The premiums for the two illustrative cases are shown in Table B-1 (which is identical to Table 2). Under this tier structure, premiums for full-family coverage are considerably higher, and premiums for worker plus children are somewhat lower, than they would be under the two-tier structure (single, family) used by some employer groups.

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**Table B-1: Total Monthly Premium Amounts Used in Illustrations**

<b>Coverage Tier</b>	<b>Standard Case</b>	<b>Lower-Cost Case</b>
Worker only:	\$220	\$150
Worker plus children:	\$484	\$330
Worker plus spouse and children:	\$748	\$510

SOURCE: IHPS analysis; see text for discussion.

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To check the reasonableness of these illustrative estimates, we compared them with the cost of coverage available through two currently operating purchasing pools that offer small-firm workers a choice among carriers and benefit options: (1) the Connecticut Business and Industry Association's "Health Connections" program, and (2) the Pacific Business Group on Health's PacAdvantage program (in California). Current premium rates were available on the Internet for both programs.<sup>79</sup> Our illustrative premiums for the "standard" case, by coverage tier, fall within the range of premiums for "HMO Standard" coverage (\$20 copayment) for workers age 30-39<sup>80</sup> for new coverage becoming effective in Hartford, Connecticut, in the last quarter of 2002. Our illustrative premiums for the "lower-cost" case represent approximately the lowest-cost "HMO Standard" coverage (\$30 copayment) for workers under age 30 for new coverage becoming effective in Orange

County, California, in the second half of 2002. (Note also that Connecticut is among the highest-cost states for health insurance, while premiums in California are below national average rates.)

## NOTES

- <sup>1</sup> Rick Curtis and Ed Neuschler, *Tax Credits for Individual Health Insurance: Effects on Employer Coverage and Refinements to Improve Overall Coverage Rates*, an Occasional Paper for the Covering America Project, Washington, DC: Economic and Social Research Institute, August 2002.
- <sup>2</sup> Institute for Health Policy Solutions, *Individual Tax Credits and Employer Coverage: Assessing and Reducing the Downside Risks* (based on an Expert Forum), Washington, DC: August 2002.
- <sup>3</sup> Institute for Health Policy Solutions, *Effective Coverage Expansions for Uninsured Kids and Their Working Parents: Links to Job-Based Coverage*, transcript of a policy conference on coordinating with employment-based health coverage to cover uninsured working families held in Washington, DC: May 18, 2001. (Available at [www.ihps.org](http://www.ihps.org).)
- <sup>4</sup> Kaiser Commission on Medicaid and the Uninsured, *Health Insurance Coverage in America: 2002 Data Update*, February 2002. Table 7. (Based on analysis of data from the March 2001 Current Population Survey by the Urban Institute.) We reference 250% of poverty here, rather than 200%, for two reasons. First, public programs in many states apply disregards or deductions from income that raise the effective income eligibility standard above its nominal (often 200% of poverty) level. Second, under the Bush administration's health-insurance tax credit proposal, significant subsidies would be available to people with incomes above 200% of poverty.
- <sup>5</sup> Even among working families (those with at least one worker who is not self-employed), about two-thirds of the uninsured do not have access to employer-sponsored insurance (author's calculations are based on data presented in Bradley C. Strunk and James D. Reschovsky, "Working Families' Health Insurance Coverage, 1997-2001," Tracking Report No. 4 from the Community Tracking Study, Washington, DC: Center for Studying Health System Change, August 2002). (Accessed from <http://www.hschange.org/CONTENT/463/>.)
- <sup>6</sup> Kaiser Commission on Medicaid and the Uninsured, *Health Insurance Coverage in America*, tables 7 and 8. Even among the uninsured with incomes below 200% of poverty, 60% live in a family with a full-time worker. If the comparison were limited to low-income families above poverty, the percentage of uninsured living in full-time working families would no doubt be even higher.
- <sup>7</sup> One exception is S. 590, sponsored by Senators Jeffords, Breaux, et al. Under it, workers who enrolled in an employer-sponsored plan could qualify for a credit equal to 40% of the credit that would be available if they purchased insurance on their own. Also, when expanding public coverage above traditional welfare levels, especially for adults, a number of states have sought to make use of available employer coverage, through premium assistance, wherever possible.
- <sup>8</sup> See, for example, the Health Insurance Association of America's "InsureUSA" plan at [www.insureusa.org](http://www.insureusa.org).
- <sup>9</sup> James D. Reschovsky and Jack Hadley, "Employer Health Insurance Premium Subsidies Unlikely to Enhance Coverage Significantly," Issue Brief No. 46, Center for Studying Health System Change, December 2001.
- <sup>10</sup> For a discussion of this risk as it pertains to health insurance tax credit proposals, see Curtis and Neuschler, *Tax Credits for Individual Health Insurance*, and Institute for Health Policy Solutions, *Individual Tax Credits and Employer Coverage*.

