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Expanding Health Coverage for the Uninsured: Fundamentals of the Tax Credit Option

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OVERVIEW — *This paper seeks to provide the basics for understanding the current debate over tax credits as a vehicle for reducing the number of uninsured Americans and focuses attention on some of the associated issues: How is health insurance treated under current tax law? Why tax credits and not deductions? What are the major issues in designing tax credits? Who should be eligible and for what size credit? What changes, if any, would be needed to the insurance market to ensure that policies are available and affordable for people eligible for tax credits? What are the major issues related to administering a tax credit? Proposals pending in Congress are referenced as illustrations of the varied way in which tax credits can be designed and implemented.*

Expanding Health Coverage for the Uninsured: Fundamentals of the Tax Credit Option

Tax credits to help subsidize the purchase of health insurance have been proposed in one form or another since at least the early 1970s, when Reps. Richard Fulton (D-Tenn.) and Joel Broyhill (R-Va.) introduced Medicare. Developed by the American Medical Association (AMA), the legislation was the first of many tax credit bills that were offered as market-based alternatives to public program expansions, such as those supported by many in the Democratic party.¹

In 1990, Congress enacted a small tax credit as a supplement to the Earned Income Tax Credit (EITC) for low-income families buying coverage for their children. Viewed by many as wasteful and unworkable, it was repealed soon thereafter.² More broadly targeted tax credits fueled debate but no serious legislative action when, in 1992, President George Bush proposed a program of refundable tax credits for low- and middle-income individuals to help them pay for health insurance.³

Once again at the center of the debate about ways to reduce the number of uninsured Americans, tax credits are included in current congressional bills that reflect a wide range of philosophies about how to expand health insurance coverage. Most proposals simply use the tax system as a convenient way to channel premium subsidies to people who would otherwise remain uninsured. President George W. Bush has proposed \$89 billion over ten years in refundable tax credits to help lower-income families buy health insurance coverage, primarily in the private individual health insurance market. Many Democrats in Congress have supported tax credits to subsidize the purchase of public insurance, such as Medicaid or the State Children's Health Insurance Program (SCHIP), or to help pay for continuation health insurance coverage through the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA)⁴ or similar state programs. Some more sweeping proposals, however, would use tax credits to promote major change in the health system. At least one proposal would entirely replace the current tax subsidies for employer-paid health insurance with tax credits for the individual purchase of coverage; the aim would be to reduce or eliminate the role of employers in the health insurance market.⁵

Although no action has occurred on the president's proposal or the more ambitious tax credit proposals to encourage individual purchase of insurance, Congress has passed and the president has signed into law

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H.R. 3009, the Trade Act of 2002 (P.L. 107-210). This legislation establishes a new temporary tax credit for the health insurance costs of workers receiving trade readjustment assistance. A tax credit will also be available to retirees age 55 or older who receive their pensions from the Pension Benefit Guarantee Corporation. The tax credits, which will be refundable and payable at the time coverage is purchased, will equal 65 percent of the amount paid for COBRA continuation coverage or other forms of qualified health insurance coverage. Such coverage includes state-based or state-sponsored plans and, in limited circumstances, coverage sold in the individual market. State-based coverage must be made available to qualifying individuals on a guaranteed issue basis without exclusion of coverage for preexisting conditions. A House provision to phase out the credit with increased income was eliminated in conference.

Much has been written lately about health insurance tax credits and specific tax credit proposals,⁶ and the debate in Congress over health insurance tax credits for recently unemployed workers was in many ways a sideshow. Such proposals address only a small share of the uninsured population. The greater challenge for lawmakers is presented by the persistent high rates of uninsured Americans, even at times of economic prosperity. In 2000, when the economy was still booming, the number of uninsured Americans for the full year was almost 39 million (or nearly 16 percent of the population under age 65).⁷ Perhaps as many as 55 million Americans lacked insurance at some time during the year, as they moved in and out of jobs or public sources of coverage.⁸ The return of double-digit annual increases in health insurance premiums and a slowed economy is likely to produce higher rates of uninsured for the foreseeable future. The question of whether tax credits or other forms of tax subsidies can make a significant dent in the number of uninsured Americans is thus important and timely.

CURRENT TAX TREATMENT OF HEALTH INSURANCE

Current tax law provides three basic forms of subsidies for health insurance premiums. The following summary is limited to basic health insurance rules and does not include special provisions of the tax code relating to long-term care insurance or to medical savings accounts.

Treatment of Employer-Paid Benefits

When an employer contributes to a health benefit plan on behalf of employees and their dependents, the costs are a deductible business expense for the employer, and the value of the benefits is excluded from the employees' taxable income—for the purposes of calculating both income tax and Social Security and Medicare payroll taxes. Any amounts that employees must contribute toward premiums for themselves and their families are generally *not* excluded from taxable income and are

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not deductible except under the medical expense deduction (see below). However, an employer's benefit plan may give an employee the option of designating a sum to be deducted from his or her wages and deposited into a "flexible spending account"; the amount deposited is nontaxable. The employee may draw on the account to pay coinsurance or deductible requirements under the health plan or to pay for medical services, such as dental care or eyeglasses, not covered under the plan.⁹

In June 2002, the Internal Revenue Service announced rules for a new type of tax-excluded benefit plan, a "health reimbursement arrangement" (HRA). Under an HRA, the employer provides a fixed amount of money that may be used by the employee to pay medical expenses or health insurance premiums. An HRA differs from a flexible spending account in two key ways. First, the HRA is funded entirely with direct employer dollars, rather than through a wage reduction. Second, amounts not spent in one year can be carried over into the next.

