
MARKET WATCH

Use Of Subsidies To Low-Income People For Coverage Through Small Employers

A proposal to extend employment-based options under publicly funded coverage expansions.

by **Ed Neuschler and Rick Curtis**

ABSTRACT: If tax credits or other public subsidies are made available only for health insurance that is not employment-based, serious erosion of employer coverage could result. To prevent this, public subsidies targeted to low-income workers and families could be applied in ways that broaden employer coverage for low-income workers and their families by encouraging small employers with largely low-wage workforces to offer and partially fund health coverage for their workers. To accomplish this, such employers—very few of which now provide health coverage—must be allowed to contribute much less than normally required in the commercial market.

TO EXPAND health insurance coverage to the uninsured, policymakers 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 subsidize the purchase of health insurance coverage by specific populations based on personal (family) income. Although a substantial majority of the uninsured are in working families, these proposals generally do not attempt to work with or through employers to expand coverage.¹ The Bush administration's proposal for health insurance tax credits, for example, would not allow tax credits to be used toward what the worker pays for employer-sponsored coverage.²

If sizable tax credits are made available only for non-employment-based coverage or if di-

rect public coverage is made available for working adults, a number of employers are likely to rethink their role in covering their employees, and a serious erosion of employer coverage could result.³ Among people with incomes between 100 percent and 200 percent of the federal poverty level, many more (46.6 percent) have employer coverage than are uninsured (26.3 percent).⁴ As a practical budgetary matter, government is unlikely to have the wherewithal to replace employers' current contributions toward health coverage for their low-income workers. It therefore makes sense to examine approaches that would help to maximize net coverage gains by allowing public subsidies to be applied in ways that complement existing employment-based coverage instead of crowding it out.

Direct subsidies for uninsured or low-wage small firms have also been proposed as a way to encourage them to offer coverage to their employees.⁵ But these proposals are difficult to

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target efficiently, because some workers in such firms do not have low (family) incomes.⁶

This paper investigates how public subsidies targeted to low-income people—including both public program subsidies and tax credits—might also be applied in ways that broaden employment-based coverage for low-income workers and their families and lessen the risk of a cascading erosion in employer coverage. The approach outlined here could work with a variety of subsidy mechanisms as a cost-effective way to make job-based enrollment, payroll contributions, and coverage work for more Americans, including the many uninsured people who work for firms that do not now offer health insurance coverage.

The Concept

The overall objective of our proposed approach is to maximize the net increase in health insurance coverage for low-income workers and their families, regardless of the type of public subsidy funds that are made available. By allowing available government subsidies to be combined with workers' and employers' contributions, our approach would make coverage more affordable for many workers and their families. It also would parlay the key advantages of job-based insurance: simplicity of enrollment, premium payment through payroll withholding, and pooling of risk. Signing up for health insurance at work is an easy, effective way to enroll in health coverage. Also, enabling all family members to be covered by a single health plan is convenient for parents and important for children, who are more likely to be covered and get needed care if they can be enrolled in the same health plan as their parent(s).⁷

Our approach focuses on allowing subsidies that are or may become available for low-income people to be applied to employment-based coverage for workers and their dependents, but only for employees of small firms with largely low-wage workforces.⁸ If sizable tax credits became available only for non-employer-group coverage, insured small firms with low-wage workforces are most likely to be the first wave of employers that

drop coverage to allow their workers to benefit from higher tax subsidies. Moreover, small firms with low-wage workforces employ a sizable share of all uninsured workers and are much less likely than other small firms are to offer coverage.⁹ Also, low-wage workers tend to be concentrated in low-wage businesses.¹⁰ Therefore, focusing on workers in these firms could extend coverage further and thus maximize the “bang for the subsidy buck.” Further extensions of the concept could allow tax credits to be applied to larger low-wage firms or to low-wage collective bargaining units for group coverage across multiple employers.