**Notes (cont'd)**

- <sup>11</sup> Kaiser Commission on Medicaid and the Uninsured, *Health Insurance Coverage in America*, Table 7 (as to total population) and author's calculations derived from Table 1 (as to population with employment-based coverage).
- <sup>12</sup> Institute for Health Policy Solutions, *Individual Tax Credits and Employer Coverage*.
- <sup>13</sup> Urban Institute analysis of data from the March 2001 Current Population Survey, as presented in Kaiser Commission on Medicaid and the Uninsured, *Health Insurance Coverage in America: 2002 Data Update*, February 2002, Table 1.
- <sup>14</sup> Estimates of this potential effect vary widely. Despite considerable published research on the price elasticity of demand for health insurance, the probable effects of large changes in out-of-pocket premiums are not well understood. Knowledgeable experts generally concur that there is a high degree of uncertainty associated with such estimates. See, for example, the discussion in *Individual Tax Credits and Employer Coverage: Assessing and Reducing the Downside Risks* (based on an Expert Forum), Washington, DC: Institute for Health Policy Solutions, August 2002.
- <sup>15</sup> Almost 70% of uninsured workers in the February 1997 Contingent Worker Supplement to the Current Population Survey worked for a firm that did not offer health benefits (Kenneth E. Thorpe and Curtis S. Florence, "Why Are Workers Uninsured? Employer-Sponsored Health Insurance in 1997," *Health Affairs* 18:2 (March/April 1999): 213-18. (Exhibit 1 shows that 14.1 million of 20.3 million uninsured workers worked for firms that did not offer insurance. These figures include the self-employed, independent contractors, and "alternative workers" of various sorts. If the comparison is limited to "traditional" workers, the proportion of the uninsured who work for non-offering firms falls to about 63%.) Unpublished tabulations from the 1996-97 Community Tracking Survey by the Center for Studying Health Systems Change show that almost 60% of uninsured working adults either were self-employed or worked for a non-offering firm. If the self-employed are excluded, the percentage of uninsured who worked for non-offering firms falls to just under half. (Thorpe's analysis included workers ages 16-18, while the tabulations from the Community Tracking Survey did not.) In California, in 2001, 61.6% of uninsured employees ages 18-64 worked for a firm that did not offer health insurance. E. Richard Brown et al., *The State of Health Insurance in California: Findings from the 2002 California Health Interview Survey*, UCLA Center for Health Policy Research, June 2002, Exhibit 18.
- <sup>16</sup> Author's analysis based on data from the U.S. Agency for Healthcare Research and Quality, *Employer-Sponsored Health Insurance Data. Private-Sector Data by Firm Size, Industry Group, Ownership, Age of Firm, and Other Characteristics* (various years), Rockville, MD: September 2002 ([http://www.meps.ahrq.gov/data\\_pub/ic\\_tables.htm](http://www.meps.ahrq.gov/data_pub/ic_tables.htm)).
- <sup>17</sup> For a discussion of the importance of having all family members covered, see the Institute of Medicine's recent report, *Health Insurance Is a Family Matter*, Washington, DC: September 2002.
- <sup>18</sup> Premium collection can be a difficult task for public programs. For example, states are permitted to charge modest-income families premiums to enroll their children in State Children's Health Insurance Programs (SCHIPs). A recent seven-state study of families whose SCHIP coverage lapsed (i.e., the children were dropped from the program even though they appeared to still be eligible) found that 41% of the families were dropped for failure to pay premiums. And, although most of these said they did not pay the premium when it was due for financial reasons, one-third said they simply forgot or did not get around to making the payment or they did pay but their payment was not received or properly recorded by the state. See Michael Perry et al., *Why Eligible Children Lose or Leave SCHIP: Findings from a comprehensive study of retention and disenrollment*, National Academy for State Health Policy, February 2002. Table 4.