Deduction for the Self-Employed

The self-employed may deduct from their taxable income a percentage of the amount they pay for health insurance coverage for themselves and their families. This deduction is limited to the lesser of (a) net profit or earnings from self-employment, not counting certain other deductions, and (b) 60 percent of the premium cost through 2001 and 70 percent in 2002; 100 percent of the cost will be deductible in 2003 and later years. The deduction is not available to a self-employed person who is eligible for coverage under another subsidized employer plan, either directly or through a spouse. The deduction for the self-employed is "above the line," that is, it may be subtracted from taxable income whether the taxpayer itemizes other deductions or takes the standard deduction. Unlike the employer exclusion, this deduction does not affect Social Security and Medicare tax liability.

Itemized Deduction for Medical and Dental Expenses

A taxpayer who itemizes deductions may deduct most unreimbursed medical and dental bills for the taxpayer and dependents, including any insurance premiums, but only to the extent that the costs exceed 7.5 percent of adjusted gross income (AGI).¹⁰ If a taxpayer had an AGI of \$50,000 and medical expenses of \$5,000, the taxpayer could deduct \$1,250 (\$5,000 minus 7.5 percent of \$50,000). Premiums may be included only when paid by the taxpayer; thus the employee share of group health premiums can be deducted, but not the amount contributed by the employer. Because the medical expense deduction is itemized, it is beneficial to the taxpayer only if the sum of it plus other itemized deductions (such as mortgage interest and state and local taxes) is greater than the standard deduction. Relatively few low-income people have other deductions sufficient to meet this test. On the other hand, low-income

In June 2002, the IRS announced rules for a new type of tax-excluded benefit plan, a "health reimbursement arrangement."

people who do itemize are much more likely than higher-income itemizers to take the medical expense deduction, because a smaller expenditure is needed to meet the 7.5 percent-of-AGI test.¹¹

The three basic tax preferences for health insurance and health care are projected to cost the treasury \$630 billion during fiscal years 2003 through 2007. Of this amount, \$581 billion—or 92 percent—will go for the employer exclusion, \$18 billion for the self-employed deduction, and \$31 billion for the medical expense deduction.¹²

DESIGN OF A TAX SUBSIDY FOR INDIVIDUAL COVERAGE

Over the years, there have been many proposals to provide new tax subsidies to encourage individuals to buy health insurance or to promote offers of health insurance by small employers who currently do not provide health coverage. This paper focuses on measures targeted at individuals because these are currently receiving the most attention from policymakers. However, proposals to aid employers continue to be discussed. (Recent examples include a joint proposal by the Health Insurance Association of America and Families USA and an employer tax credit included in President Clinton's last budget proposal.)¹³

In considering tax subsidies for individual coverage, policymakers must address several basic design questions:

- What form should the tax subsidy take: a deduction, a credit, a refundable credit?
- Who should be eligible for the subsidy—all taxpayers or a defined target population?
- How large should the maximum subsidy be, and should there be any adjustments for factors such as geography or age?
- Should the subsidy be available for any kind of health insurance, or should there be some minimum standards for insurance plans?

Form of the Tax Preference

A new tax preference for individual coverage could take several basic forms:

- **Itemized deduction** — Taxpayers could be allowed to deduct all of their unreimbursed expenses for insurance premiums, instead of just the part of their expenses exceeding 7.5 percent of AGI.¹⁴ The deduction would benefit only taxpayers whose total itemized deductions (including the health insurance deduction) were greater than the standard deduction. The value of the deduction would depend on the individual's marginal tax bracket. For each dollar spent on health insurance, a taxpayer might receive a subsidy ranging from 10 cents to 38.6 cents (at 2002 rates).

The three basic tax preferences for health insurance and health care are projected to cost the treasury \$630 billion during fiscal years 2003 through 2007.

■ *Above-the-line deduction* — Taxpayers could deduct insurance premiums, whether or not they itemized other deductions. This would reduce taxable income and would again be more valuable to those with income in the higher tax brackets. There would be no benefit to a taxpayer if exemptions and other deductions had already reduced taxable income to zero.

■ *Nonrefundable credit* — A credit for health insurance would reduce the actual amount of tax paid, rather than taxable income. It thus would provide a dollar of subsidy for each dollar spent. However, a “nonrefundable” credit could not exceed total income tax liability; the maximum credit would thus be available only to taxpayers with a tax bill above the maximum.

■ *Refundable credit* — A refundable credit could exceed tax liability, with the excess refundable to the taxpayer. The full credit amount would thus be available to low-income families, who often have no tax liability or are actually owed money by the federal government as a result of the earned income credit. A refundable credit proposal could also provide for advance payment. That is, a participant could receive the credit over the course of the year, instead of waiting for tax filing time. Some proposals would make advance payments directly to insurers instead of to the taxpayer. These options are considered below in the section on administration.