Employers' Contributions

Small employers cite a variety of reasons for not offering health benefits, but not being able to afford the cost is the primary reason.¹¹ Insurers will not issue a group plan to a small firm unless a substantial majority of its otherwise uninsured workers agree to enroll. To induce enough workers to participate, employers usually have to pay a substantial portion of the premium.¹² In fact, for the relatively few workers who had worker-only coverage through a low-wage small employer in 2000, the average contribution requirement for such coverage was only 20 percent of premium, and half had no contribution requirement.¹³

With the average premium for worker-only coverage now in excess of \$3,000 per year and family coverage approaching \$8,000, it is not surprising that neither low-wage small employers nor their workers see health insurance as affordable.¹⁴ However, local pilot program experience indicates that many small employers with mostly low-wage workers will offer health insurance if they feel the amount they must 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.¹⁵ Based on this experience, we believe that by allowing such employers to make much smaller contributions than are required in the regular commer-

cial market, public subsidies otherwise available for low-income workers and families could also be used to encourage small employers with largely low-wage workforces to offer and partially fund health coverage.

Small, low-wage firms could be allowed to offer coverage through a venue that channels public subsidies to their low-income workers and requires them to contribute only a flat \$50 per covered worker per month (in 2002 dollars), regardless of the worker's age, the plan the worker selects, or whether dependents are covered. Local pilot program experience suggests that \$50 is low enough to attract a sizable number of small businesses that do not offer coverage now. Although we do not prescribe a specific qualifying definition for such firms, a reasonable sample criterion might be firms with twenty-five or fewer employees, the majority of whom earn less than \$10 per hour.¹⁶ Nationwide, there are about 8.3 million workers in such firms; about five million of them are in firms that do not offer coverage.¹⁷ Limiting participation to small, low-wage firms greatly reduces the risk that public subsidies will simply replace employers' and workers' current contributions toward health coverage—known as crowding out—because more than two-thirds of small, low-wage firms do not offer health coverage now.¹⁸ Those that do offer coverage are very likely to drop it without such an option.¹⁹

While firms would qualify for participation based on the number and compensation of their employees, workers would qualify for subsidies based on the rules governing the program providing the subsidy, whether a public program or a new income tax credit. In either case, workers' eligibility for subsidies would be based on total family income, so that public funds are targeted to people who need help paying for health coverage and not to higher-income coworkers.

“Limiting participation to small, low-wage firms greatly reduces the risk that public subsidies will replace employers’ and workers’ current contributions toward health coverage.”

Two more considerations are important if the objective is to obtain broad participation of low-wage small employers in offering coverage. First, to ensure that enough low-wage workers can afford to participate, eligibility for subsidies must continue above 200 percent of poverty, on a sliding scale, particularly for unmarried, childless workers. Because the federal poverty level is so low for a one-person household (\$8,860 in 2002), a full-time worker with no dependents who earns more than \$8.52 per hour has income above 200 percent of poverty. Further, almost half of uninsured workers are unmarried and do not have children.²⁰ Thus, a subsidy program with an eligibility cutoff at 200 percent of poverty could leave many low-wage, small-firm workers unable to afford coverage and could lead many eligible small firms to decline to participate.

Second, employers will be more willing to participate if they can offer coverage to their entire workforce, 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 because of increased or decreased earnings at that job.

Sliding-Scale Public Subsidies

To illustrate our proposed approach, we examine two primary subsidy constructs, each of which uses a sliding-scale arrangement wherein the public subsidy falls as a worker's income rises up to, potentially, 300 percent of poverty. The constructs differ primarily with respect to how much of the risk for higher premium costs is borne by the government and how much by the worker. Each construct could work in conjunction with a variety of approaches to publicly subsidized coverage, including (1) the expansion of means-tested public programs such as Medicaid and SCHIP to offer premium assistance to low-income workers, or (2) tax credits to allow individuals

to purchase health insurance.

■ **Worker contribution defined, based on worker's income.** Under this approach, the worker makes a defined contribution to the premium cost that increases as the family's income (or, possibly, the worker's wage) increases, up to a specified percentage of poverty or dollar amount. The public subsidy pays the remaining premium cost (net of the employer's contribution). For purposes of illustration, we analyze a sliding-scale arrangement under which workers contribute an increasing proportion of their income toward their health coverage, ranging from 1 percent of income for workers with incomes below poverty to 5.4 percent of income for workers with incomes between 250 percent and 300 percent of poverty. Above that level there is no subsidy. This approach could be adopted by public programs, such as SCHIP or Medicaid, that can assist eligible people in paying required employee contributions—a practice referred to as providing “premium assistance.” (At present, however, these programs generally do not provide assistance on a sliding scale.)