**Notes (cont'd)**

- <sup>19</sup> For a business to qualify for participation in Access Health or HealthChoice, at least half of its workers must earn \$10 per hour or less. Note, however, that while their employer contribution requirements are similar to those under FOCUS, the Michigan county programs do not target subsidies specifically to the low-income workers in the firm. Instead, all workers in the firm benefit from the subsidies if most of the firm's workers earn low wages.
- <sup>20</sup> Access Health has enrolled about 1,300 members in more than 300 businesses; see Appendix A. Information on enrollment in Wayne County's HealthChoice program (22,000) obtained from the 2000 Annual Report of the Wayne County Department of Public Health, available at <http://www.waynecounty.com/hcs/phealth/annual.htm>.
- <sup>21</sup> Current premium information for HealthChoice obtained from <http://www.waynecounty.com/hcs/healthchoice.htm>.
- <sup>22</sup> But employers would pay \$75 per month per worker—substantially more than the local pilots—and workers would pay up to \$35 per month, depending on income. Coverage would be available for spouses but not for children, so family members might not all be covered through the same health plan. Workers' children would continue to be eligible for coverage through New Mexico's regular Medicaid and SCHIP programs. Adults without an employer also could participate, but they must pay the \$75 employer contribution themselves. Implementation is planned for early 2003.
- <sup>23</sup> Lisa Rapaport, "Health help for workers: County program to assist small firms," *Sacramento Bee*, October 30, 2002. (Accessed from <http://www.sacbee.com/content/business>.)
- <sup>24</sup> David Parrella of Connecticut and Bob DiPrete of Oregon discussed these plans at the May 3, 2002, roundtable. Many of the basic concepts involved here also were discussed at an IHPS roundtable in May 2000 and at a policy conference co-sponsored by IHPS and the National Governors' Association in May 2001.
- <sup>25</sup> Insurers usually require that employers contribute a minimum of 50% of the worker-only premium under a group plan. But, because insurers also will not issue a group policy unless a significant percentage of all the workers in a small business participate, and because low-income workers often will not participate if they have to pay more than a token amount out of their paycheck, small businesses with many low-wage workers often have to pay the entire worker-only premium to maintain a group plan. In 1998, 56% of all small-firm workers eligible for employer coverage had access to at least one plan for which their employer would pay the entire premium, compared to 26% of eligible workers in larger firms. (In this analysis, small firms have 50 or fewer employees.) (Unpublished tabulations of the 1998 Medical Expenditure Panel Survey—Insurance Component prepared by the U.S. Agency for Healthcare Research and Quality for a consortium of states organized by IHPS.) The need for a very significant employer contribution to establish a group plan, and the apparent preference of low-wage workers for cash compensation, are two reasons very few small, low-wage employers offer health coverage.
- <sup>26</sup> In 2002, the national average worker-only premium was \$3,060 annually (Kaiser Family Foundation and Health Research and Educational Trust, *Employer Health Benefits: 2002 Annual Survey*. Exhibits A and 1.13). The minimum employer contribution, at 50% would then be \$1,530. Total annual earnings for a minimum-wage (\$5.15 per hour) worker working 40 hours per week for 52 weeks would be \$10,712. Dividing \$1,530 by \$10,712 yields 0.143 or 14.3%. In California, where the minimum wage is \$6.75 per hour, this figure becomes 10.9% (\$1,530/\$14,040).
- <sup>27</sup> U.S. Department of Labor, Bureau of Labor Statistics, *Employer Costs for Employee Compensation, 1986-99* (Bulletin 2526), March 2000, Table 5. Wages and salaries represent 73.0% of total compensation for all