While legislative proposals embodying each of these approaches have been offered in recent years, policy interest has focused on a refundable tax credit because it would provide the most help to people who are least able to afford coverage on their own.

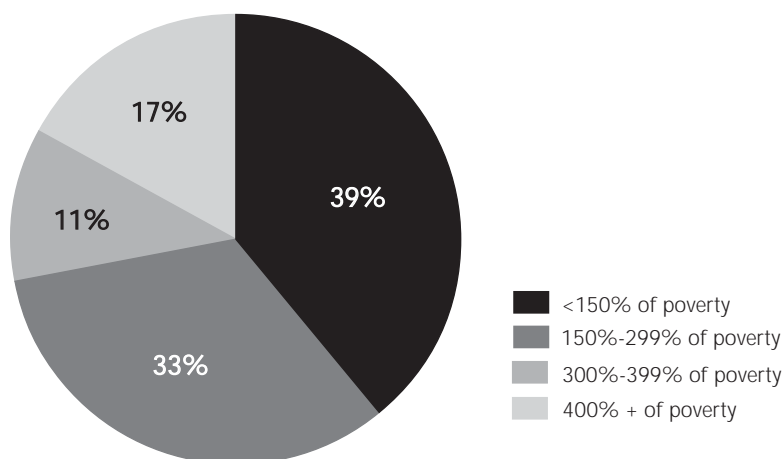
Target Population

Income — Refundable credit proposals typically would provide a fixed maximum credit to individuals and families with incomes below a specified threshold and would gradually phase down the credit amount for higher-income families, with the credit reaching zero at some income level. For example, the president’s proposal would extend a maximum credit of \$1,000 to a single adult with income of \$15,000 or less; the maximum drops to \$556 for someone whose income is \$20,000, and no credit is available when income is \$30,000 or more. A gradual phase-out of the credit amount prevents a “cliff” effect. (If a credit went from \$1,000 at \$15,000 annual income to zero at \$15,001 income, someone making \$15,000 a year would have a strong disincentive to earn another dollar.)

Income limits obviously narrow the population that would be reached by a tax credit. Figure 1 shows the population without health insurance in 2000 by family income as a percent of the federal poverty level. (The poverty income guideline for 2002 is \$8,860 for a single person and \$18,100 for a family of four.) While many uninsured people have very low incomes, more than one in four, or over 10 million, uninsured people are in families with incomes of 300 percent of poverty or higher.

Of the tax-based approaches, policy interest has focused on a refundable tax credit because it would provide the most help to people who are least able to afford coverage on their own.

FIGURE 1
Proportion of Uninsured People
with Various Levels of Family Income,*
2000



*Family income expressed as a percent of the federal poverty level.

Source: U.S. Census Bureau, Current Population Survey, March 2001 Supplement.

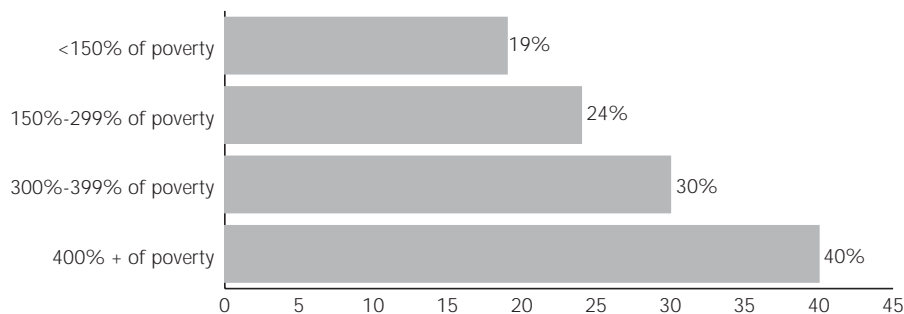
There are several reasons for an income-based phase-out. First, of course, it limits the potential cost of the proposal. Second, it limits the extent to which the credits might induce people to drop employer coverage, because the higher-income people most likely to have access to employer plans are excluded. If there is a limit to the amount of revenue reduction policymakers are willing to commit, the phase-out assures that the assistance is targeted to those most in need.

Income limits entail some assumption, necessarily arbitrary, about the point in the income scale at which people can afford health insurance without a subsidy. Figure 2 shows, by family income as a percent of poverty, the likelihood that people who do not have either employer-based or public coverage will obtain nongroup coverage rather than go uninsured. The highest-income people are about twice as likely as the lowest-income people to buy individual coverage. Still, three out of five people who have no other source of coverage and have incomes greater than 400 percent of poverty fail to get insurance.

Current Coverage or Access to Coverage — Proposals differ widely in their treatment of people who currently have insurance or who are eligible for insurance. Nearly all proposals exclude Medicare beneficiaries, meaning that a credit could not be used to purchase a Medicare supplemental policy. Some would exclude people who were eligible for Medicaid or SCHIP. The aim presumably is to prevent states from

More than one in four, or over 10 million, uninsured people are in families with incomes of 300 percent of poverty or higher.

FIGURE 2
**Proportion of People in Various Income Groups*
Who Had No Employer or Public Health Insurance Coverage
but Purchased Nongroup Coverage, 2000**



*Expressed as family income as a percent of poverty.