■ **Public subsidy contribution defined, based on worker's income.** A second approach is to specify a maximum subsidy amount the government is willing to provide and then decrease 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 premium. This approach is most commonly thought of in conjunction with federal tax credits for the individual purchase of health insurance coverage, such as the Bush health insurance tax credit proposal.²¹

■ **Tax credit with higher caps.** Preliminary analysis showed that even if the health insurance tax credits under the Bush administration's proposal were added to modest employer contributions, the maximum credit amounts of \$1,000 per adult and \$500 per child would be too small to make even relatively low-cost employer coverage affordable for

most low-income working families with children. Therefore, we examine a tax credit approach based on the structure of the Bush administration's proposal but using higher maximum credit amounts of \$1,800 per adult and \$900 per child.²²

■ **A possible third option for states.** A hybrid approach to subsidies for employment-based coverage may be of particular interest to states. If the president's proposed tax credit amounts could be applied toward employer coverage at qualified small firms, a state might add premium assistance for children under Medicaid or SCHIP to small employers' contributions and tax credits for the adults to make employment-based coverage affordable for low-wage, uninsured small-firm workers and their children.²³ We included this approach as a third option in our analysis.

Illustrative Analysis

■ **Assumptions.** The impact of different subsidy approaches on public subsidy costs and on workers' contribution levels varies depending on the underlying premium cost for the coverage being provided. To illustrate a reasonable range of potential variation, we applied two cases of underlying premium costs, as shown in Exhibit 1: (1) a “standard case,” reflecting the typical premium for employer-sponsored health maintenance organization (HMO)-style coverage in 2002; and (2) a “lower-cost case,” reflecting current market rates for the lowest-cost HMO coverage available to young workers in low-cost areas (or reflecting rates for preferred provider organization, or PPO, coverage with higher cost-sharing amounts than are typically used now).²⁴ These illustrative rates are also in line with premiums for coverage available through small-employer purchasing pools in Connecticut and California at the end of 2002.²⁵

■ **Workers' contribution levels.** We calculated workers' contribution amounts for each of three coverage tiers at several different income levels.²⁶ Exhibit 2 shows, both in dollar terms and as a percentage of income, the annual amount eligible workers at various income levels would have to pay to cover them-

**EXHIBIT 1
Total Premium Amounts, Monthly And Annual, Used In Analysis**

Coverage tier	Standard case		Lower-cost case	
	Monthly	Annual	Monthly	Annual
Worker only	\$220	\$2,640	\$150	\$1,800
Worker, children	484	5,808	330	3,960
Worker, spouse, children	748	8,976	510	6,120

SOURCE: Analysis by the Institute for Health Policy Solutions.

NOTES: The standard case is intended to reflect the typical cost of employer-sponsored, health maintenance organization (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.

selves and two children (but not their spouses) under the three alternative subsidy approaches. Results for worker-only coverage and full family coverage are not shown.²⁷

Given the parameters we specified, the income-based worker contribution approach yields the most affordable worker contributions for standard-cost coverage, measured as a percentage of the worker's income. Under this approach, subsidies automatically adjust

as needed to achieve the prespecified worker contribution level. For standard-cost coverage, workers' contributions are much higher under either of the other two approaches. Bringing standard-cost employer coverage within reach of workers and their children using the other approaches would require either larger increases in the maximum tax credit proposed by the Bush administration or further state premium assistance for children added to the

**EXHIBIT 2
Annual After-Tax Worker Contributions For A Single Worker With Children, In Dollars
And As A Percentage Of Income, Under Alternative Subsidy Approaches**

Subsidy approach	Income (as percent of poverty)							
	125 percent		175 percent		225 percent		275 percent	
	Dollars	Percent of income	Dollars	Percent of income	Dollars	Percent of income	Dollars	Percent of income
Income-based worker contribution								
Lower-cost premium	\$ 309	1.6%	\$ 712	2.7%	\$1,307	3.9%	\$2,236	5.4%
Standard premium	309	1.6	712	2.7	1,307	3.9	2,236	5.4
Tax credit with higher caps ^a								
Lower-cost premium	336	1.8	447	1.7	1,096	3.2	1,745	4.2
Standard premium	1,608	8.6	1,740	6.6	2,513	7.4	3,285	8.0
Hybrid ^b								
Lower-cost premium	200	1.1	537	2.0	751	2.2	2,292	5.5
Standard premium	2,048	10.9	2,385	9.1	2,599	7.7	4,140	10.0

SOURCE: Analysis by the Institute for Health Policy Solutions.