**Notes (cont'd)**

- workers in private industry, while health insurance costs represent 5.4% of total compensation ( $5.4/73.0 = 7.4\%$ ).
- <sup>28</sup> This was an observation by Dr. Len Nichols, Vice President of the Center for Studying Health System Change. More precisely, Dr. Nichols's observation pertains to the smallest firms (those with fewer than 10 employees) *with a majority of low-wage workers*—those earning less than \$6.50 per hour—in 1999. About 39% of all businesses with fewer than 10 workers offered health coverage to their workers that year (U.S. Agency for Healthcare Research and Quality, *1999 Employer-Sponsored Health Insurance Data. Private-Sector Data by Firm Size, Industry Group, Ownership, Age of Firm, and Other Characteristics*, Rockville, MD: July 2002, Table I.A.2. [<http://www.meps.ahrq.gov/mepsdata/ic/1999/index199.html>]). (In 2000, using an updated definition of “low-wage” business—those with a majority of workers earning less than \$9.50 per hour—25% of the smallest low-wage firms offered health coverage to their workers; see Table 1 in the text.)
- <sup>29</sup> James D. Reschovsky and Jack Hadley, “Employer Health Insurance Premium Subsidies Unlikely to Enhance Coverage Significantly,” Issue Brief No. 46, Center for Studying Health System Change, December 2001.
- <sup>30</sup> Common sense suggests that parents will know better how to get care for their children if they are familiar with how the health plan works because they use it themselves. Available research documents that children are more likely to use care if their parents use care. And the effect is even stronger if both parent and child are insured; see Karla Hanson, “Is Insurance for Children Enough? The Link Between Parents’ and Children’s Health Care Revisited.” *Inquiry* 35:294-302 (Fall 1998). Children are also more likely to use care if their parents are insured. Low-income insured children whose parents were also insured were more likely to have received a well-child visit in 1999 (69.8%) than were low-income insured children whose parents were not insured (65.4%) (Lisa Dubay, Ian Hill, Genevieve Kenney, Jennifer Haley, and Harold Leibovitz, *Highlights from The Urban Institute’s SCHIP Evaluation* (slide presentation), Washington, DC: The Urban Institute; accessed October 1, 2002, from [http://www.urban.org/Presentations/ANF\\_SCHIP\\_eval/SCHIPeval\\_files/frame.htm](http://www.urban.org/Presentations/ANF_SCHIP_eval/SCHIPeval_files/frame.htm)).
- <sup>31</sup> This situation arises in states that operate separate Medicaid and SCHIP programs while maintaining “stair-step” Medicaid eligibility rules under which younger children (under age one and/or under age six) qualify for Medicaid at higher family incomes than do older children.
- <sup>32</sup> Department of the Treasury, “General Explanations of the Administration’s Fiscal Year 2003 Revenue Proposals,” February 2002.
- <sup>33</sup> For a discussion of the importance of having all family members covered, see the Institute of Medicine’s recent report, *Health insurance Is a Family Matter*, Washington, DC, September 2002.
- <sup>34</sup> In 2002, 93% of employers with fewer than 200 workers offered only one health plan (Kaiser Family Foundation and Health Research and Educational Trust, *Employer Health Benefits: 2002 Annual Survey*, Exhibit 4.2).
- <sup>35</sup> Lynn Etheredge, “How to Administer Health Insurance Tax Credits for Working Families,” Heritage Foundation *Backgrounder* No. 1516, January 31, 2002.
- <sup>36</sup> In 1997, 21% of workers in firms with fewer than 10 employees worked for a firm that had offered coverage in 1995 but no longer offered coverage in 1997 (Stephen H. Long and M. Susan Marquis, “Stability and Variation in Employment-Based Health Insurance Coverage, 1993-1997,” *Health Affairs* 18:6 (November/December 1999), Exhibit 3). In later published research based on the same 1997 Robert Wood Johnson Foundation Employer Health Insurance Survey, Long and Marquis also found that workers in low-wage businesses (in which two-thirds of workers earned less than \$7 per hour in 1997) “confront much greater turnover in the offer of insurance than other workers” (S.H. Long and M.S.

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Marquis, "Low Wage Workers and Health Insurance Coverage: Can Policymakers Target Them Through Their Employers?" *Inquiry* 38:3 (Fall 2001): 331-7).