Source: U.S. Census Bureau, Current Population Survey, March 2001 Supplement.

shifting recipients from these programs, which are partially state-funded, to private coverage funded entirely through a federal tax subsidy. It is not clear how such a requirement could be enforced; would people have to apply for Medicaid or SCHIP and be rejected before they could obtain the credit?

Treatment of employer coverage is a key issue in the design of a credit proposal. Some proposals would allow a credit only for people who were not offered coverage through their own employment or that of a family member. The goal is to prevent shifts from employer coverage to credit-subsidized nongroup coverage. Other proposals would allow such shifts, but would not permit people remaining in group coverage to use the credit for required employee contributions toward premiums; still other proposals would permit the credit to be used for this purpose. The rationale for these different approaches is discussed below in the section on substitution.

Finally, some proposals would allow the credit only for people who had been without any insurance for some period before applying. In the absence of this provision, much of the tax expenditure for a new credit might go to people who are already buying nongroup coverage. While denying a credit to these people might reduce costs and would seem to improve targeting, it also raises equity questions. Why should someone who has not previously bought insurance receive a subsidy, while someone else at the same income level who has been paying for coverage all along does not? Enforcement might also be difficult; it is hard to see how the Internal Revenue Service would establish who did and did not have prior coverage without some form of universal reporting system.

Amount of the Credit

Most proposals provide a credit that would be the lesser of actual premiums paid or some fixed dollar limit. Some proposals also specify that the credit cannot exceed a fixed percentage of the premium—for example, 90 percent—meaning that all participants, even those with very low incomes, would have to contribute something toward premiums. For the sake of simplicity, the following discussion focuses on the fixed dollar credits that are most commonly suggested. How big should a credit be? Should it be adjusted for age, geography, or other factors commonly used by insurers in setting premiums?

Maximum Credit Amount — Current proposals offer very different maximum credit amounts. Fixing the credit amount necessarily involves some balancing between the policy goal of helping people obtain coverage and competing budgetary priorities. Assuming that resources for a tax subsidy are not unlimited, how big must the subsidy be to have a meaningful effect on the uninsured population? There is considerable disagreement surrounding several key questions:

- How much are people willing or able to pay?
- How much does health insurance cost?
- Why are participation rates important?

How much are people willing or able to pay? If a credit is not large enough to pay the entire cost of health insurance, not everyone who is eligible will actually obtain coverage. Any credit will lower the effective price of coverage and induce at least some uninsured people to participate. But there is considerable uncertainty about just how much the price must be lowered to encourage large numbers of modest-income people to buy insurance.

Economists have developed a variety of models for estimating the effects of tax credit proposals, all involving some estimate of “elasticity” of demand—that is, the relationship between cost and the likelihood that people will buy coverage.¹⁵ There has also been what amounts to a set of natural experiments, in the form of public insurance programs that require an income-based premium contribution. Ku and Coughlin, examining four of these programs, found that participation rates drop rapidly when premiums rise as a percent of income (Table 1).¹⁶ This effect is probably not uniform. Higher-income people are willing or able to contribute a higher share of income, and older or sicker people are likely to be willing to spend more than young and healthy ones. Moreover, there are factors other than premium rates that may have affected participation in these programs, such as burdensome application procedures or the perceived “welfare stigma” that may be associated with some public programs.

The following hypothetical assumptions, based on the Ku and Coughlin findings, illustrate the importance of having some idea of what insurance costs when assessing whether a given credit will attract many

TABLE 1
An Illustration:
Participation in State
Insurance Programs,
by Premium
as a Percent of Income

Premium as % of Income	Estimated Participation Rate
1%	57%
3%	35%
5%	18%

Based on Ku and Coughlin, “Use of Sliding Scale Premiums in Subsidized Insurance Programs.”

participants: To achieve 57 percent participation among individuals making \$15,000 a year, the amount they would have to pay for coverage after a tax credit could be no more than \$150 a year. If the available credit were \$1,000, this level of participation would be achieved only if people could find insurance for \$1,150 or less. If, on the other hand, most people could only find insurance that cost \$1,750 or more, then post-credit premiums would rise to 5 percent of income, and participation would be expected to drop to 18 percent. To keep participation at 57 percent, the credit would have to rise to \$1,600.

How much does health insurance cost? There has been a heated debate in recent months about what kind of coverage people can actually buy at what premium rate. Some studies contend that most people could get “good” coverage for \$1,000, while others point out that, even leaving aside the higher prices paid by older people or those in high-cost areas, a \$1,000 a year premium would usually buy a policy considerably less comprehensive than those common in employment-based plans.¹⁷ (The effects of age and geography on premiums are discussed below.)

Obviously, people will differ about how much coverage is “good” enough, and opinions may reflect differing views of why uninsurance is a problem and what kind of insurance is appropriate. If the aim is to protect families from catastrophic losses in the event of a serious illness, a low-cost policy with a high deductible might do the job. If the aim is to promote early entry into primary and preventive care, something closer to first-dollar coverage is needed, entailing much higher premiums. Assuming that available resources are limited, a credit that will provide at least some basic coverage is obviously better than no credit at all. However, if people are going to have to contribute something towards their premiums, participation levels are likely to drop if the available products do not appear valuable to potential purchasers. Past attempts at the state level to offer low-priced “bare bones” coverage did not attract many buyers.