NOTES: Income at 125 percent of poverty, for a single worker with dependents, is \$18,775; 175 percent, \$26,285; 225 percent, \$33,795; and 275 percent, \$41,305. For specification of standard and lower-cost premium levels, see Exhibit 1.

^a The maximum annual tax credit amounts applicable to this variant of the Bush administration's proposal are \$1,800 per adult and \$900 per child (with a maximum of two children).

^b The hybrid approach uses the Bush administration's basic \$1,000 tax credit for adults combined with premium assistance for children through Medicaid and the State Children's Health Insurance Program (SCHIP).

Bush tax credits for adults. In geographic areas with lower premium costs, any of the approaches could yield affordable worker contributions.

■ **Total costs.** The sophisticated simulation modeling necessary to estimate likely participation rates under our three alternative subsidy constructs and two different premium levels would have been well beyond the scope of this policy study. Therefore, this paper does not provide estimates of the relative effectiveness of the alternatives in reaching uninsured workers and dependents.²⁸ Instead, we used a simple illustrative model to provide a rough

sense of the relative costs of subsidizing employer-based coverage for a specified number of low-income small-firm workers and their families. We estimated total and per capita costs of covering a standard population of 10,000 subsidy recipients, both workers and dependents, with a range of incomes and family structures typical of workers in low-wage firms that do not offer coverage.²⁹

The differences among the three subsidy constructs are most evident under the standard-cost case shown in Exhibit 3. By design, employers pay essentially the same amount under each alternative, since their per worker

EXHIBIT 3
Standard-Cost Health Plan Case: Illustrative Annual Costs Of Covering 10,000 Subsidized Workers And Dependents Through Alternative Subsidy Approaches, With Premiums In Millions Of Dollars

	Income-based worker contribution approach	Higher-cap tax credit approach	Hybrid approach (Bush tax credit for adults plus Medicaid/SCHIP premium assistance for children)
Total premium	\$23.1	\$23.1	\$23.1
Employer payment (net) ^a	2.7 ^a	3.0	3.0
Worker payment (net of tax savings) ^a	2.8 ^a	7.6	11.1
Federal tax contribution ^a	\$ 1.0 ^a	12.5	5.3
Federal Medicaid/SCHIP contribution ^b	– ^b	0.0	2.2 ^{b,c}
State Medicaid/SCHIP contribution ^b	– ^b	0.0	1.5 ^{b,c}
Public program subsidy required (federal share) ^{b,c}	7.5 ^{b,c}	– ^d	– ^d
Public program subsidy required (state share) ^{b,c}	9.1 ^{b,c}	– ^d	– ^d
Total public contribution	17.6	12.5	9.0
Public contribution per subsidized person	\$1,763	\$1,246	\$898

SOURCE: Analysis by the Institute for Health Policy Solutions.

NOTES: The premium in the standard-cost health plan case reflects typical premiums nationally for employer-sponsored health maintenance organization (HMO)-style coverage in 2002; see Exhibit 1. Results include costs only for subsidized workers and dependents. Nonsubsidized workers and dependents could also participate. For a description of the alternative subsidy approaches, see text. SCHIP is State Children’s Health Insurance Program.

^a Under the “income-based worker contribution” approach, employers’ and workers’ 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 is derived from existing spending cannot be determined precisely. The hybrid approach 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 zero for subsidies to childless workers, 50 percent for parents and children below the federal poverty level, and 65 percent for parents and children above poverty.

^d Not applicable.

contribution is fixed.³⁰ Workers pay the least under the income-based worker contribution approach, and many times more under the hybrid approach. Public costs, on the other hand, are lowest under the hybrid approach and greatest—almost double—under the income-based worker contribution approach. Under the lower-cost case (not shown), the range of variation in total worker contributions and public subsidy costs across approaches is much narrower.