- <sup>37</sup> Very small, low-wage businesses that offer health coverage do so, no doubt, because the workers value health coverage highly and have asked their employer to offer it. (Most low-wage workers tend to prefer cash wages over employee benefits.) And, because the employer offers and contributes toward health coverage, the workers' wages are lower than they otherwise would be. Because of the direct trade-off between wages and benefits, it would probably be wise, when defining "firms with mostly low-wage workforces," to use total worker compensation (i.e., wages plus benefits), rather than wages alone.
- <sup>38</sup> This analysis was limited to full-time, full-year workers so that workers' annual earnings would serve as a reasonable representation of their wage level. If part-time or part-year workers had been included, low earnings might represent less time worked, rather than a lower wage rate.
- <sup>39</sup> For a discussion of this risk as it pertains to health insurance tax credit proposals, see Curtis and Neuschler, *Tax Credits for Individual Health Insurance*, and Institute for Health Policy Solutions, *Individual Tax Credits and Employer Coverage*.
- <sup>40</sup> Under SCHIP, there have been exceptions to this general rule. States are permitted to require families to pay a small premium to enroll their children in SCHIP. A number of states have elected to do so. The premiums or enrollment fees are typically small, and typically are charged only to families with incomes above 150% of poverty. Usually, there are no more than two different contribution schedules based on income.
- <sup>41</sup> As noted earlier, even people just above the poverty line are much more likely to have employer coverage than to be uninsured or on Medicaid, and 71% of people between 200% and 300% of poverty have employer coverage (Kaiser Commission on Medicaid and the Uninsured, *Health Insurance Coverage in America*, Table 1).
- <sup>42</sup> At commercial rates in 2000, the typical minimum employer-contribution requirement for small employers—50% of worker-only premium—amounted to about \$118 per worker per month, on average. In 2000, those employers with fewer than 50 workers that did offer health coverage actually paid an average of about 85% of the worker-only premium, or about \$200 per month (U.S. Agency for Healthcare Research and Quality, *2000 Employer-Sponsored Health Insurance Data. Private-Sector Data by Firm Size, Industry Group, Ownership, Age of Firm, and Other Characteristics*, Rockville, MD: August 2002, Tables I.C.1 and I.C.2. [<http://www.meps.ahrq.gov/mepsdata/ic/2000/index100.htm>]). Under its newly approved initiative, New Mexico plans to ask employers to pay \$75 per covered worker per month. If employers are willing to pay this higher amount, the required public subsidies will be smaller than suggested by our illustrations.
- <sup>43</sup> Such leaner coverage could be appropriate for childless adults, but not for children.
- <sup>44</sup> This construct is similar, but not identical, to the one used by the FOCUS program in San Diego. FOCUS uses a chart that specifies family contributions in dollar terms by family income (seven income levels) and by number of people covered (from one to six). The dollar amounts vary from about 1% of income for the lowest income category (under 150% of poverty) to around 4% of income for the highest income categories.
- <sup>45</sup> Both of these particular difficulties could be addressed using an alternative approach that would split the cost of the (net) premium (up to some reasonable ceiling) between the worker and the government, with the worker's percentage share increasing as income increases. (Under this approach, the source or mechanism of subsidy could be either a tax credit or a direct subsidy payment, as long as the total premium on which the subsidy is based is not tightly limited in dollar terms.) For example, workers with incomes below poverty might be asked to pay 2.5% of the net premium (total premium less the

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employer's contribution), while workers with higher incomes would pay higher percentages up to, perhaps, 50% of net premium for those with incomes between 250% and 299% of poverty. (We assume there would be no subsidy above 300% of poverty.) This approach would maintain some incentive for the employer to increase its contribution amount because, if it does so, the employer's worker will benefit. It would also automatically adjust for different premium charges across plans in a "choice" environment. However, it could also lead to workers paying more for coverage based solely on their age.