Why are participation rates important? If a tax credit significantly lowers the cost of coverage, making it affordable for people of modest means, why should policymakers care if people take advantage of it or prefer to spend their money on something else? One major reason is that, if participation is low, the people using the credit are likely to be those in the poorest health. As will be discussed below, this can affect efforts to improve the functioning of the individual health insurance market. In addition, most proposals would make the credit available to people who are already buying individual health insurance. These people will presumably wish to claim the credit no matter how small it is. If it is too small to induce many additional uninsured people to seek coverage, the bulk of the new tax expenditure would go to subsidize people who are already insured. This might be defensible on equity grounds but might not be an efficient use of federal resources to address the problem of the uninsured.

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While the net cost of coverage is a key factor in participation, it is not the only factor; ease of obtaining coverage is also important. Most people eligible for employer group coverage participate, not just because the employer pays part of the premium, but also because sign-up is easy, the worker does not have to shop for a policy, and required employee contributions are automatically deducted from paychecks. Attaining similar levels of participation in an individual tax credit may depend in part on how the credit is administered. Administrative options are considered later in this report.

Geographic Adjustment — Health insurance premiums are much higher in some geographic areas than in others. The Council of Economic Advisers found that premiums for a family of four ranged from \$1,272 in Bloomington, Illinois, to \$9,675 in Boston, while a recent study for the Henry J. Kaiser Family Foundation found that nongroup premiums for single buyers in Miami were twice as high as in some other areas.¹⁸ Clearly, this means that a fixed credit will cover a higher share of the premium, or will buy richer benefits, in some places than it will in others. It would theoretically be possible to more nearly equalize the buying power of the credit through some form of geographic adjustment.

Establishing a local index value would be controversial—geographic adjustment factors under Medicare have been a source of debate for years—and administration might be cumbersome. (Constitutional issues may also arise.) Moreover, although general cost of living varies geographically, there is no adjustment in other elements of the tax code, such as brackets, exemptions, or the standard deduction. It might be appropriate to treat health insurance differently if variation in health insurance premiums is much greater than variation in general cost of living. Although there is no one agreed index of local cost of living, various privately developed measures show differences in the range of 2.5:1. This is greater than the premium difference observed in the Kaiser study, but much less than that found by the Council of Economic Advisors.

Age Adjustment — Except in the handful of states that have adopted community rating,¹⁹ insurers in the individual market charge older buyers much more than younger ones. The Council of Economic Advisors reports that the median premium for a 55 year-old male is \$2,464, while it is \$772 for a 25 year-old male buying comparable benefits. A fixed-dollar credit would leave the older buyer paying a much higher share of income towards premiums than a younger buyer with the same income. One possible solution would be to adjust the credit amount by age. This option, and its possible effect on the market, is considered below.

Qualified Coverage

As defined under current tax law, health insurance includes any policy that pays for medical expenses. (This definition excludes so-called “dread disease” policies, which make payments if a policyholder develops a

Insurers in the individual market often charge older buyers much more than younger ones.

given problem, such as cancer, whether or not the policyholder incurs any medical bills.) Most credit proposals would allow the credit to be used for any kind of health insurance meeting the very broad current definition. However, there may be concerns that some people would buy substandard coverage; this was one of the reported problems with the child health insurance tax credit in the early 1990s. A credit proposal could define some minimum standards for health insurance benefits. Setting a minimum benefit package would probably be controversial, and there might need to be some system for certifying that available health insurance plans met the standards. Many proponents of the tax credit approach would contend that benefits should be determined by individual preferences, not regulation. An alternative view is that the government has an interest in assuring that a new tax expenditure be used for coverage that meets the intended purpose.

MAKING INDIVIDUAL HEALTH INSURANCE COVERAGE AVAILABLE

The Individual Insurance Market

About 12.6 million people under the age of 65 bought health insurance directly in 2000,²⁰ without the benefit of purchasing through an employer group. Individual coverage is sold by commercial carriers, the Blues (Blue Cross and Blue Shield plans), and managed care organizations. A much smaller number of individuals buy coverage through professional associations, fraternal organizations, and similar entities.²¹

As is the case for group health insurance, individual insurance is designed to protect policyholders from unexpected (unpredictable) medical expenses. The costs of insuring higher users of insured medical services are pooled with the costs of below-average users of services. In large employer groups, costs can be averaged out across a large number of people. As the group gets smaller, however, the ability to offset above-average costs with below-average costs gets more difficult. In the individual market, no natural group exists across which to spread risks, although, for purposes of designing and rating policies, an insurer will generally consider its individual policyholders as one risk pool. There also is an added concern. Whereas, in the employer group market, people associate with the group for purposes other than to buy insurance, in the individual market, persons who are seeking coverage are there solely for the purpose of buying insurance and thus present a higher risk to insure than persons obtaining coverage through an employer group plan. This is because younger and healthier individuals typically decline to purchase health insurance until they anticipate significant medical expenses.

In addition, it is more costly to market, underwrite, enroll, and administer individual insurance policies than group policies. This is reflected in the higher “administrative load” that goes into the nongroup premium.

Most credit proposals would allow the credit to be used for any kind of health insurance meeting the very broad current definition.