Discussion

If tax credits or other public subsidies are made available only for health insurance that is not employment-based, employer coverage could erode. To prevent this, and to strengthen rather than undermine the market demand for employment-based insurance, public subsidies targeted to low-income workers and families—including both public-program subsidies and tax credits—could be applied in ways that broaden employment-based coverage for low-income workers and their families by encouraging small firms with largely low-wage workforces to offer and partially fund health coverage for their workers. To accomplish this, such firms—very few of which now provide health coverage—must be allowed to contribute much less than normally required in the regular commercial market.

■ **Sliding-scale subsidies: important considerations.** A major question about alternative subsidy approaches is the trade-off between affordability for workers and families and cost to the government. Although this paper does not estimate participation rates, if public subsidies for health insurance coverage for low-income workers and families are not large enough, the intended beneficiaries clearly will not participate; however, the larger the subsidies, the greater the costs to taxpayers.

The public subsidy level can be adjusted under any of the general approaches discussed here, but the following dilemma still pertains: Public subsidy approaches that limit workers'

contributions to a relatively small percentage of income focus primarily on the affordability issue and thus are more likely to cover a sizable number of uninsured low-income workers and families. Such approaches are costly, however, and the cost rises as employer coverage premiums rise. To counteract these inflationary tendencies, purchasers—whether individual employers or larger pools—must have incentives to keep premiums as low as possible. Furthermore, approaches that require percentage-of-

income worker contributions are administratively cumbersome, because the subsidy amount required varies depending on the plan chosen by the worker, and an experienced administrative agent may be needed to implement them.

Public subsidy approaches that limit the dollar amount

of the subsidy available to any particular worker and family, by definition, limit government's liability. They are also easier to administer than percentage-of-income approaches are. The drawback of these approaches, however, is that they are more likely to require contributions from workers that are too high to be affordable, particularly as premiums rise, and that deter workers' participation. Even if the Bush tax credits 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 by increasing the maximum credit amounts.

■ **Mechanisms to combine contributions from multiple sources and allow consumer choice.** The application of any kind of public subsidy toward employment-based coverage could be facilitated by using organizations that have 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. As

“A tax credit approach could be made affordable for working families by increasing the maximum credit amounts.”

reflected in both current public programs and proposed individual tax credits, many policy-makers believe that such applications should give recipients a choice of competing health plans. Some oppose subsidized coverage through small firms, specifically because they rarely offer such choice. If desired, however, subsidies could be made available only when the employer uses a coverage venue that extends choice of plans. A number of potential mechanisms to accomplish this, such as purchasing pools or clearinghouses, also could be designed to combine contributions from multiple sources.

THE APPROACH OUTLINED in this paper could work with a variety of individual income-based subsidy programs—whether they use the income tax system or traditional public programs—as a cost-effective way to make job-based enrollment and coverage work for more Americans. By increasing total (employer plus subsidy) contributions, while reducing the risk that such subsidies might precipitate cascading erosion in employer coverage, the approach could increase the number of uninsured people covered through such programs.

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NOTES

1. One exception is the Relief, Equity, Access, and Coverage for Health (REACH) Act, S. 590 (107th Congress), sponsored by Sen. James Jeffords (I-VT) and nine cosponsors. Under it, workers who enrolled in an employer-sponsored plan could qualify for a credit equal to 40 percent 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.
2. U.S. Department of the Treasury, *General Explanations of the Administration's Fiscal Year 2004 Revenue Proposals* (Washington: Treasury Department, February 2003).
3. Low-wage employers would have the greatest incentives to drop coverage initially. The concern is that these initial effects could cascade as other employers respond to their competitors' decisions to drop coverage. See R. Curtis and E. Neuschler, "Tax Credits for Individual Health Insurance: Effects on Employer Coverage and Refinements to Improve Overall Coverage Rates," Occasional Paper for the Covering America Project (Washington: Economic and Social Research Institute, August 2002); and Institute for Health Policy Solutions, *Individual Tax Credits and Employer Coverage: Assessing and Reducing the Downside Risks* (based on an Expert Forum) (Washington: ESRI, August 2002).
4. Kaiser Commission on Medicaid and the Uninsured, *Health Insurance Coverage in America: 2002 Data Update* (Washington: Kaiser Commission, February 2002), Table 1.
5. See, for example, the Health Insurance Association of America's "InsureUSA" plan at www.insureusa.org. Also, Sen. Debbie Stabenow (D-MI) plans to introduce legislation that would authorize federal tax credits for small businesses that provide health insurance to their workers. S. Hall, "Stabenow Seeks Aid for Health Plans," *Detroit News*, 4 March 2003.
6. J.D. Reschovsky and J. Hadley, *Employer Health Insurance Premium Subsidies Unlikely to Enhance Coverage Significantly*, Issue Brief no. 46 (Washington: Center for Studying Health System Change, December 2001).
7. 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. 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. K.