- <sup>46</sup> In the FOCUS project, worker contributions are based on total family income, not on just the worker's own earnings. To simplify for purposes of illustrating the potential problem, we assume here that the family has no income other than the worker's wages.
- <sup>47</sup> In presenting a percentage-of-income approach at the May 3, 2002, roundtable, we attempted to correct for this potential difficulty by calculating workers' contributions as a percentage of the amount by which their income exceeds the poverty level and by increasing the applicable percentage as the number of people covered increases—5% of income over poverty for each adult, plus 2% of income over poverty to cover all children. However, because the poverty level increases rapidly with family size, the same kind of discrepancy in dollar contribution amounts arose. We subsequently discarded this approach.
- <sup>48</sup> Department of the Treasury, "General Explanations of the Administration's Fiscal Year 2003 Revenue Proposals," February 2002.
- <sup>49</sup> Ibid. The Treasury's "General Explanations" say that the income figures would be based on "modified" adjusted gross income but do not specify what modifications would be made.
- <sup>50</sup> Poverty-level equivalents were calculated using 2002 federal poverty guidelines from Department of Health and Human Services, "2002 HHS Poverty Guidelines." (Accessed from <http://aspe.hhs.gov/poverty/02poverty.htm>.)
- <sup>51</sup> For a discussion of the rationale for this proposed modification, see Rick Curtis and Ed Neuschler, *Tax Credits for Individual Health Insurance: Effects on Employer Coverage and Refinements to Improve Overall Coverage Rates*, an Occasional Paper for the Covering America Project, Washington, DC: Economic and Social Research Institute, August 2002.
- <sup>52</sup> Higher-income workers in these firms (other than self-employed proprietors) would be disadvantaged under this proposal, because they would lose all current income-tax preferences for employer-paid health insurance. Thus, firms with more than one or two higher-wage employees would be unlikely to use the option. If desired, the proposal could be made less restrictive by allowing workers to choose between the new tax credit and current tax subsidies. Low-income workers presumably would choose the new credit, while higher-income workers (and the proprietor) probably would stay with the current system. Worker choice of tax option, however, could lead to confusion about income reporting and would be difficult to audit. Also, this alternative would make tax credits attractive to many more businesses and could increase the budgetary cost significantly beyond current estimates. Therefore, we have not included it in the illustration.
- <sup>53</sup> Similarly, it is unlikely that the administration's proposal would bring non-group policies providing comprehensive benefits for children within the financial reach of low-income families. As discussed earlier, covering parents and children in the same health plan helps to assure that children actually will use needed services.
- <sup>54</sup> For a discussion of the potential importance of adjusting tax credit amounts according to the age of the recipient, see Curtis and Neuschler, *Tax Credits for Individual Health Insurance*.
- <sup>55</sup> An approach to adjusting health-insurance tax credit amounts by age is discussed in Curtis and Neuschler, *Tax Credits for Individual Health Insurance*.

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- <sup>56</sup> State Medicaid programs are required to cover poor children through age 18 and children in families with incomes below 133% of poverty through age five. Many states use even higher Medicaid income-eligibility standards for children, and all states have implemented SCHIP programs to cover children above Medicaid income levels. Only six relatively small states still set their income-eligibility standards for children below 185% of the federal poverty level.
- <sup>57</sup> Under Medicaid, premium assistance is often referred to as “health insurance premium payment” or “HIPP.” Some states use the term, “premium support.”
- <sup>58</sup> Karla Hanson, “Is Insurance for Children Enough? The Link Between Parents’ and Children’s Health Care Revisited,” *Inquiry* 35 (Fall 1998): 294-302).
- <sup>59</sup> Low-income insured children whose parents were also insured were more likely to have received a well-child visit in 1999 (69.8%) than were low-income insured children whose parents were not insured (65.4%) See Dubay et al., *Highlights from The Urban Institute’s SCHIP Evaluation*.
- <sup>60</sup> Under employment-based health plans, premiums for family coverage typically do not vary by how many children there are in a family. To avoid unnecessary complexity and confusion, and to treat all workers in a firm equitably, it probably would make sense for Medicaid/SCHIP to make their payment based on the estimated average number of children in all participating families, rather than on the actual number of children in each participating family.
- <sup>61</sup> The refundable tax credit could be paid in advance or credited on the family’s tax return at the end of the year. The President’s proposal includes a mechanism for making the credits available in advance, based on the family’s prior-year tax return.
- <sup>62</sup> We assumed that both single-parent and two-parent families have an average of two children. If two-parent families tend to have more children, Medicaid/SCHIP contributions under the “hybrid” approach could be adjusted to account for this difference.
- <sup>63</sup> Note also that, under the “hybrid approach,” an ambiguity would arise about how to calculate the tax credit for a single-parent family. Under the President’s tax credit as proposed, the credit phases out more quickly if one adult is the only person covered under the policy (i.e., the credit falls to zero at \$40,000 rather than \$60,000). In this case, the policy would “cover” the worker’s children in addition to the worker, but the cost of the children’s coverage would be covered by Medicaid/SCHIP. So, which phase-out schedule should be used? We assume here that the slower phase-out, ending at \$60,000, would be used.
- <sup>64</sup> For a discussion of this issue, see Institute for Health Policy Solutions, *Individual Tax Credits and Employer Coverage*.
- <sup>65</sup> Lynn Etheredge, “How to Administer Health Insurance Tax Credits for Working Families,” Heritage Foundation *Backgrounder* No. 1516, January 31, 2002.
- <sup>66</sup> Kathlyn Mead, CEO of Sharp Health Plan, summarized the project at the May 3, 2002, roundtable. Additional detailed information presented here was excerpted directly from Sharp Health Plan’s website (<http://www.sharp.com/HealthPlan/>). In addition, some of the information was obtained via a site visit with Ms. Mead by Institute for Health Policy Solutions staff in March 2000.
- <sup>67</sup> To qualify, employers must not have offered health insurance to their workers in the past 12 months.
- <sup>68</sup> Employers pay \$46.79 per month for employee-plus-spouse coverage and \$42.41 for employee-plus-child(ren) coverage.