Although estimates vary, roughly 35 cents of every premium dollar for individual coverage goes for administration and profit; 65 cents goes to pay claims costs. (For very large group policies, the average paid for administration and profit may range from 5 percent to 15 percent.).²²

The other key difference between group and nongroup insurance is that, in employer groups, low-risk people who might otherwise not be interested in insurance will enroll because of the employer subsidy, ease of enrollment, and so on. This is what makes pooling work. The idea behind the tax credit is that if low-risk people got sufficient subsidy to induce them to enroll in the individual market, pooling would be possible there as well.

The regulation of health insurance sold by insurers was for a long time the sole responsibility of the states, and, with the exception of requirements under the Health Insurance Portability and Accountability Act (HIPAA), remains so today (see box). States require insurers in the individual market to comply with requirements relating to financial standards, policy forms (what can and cannot be in the contract offered to purchasers), access to coverage and required benefits, the rating of premiums, market conduct, and renewability of coverage.

Insurers selling in the individual market are generally permitted by state regulators to manage the risk of their business by restricting access to their policies and pricing their policies on the basis of the expected costs of insuring the policyholder. For persons who are not HIPAA-eligible and with the exception of a few states where regulations are more protective for policyholders, an insurer may accept, reject, or accept with conditions any applicant for an individual policy. Most states permit individual insurers to evaluate and classify applicants for acceptance or rejection on the basis of "risk factors," such as their state of health, medical history, age, gender, habits (for example, whether they smoke), geography, and other insurance that the person may have. Also, with the exception of a few states, insurers are permitted to vary the premiums of policies offered to individuals who are accepted for coverage on the basis of their expected risk of incurring health expenditures.

Thus, a young person with no existing or prior medical conditions will generally be classified as a good risk and accepted for coverage at the insurer's average (standard) premium for individual policies. An applicant who has a current or preexisting medical condition is likely to be classified as high-risk. The insurer may reject the applicant entirely or accept the applicant at an above-average (substandard) rate. If the

HIPAA

Under HIPAA, states must establish a means by which individuals moving from group to individual coverage and who meet certain requirements can buy coverage without preexisting-condition limitations. Such individuals are known as "HIPAA-eligibles." In some states, all insurers participating in the individual market or one designated insurer must provide coverage to HIPAA eligibles on a guaranteed-issue basis. Other states have designed their high-risk pools to meet the guaranteed-issue requirement. HIPAA also requires that all coverage in the individual market be guaranteed-renewable. HIPAA does not, however, impose any rating requirements on health insurance policies, either in the group or individual health insurance markets.

HIPAA has made it easier for people transitioning out of employer-sponsored health insurance to find a source of coverage. It has not, however, made health insurance less costly. Some evidence suggests that HIPAA has, in fact, contributed to premium increases in the individual market. This is because of the overall higher risk of those individuals electing coverage under HIPAA-eligible policies.

applicant is accepted, the insurer may impose a temporary or permanent exclusion of coverage for the preexisting medical condition. People with chronic conditions are especially vulnerable to being denied coverage or to being accepted with preexisting condition limitations or exclusions and at higher premiums.²³

Age is itself an important risk factor. Insurers will generally price the policy of a healthy person over age 50 at least twice the premium of a person who is less than 50. Often the difference between a 25-year-old and a 55-year-old can be four-fold. Geography is also highly predictive. Premiums tend to be higher in urban areas than in rural areas and are also higher in areas with higher utilization of health care services.

Insurers also manage their risks and the cost of their policies through benefit design. Higher enrollee cost-sharing is used to keep premiums low enough to attract average-risk individuals. Cost-sharing features, such as deductibles, copayments, coinsurance, and benefit limits are generally less generous than in the group marketplace. Benefit value is also lower. Many individual policies have limited or no mental health, maternity, or prescription drug coverage because these benefits are known to attract above-average-cost enrollees.

Some states impose strict limits on the selection (underwriting) and pricing (rating) practices used by individual insurers. New York and New Jersey, for example, require that insurers participating in the individual market accept all applicants (guaranteed issue), and use pure or modified community rating to derive their premiums.²⁴ Although some carriers have left these markets, individuals are able to choose nongroup policies from a number of carriers. Young people may be paying more than they would have absent the reforms, but older and sicker people are able to obtain insurance that is both available without limitation and less costly than it would have been. In some states, however, such as Kentucky, New Hampshire,²⁵ and Washington, reforms led to significant market disruptions because many insurers elected to exit those states rather than conduct business under what they perceived as adverse business conditions. Moreover, insurance coverage rates generally did not improve, although it is dangerous to assert cause and effect given the confounding role played by state labor markets, consolidation in the insurance industry, and other factors.²⁶

Options for Individual Insurance Market Reforms

If refundable tax credits were made available to people buying individual insurance, insurers might voluntarily take steps to make their products available and attractively priced to those individuals. It is also possible, however, that people who would benefit from tax credits might find few or no insurance options in their area. To ensure that this does not happen, lawmakers could require insurers to make some or all of their insurance policies available to tax-credit-eligible individuals at community-rated

Higher enrollee cost-sharing is used by insurers to keep premiums low enough to attract average-risk individuals.

premiums. Such requirements could be imposed on a state-by-state basis or through federal law and regulation.