- Hanson, "Is Insurance for Children Enough? The Link between Parents' and Children's Health Care Revisited," *Inquiry* (Fall 1998): 294–302. Children are also more likely to use care if their parents are insured. L. Dubay et al., "Highlights from the Urban Institute's SCHIP Evaluation" (slide presentation), www.urban.org/Presentations/ANF_SCHIP_eval/SCHIPeval_files/frame.htm (25 April 2003).
8. As used here, "firms with largely low-wage workforces" means firms in which half or more of the workers earn less than a specified hourly wage rate. In employer-survey data for 2000 from the Agency for Healthcare Research and Quality, the wage rate used is \$9.50 per hour.
 9. Most uninsured workers work for firms that do not now offer health coverage. K.E. Thorpe and C.S. Florence, "Why Are Workers Uninsured? Employer-Sponsored Health Insurance in 1997," *Health Affairs* (Mar/Apr 1999): 213–218, Exhibit 1. Nonoffering employers are overwhelmingly small firms with fifty or fewer workers—about seven of eight jobs in firms that do not offer health coverage are in small firms, and almost half of such jobs are in small firms with majority low-wage workforces. Authors' analysis based on data from 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*, September 2002, www.meps.ahrq.gov/data_public/ic_tables.htm (9 September 2002).
 10. In 1997, 58 percent of low-wage workers (earning less than \$7 per hour) were employed by low-wage businesses (in which two-thirds of workers earned low wages). In low-wage businesses, 87 percent of all workers earned low wages. S.H. Long and M.S. Marquis, "Low Wage Workers and Health Insurance Coverage: Can Policy-makers Target Them through Their Employers?" *Inquiry* (Fall 2001): 331–337, especially Table 1.
 11. P. Fronstin and R. Helman, *Small Employers and Health Benefits: Findings from the 2002 Small Employer Health Benefits Survey*, EBRI Issue Brief no. 253 (Washington: Employee Benefit Research Institute, January 2003), Figure 23.
 12. We recognize that an employer's contribution toward health benefits is part of its workers' total compensation, and, in that sense, workers pay the entire cost of health coverage. But by contributing funds that can be used only to enroll in health coverage, the employer assures that most workers will enroll.
 13. AHRQ, *2000 Employer-Sponsored Health Insurance Data*, Tables I.C.3 and I.C.4.a.
 14. Henry J. Kaiser Family Foundation and Health Research and Educational Trust, *Employer Health Benefits: 2002 Annual Survey* (Menlo Park, Calif.: Kaiser Family Foundation, 2002).
 15. One such local pilot program is the FOCUS (Financially Obtainable Coverage for Uninsured San Diegans) program, run by Sharp Health Plan. It offered heavily subsidized coverage to about 2,000 workers and dependents through previously uninsured small employers in San Diego County. See the presentation by K. Mead, CEO of Sharp Health Plan, in 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 held 18 May 2001, available at www.ihps.org. Additional information is available on the Sharp Health Plan Web site, www.sharp.com/HealthPlan (25 April 2003). Also, two local projects in Michigan—Access Health in Muskegon County and HealthChoice in Wayne County—have enrolled previously uninsured small businesses with mostly low-wage workers by asking employers and workers each to pay about one-third (or a little less) of the cost of coverage. Information is available on the Access Health Web site, www.mchp.org/html/prahhealth1.html (25 April 2003). Limited information about Wayne County's HealthChoice program is contained in the 2000 Annual Report of the Wayne County Department of Public Health, www.waynecounty.com/hcs/phealth/annual.htm (25 April 2003).
 16. Note that the criteria under which firms qualify are based on characteristics of the firm that are observable, or at least auditable, from routine tax filings or the firm's own records: number of employees and compensation paid.
 17. Authors' analysis based on data from AHRQ, *2000 Employer-Sponsored Health Insurance Data*, Tables I.B.1 and I.B.2.
 18. In 2000 only 28.9 percent of businesses with fewer than twenty-five workers and in which a majority of workers earned less than \$9.50 per hour offered health coverage to their workers. *Ibid.*, Table I.A.2.
 19. In 1997, 21 percent of workers in firms with fewer than ten employees worked for a firm that had offered coverage in 1995 but no longer offered coverage in 1997. S.H. Long and M.S. Marquis, "Stability and Variation in Employment-Based Health Insurance Coverage, 1993–1997," *Health Affairs* (Nov/Dec 1999): 133–139, especially Exhibit 3. Also, workers in low-wage businesses "confront much greater turnover in the offer of insurance than other workers." Long and Marquis, "Low Wage Workers and Health Insurance Coverage."
 20. B. Garrett, L.M. Nichols, and E.K. Greenman, *Workers without Health Insurance: Who Are They and How Can Policy Reach Them?* (Battle Creek, Mich.:

- W.K. Kellogg Foundation, no date), Appendix Table 1 (based on analysis of the 1999 Current Population Survey).
21. Department of the Treasury, *General Explanations*.
 22. One reason the administration's proposed tax credit is limited to \$1,000 is that a larger credit would risk "crowding out" employer coverage. The approach here addresses that concern in a different way.
 23. Under this approach, we assumed that a typical state contribution would be \$90 per month per child.
 24. 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 3–199 workers. Kaiser/HRET, *Employer Health Benefits*, Exhibit I.13. However, we assume that newly insured workers will be younger than currently insured workers and would therefore cost about 5–6 percent less than current market rates—that is, \$220 per month. Such leaner coverage could be appropriate for childless adults, but not for children.
 25. For the "standard-cost" case, our illustrative premiums fall within the range of premiums for "HMO Standard" coverage (\$20 copayment) for workers ages 30–39 for new coverage becoming effective in Hartford, Connecticut, in the last quarter of 2002, as offered through the Connecticut Business and Industry Association's Health Connections program. Premiums for Health Connections coverage were accessed electronically at www.cbia.com/ins/hlt/vr/3-50rates.htm (30 April 2002). For the "lower-cost" case, our illustrative premiums represent approximately the lowest-cost "HMO Standard" coverage (\$30 copayment) for workers under age thirty for new coverage becoming effective in Orange County, California, in the second half of 2002, as offered through the Pacific Business Group on Health's PacAdvantage program (in California). Premium rates were accessed electronically on the PacAdvantage Web site, www.pacadvantage.org (30 September 2002). Note also that Connecticut is among the highest-cost states for health insurance, while premiums in California are below the national average.
 26. Exhibit 2 shows the actual or nominal amount the worker would pay to enroll in coverage. The amount the employer contributes—\$600 per year or about twenty-nine cents per hour worked for a worker working forty hours per week—is also part of the worker's total compensation and, over time at least, substitutes for direct wages the worker would otherwise have received. This amount is the same under all of the alternatives, however, and was not included in our calculations of the workers' contributions.
 27. For complete results, see E. Neuschler and R. Curtis, *Applying Large-Scale Subsidies for Low-Income Populations to Health Insurance Coverage through Small Employers* (Washington: IHPS, December 2002).
 28. Nor are we able to estimate what percentage of participants are likely to have been insured previously. However, full-time workers with low family income are unlikely to have a working spouse with generous benefits, and only 20 percent of workers in low-wage small firms have coverage through their own employer. Authors' analysis based on data from AHRQ, 2000 *Employer-Sponsored Health Insurance Data*.
 29. The 10,000 subsidized people include 4,943 workers, 1,285 spouses, and 3,772 children. While there is no doubt that participation rates by income would vary under the three alternative subsidy constructs, our simplified model assumes the same participation rates by income for all alternatives.
 30. Note that employers have about \$0.3 million in offsetting Social Security and Medicare (FICA) tax savings under the income-based worker contribution approach, because we assume that workers' contributions would be made through a Section 125 "POP" (premium-only plan), which provides tax savings to both the worker and the employer.