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- <sup>69</sup> FOCUS is funded by grants from the Alliance Healthcare Foundation, the California Endowment, and the California HealthCare Foundation.
- <sup>70</sup> Participating physicians are paid approximately 40% and hospitals about 35% of billed charges. For physicians, FOCUS payment rates are about the same as their Healthy Families (SCHIP) reimbursement rates. For hospitals, FOCUS rates are lower than for Healthy Families but higher than for Medi-Cal (Medicaid). Commercial rates are considerably higher.
- <sup>71</sup> Sharp charges only 5% of premium for its administrative overhead, while its actual costs are closer to 15% of premium. In addition, the Plan does not pay agent commissions under the FOCUS program.
- <sup>72</sup> Provider concessions on payment rates help to make the premium for the FOCUS product roughly \$30 less per member per month than Sharp Health Plan's average premium on the commercial side, and \$3 pmpm less than the Plan's Healthy Families (SCHIP) product.
- <sup>73</sup> Vondie Moore Woodbury, Director of the Michigan Community Health Project, summarized the Access Health program at the May 3, 2002, roundtable. Additional detailed information presented here was excerpted directly from the Project's website, <http://www.mchp.org/html/prahealth1.html>.
- <sup>74</sup> Kaiser Family Foundation and Health Research and Educational Trust, *Employer Health Benefits: 2002 Annual Survey*, Exhibit 1.13. Worker-only HMO premiums for small firms with 10-24 workers averaged \$274 per month in 2002. Estimates for the smallest firms (three-nine employees) were not available. Presumably, these higher premiums reflect, at least in part, some degree of self-selection among small firms that choose to offer health coverage. That is, workers who know they need health care are more likely to be willing to accept reduced wages in return for a contribution toward health insurance from their employer.
- <sup>75</sup> For example, for the second half of 2002, in Orange County, California, "standard HMO" worker-only coverage was available through the "PacAdvantage" purchasing pool for as little as \$148 per month for a worker under age 30.
- <sup>76</sup> In 2000, 49.5% of all uninsured adults (age 19-64) were under age 35, as were 55% of all *low-income* uninsured adults. (No break at age 30 was available. Figures specific to workers, as opposed to all adults, were not available.) Kaiser Commission on Medicaid and the Uninsured, *Health Insurance Coverage in America: 2002 Data Update*, February 2002, Tables 8 and 11 (based on analysis of data from the March 2001 Current Population Survey by the Urban Institute). According to the most recent Census Bureau estimates of the uninsured population, 51.6% of uninsured adults (age 18-64) are under age 35 (author's calculations from Table 1 in Robert J. Mills, "Health Insurance Coverage: 2001," *Current Population Reports* No. P60-220, Washington, DC: U.S. Department of Commerce, Census Bureau, September 2002). (Estimates of uninsured *workers* by income level were not readily available.)
- <sup>77</sup> Such leaner coverage could be appropriate for childless adults, but not for children.
- <sup>78</sup> A premium-tier structure of this type typically would also quote a separate rate for worker-plus-spouse coverage. However, we do not use worker-plus-spouse rates in these illustrations.
- <sup>79</sup> Premiums for Health Connections coverage are available electronically at <http://www.cbia.com/ins/hlt/vr/3-50rates.htm>. Premiums for coverage through PacAdvantage are available at <http://www.pacadvantage.org/pacplanchooser/wizard.asp>.
- <sup>80</sup> Although premiums vary significantly by age, it seems unlikely that the average age of workers in low-wage small firms would be higher than 39. According to the most recent Census Bureau estimates of the uninsured population, 51.6% of uninsured adults (age 18-64) are under age 35 (author's calculations from Table 1 in Robert J. Mills, "Health Insurance Coverage: 2001," *Current Population Reports* No. P60-220, Washington, DC: U.S. Department of Commerce, Census Bureau, September 2002).