State regulations reflect local conditions and may thus best fit the unique circumstances of local insurance markets. Also, as incubators of policy innovations, states could learn from one another about the best approaches for achieving expanded coverage. However, regulation on a state-by-state basis may not be the most effective way to improve availability and affordability of coverage. Insurers that do not like the rules of the game in one state can shop for more compatible regulatory environments elsewhere. This has been the experience in some states that imposed community rating or tight rating bands²⁷ and guaranteed issue on insurers selling in the individual market. Moreover, state-based regulations may create disparities across geographic borders, making it difficult for individuals to obtain seamless coverage if they move from one state to another. Such state law variations could also complicate operations for insurers that sell in more than one state, although many such insurers have traditionally preferred state-level over federal regulation, perhaps because they have grown accustomed to it.

Alternatively, federal standards could be established for health insurers wishing to sell to tax credit recipients. These might be established as minimum or “floor” standards, allowing states to provide for standards that are more protective for consumers, or they might be established as uniform national standards with no state variation permitted. The first approach often has political appeal because it gives states flexibility to go beyond federal requirements. The second approach, in which state laws are preempted (overridden) by federal law, achieves regulatory uniformity for insurers and greater simplicity for consumers. Insurers must play under the same rules, regardless of where they are located.

Regulating Underwriting — To assure that one or more policies offering adequate coverage is available to tax-credit-eligible individuals, lawmakers may want to establish certain underwriting rules. Three areas of underwriting are especially important in this regard: the initial issuance of insurance, rules relating to the temporary or permanent exclusion from coverage of preexisting medical conditions, and renewability of coverage.

Guaranteed issue. To assure that a tax-credit-eligible person is able to obtain an individual policy, insurers could be required to write individual coverage on a guaranteed issue basis, meaning, that the insurer must accept all applicants regardless of their risk factors. Exceptions may be allowed for health plans, such as managed care plans that lack the capacity to accept additional applicants, so long as any enrollment limits were not discriminatory.

Preexisting condition limitations and exclusions. Restrictions may be placed on insurers' ability to impose limits or exclusions for preexisting medical conditions. Recognizing the need to prevent insurers from

having to write policies for people who wait until they are injured or get sick to buy insurance, most proposals allow insurers to impose some period of preexisting condition exclusion (six months or one year) on an individual lacking immediate prior insurance coverage. Under HIPAA, for example, an individual is eligible for coverage without any preexisting condition limitations or exclusions only if he or she had prior continuous coverage without a gap of more than 63 days.

Renewability. This requirement assures that, once a person is accepted for coverage by an individual carrier, that coverage will not be terminated unless the person commits fraud or fails to pay his or her premium. Otherwise, the insurer must permit the enrollee to renew the policy regardless of that person's claims history. Guaranteed renewability of individual insurance products is already required by HIPAA, the only federal requirement that applies to all individual health insurance policies.

Regulating Premium Rates — Regulation of rating practices as they apply to the individual market has been considered over the years, but usually only as part of broader health insurance reform proposals. In 1996, when Congress debated the legislation that eventually became HIPAA, regulation of rating was considered too controversial. Congress left the regulation of rates to the states. In subsequent congressional sessions, only a small handful of proposals tackled this subject. Today, few if any proposals seek to regulate rating practices of insurers.

In past legislation, insurers would have been permitted to base their rates on risk factors that are not directly health-related, such as geography, age, and sometimes gender. Some proposals would have imposed no restrictions on the use of such factors, while others would have limited the range of possible variations. A few proposals would have required pure community rating.

Rating regulation alone would not in theory affect the average premium rates charged by insurers. Instead, it would restrict the extent to which the rate charged to any particular individual could vary from the average. Typically, the oldest and sickest enrollees pay several times as much as younger and healthier enrollees for the same coverage. By limiting such variation, regulation reduces rates for the high-cost enrollees and raises rates for the low-cost ones. When rating reform is coupled with underwriting reforms that bring older and sicker enrollees into the pool, the overall cost of the pool rises, as does the average premium. The challenge is to prevent the resulting premiums from climbing so high for the enrollees who had previously been paying relatively low premiums that they drop their policies. A spiraling effect could gradually foreclose coverage to younger and healthier persons who may also have relatively low incomes.

It is also the case that high-risk enrollees may not be equally distributed among insurers. This could happen by chance or because high-risk applicants may be drawn to certain insurers (for example, PPOs instead of

Today, few if any proposals seek to regulate rating practices of insurers.

closed-network HMOs) or because some insurers found ways to target their marketing to low-risk individuals. In the latter case, an insurer's success would depend on its ability to select the most favorable risks.

Interplay of Tax Credit Amount and Market Reform — If the premium for a 55-year-old male is \$2,464, compared to \$772 for a 25-year-old, then a \$1,000 credit would leave the older buyer with \$1,464 in out-of-pocket cost, while the younger buyer would pay nothing. One way of addressing this disparity is to regulate insurers' rate-setting practices to reduce the difference in premiums for younger and older buyers. An alternative is to adjust the credit amount for age. For example, if it were thought that someone making \$15,000 could spend \$150 for coverage, the maximum credit might be \$622 for a 25-year-old and \$2,314 for a 55-year-old. (A precedent exists in the tax code; the maximum deduction for long-term care insurance premiums varies by age.) The two approaches are roughly equivalent in effect; Lynn Etheredge has suggested that individual states might be allowed to decide whether to regulate or adjust the credit.²⁸

Probably older people are willing to spend a higher share of income for health insurance than younger people. Equalizing the price of coverage for older and younger buyers might mean that a smaller proportion of younger uninsured people would participate. Whether this is a concern may depend on what one sees as the primary goal of a tax credit program. If the aim is to cover the maximum number of uninsured people within a given budget, this is likely to be achieved if younger people—who make up the majority of the uninsured—were given a much stronger incentive to buy coverage. If the aim is to assure that coverage is affordable to those most in need, an age adjustment might be appropriate.

Spreading Risk to Increase Coverage

Options exist to spread the costs of high-risk enrollees more equitably among insurers, or even to spread those costs among a broader source of financing, such as taxpayers in general. Mechanisms that rely on sources of financing that are external to the individual market are likely to be the most successful in expanding health insurance coverage. If the pool is financed only within the market, low-risk people have to subsidize high-risk ones, and their participation drops. Bringing in outside money holds the average premium down for existing insureds and makes the coverage more attractive to the uninsured. Two major alternatives are possible: reinsurance and risk pools.

Reinsurance — Reinsurance is a mechanism by which insurers pay part of their premiums into a fund and may then be compensated if some of their enrollees incur especially high costs. Insurers have long purchased reinsurance voluntarily through private entities. The original insurer pays the reinsurer part of its premium revenues, and the reinsurer assumes part of the risk, such as all costs for any individual policyholder

Reinsurance and risk pools are two options for spreading the cost of high-risk enrollees more equitably among insurers.

that exceed a given threshold or aggregate costs for all policyholders in excess of some amount of money. It is important to emphasize that the costs of caring for those high-cost individuals do not disappear. The reinsurer charges a premium to the primary insurer based on its assessment of the underlying risk of having to pay claims for those amounts that are reinsured. However, the reinsurance mechanism could be designed to spread these high-cost cases across a larger pool of insuring entities, such as all health insurers in a state or all insuring entities, including self-insured employers. Alternatively, some portion of the costs could be spread to taxpayers. In this manner, the costs would be externalized, allowing the primary insurer to lower premiums. One analysis of a hypothetical reinsurance pool found that reinsuring as little as 1 percent of the highest-cost cases could reduce premium costs by about 14 percent.²⁹ Which risks would be ceded to the reinsurance pool and who would participate in its financing are just two of the challenging and politically contentious design issues that would have to be resolved.³⁰ Whatever the design, the success of the reinsurance mechanism in reducing premiums will largely depend on providing financial sources external to the individual insurance market.

Risk Pools — In risk pool arrangements, high-risk individuals are identified at the time of enrollment, and the entire excess cost of covering these individuals is then spread among all the insurers in that segment of the market. Insurers may decline to cover these applicants and refer them to a state-established program, or individuals may be able to apply directly to the risk pool if they meet certain conditions. The risk pool will then charge these enrollees a premium rate that is higher than average (often 150 percent of the statewide average) but less than the actual cost of covering them. Resulting losses are then financed in a variety of ways, as described below. In “assigned risk programs,” high-risk applicants are allocated among insurers, each of which must accept a certain share of applicants. Or such applicants may be assigned to certain designated carriers with the other (referring) carriers helping to make up the resulting losses.

In 2001, 29 states operated high-risk pools; New Hampshire recently passed legislation to create one. A total of about 113,000 people obtained their health insurance through these pools, with much of the enrollment in Minnesota (25,892), and California (20,834). In six states, premium subsidies were available for low-income enrollees. Most states used their risk pools to comply with the group-to-individual portability provisions of HIPAA. Enrollment in pools has been and is likely to remain modest because premiums are high relative to incomes and enrollees are expected to shoulder significant cost-sharing through deductibles and copayments. Most pools impose preexisting condition exclusions on non-HIPAA-eligible enrollees. Some impose a cap on total enrollment. All pools operate at a loss since claims paid are higher than premiums collected. To cover these losses, most states impose assessments on

insurers participating in the individual market. Some states finance their pools through more broad-based measures, such as surcharges on other health insurance premiums, excise taxes, or state general revenues.³¹

Renewed interest exists in Congress to provide funding to states to either establish high-risk pools or help finance them. Such assistance has been included in H.R. 3009, recently signed into law by the president as the Trade Act of 2002 (P.L.107-210). Up to \$1 million will be available to each eligible state to establish a new high-risk pool. States with existing qualified risk pools will be able to get federal matching funds to help finance their operation.³²

Public Program Buy-Ins

Instead of, or in addition to, private insurance, tax credits could be designed to subsidize public insurance coverage, such as Medicaid, SCHIP, or a publicly sponsored insurance program. Al Gore proposed the use of tax credits to help low-income families buy into Medicaid or SCHIP during his presidential campaign. Under Bush's proposal, credit-eligible individuals could buy coverage through Medicaid or SCHIP managed care plans in states where these programs contract with such plans; if there are no Medicaid or SCHIP managed care plans, states would be allowed to open up state public employee plans to tax credit recipients. The House and Senate Democratic alternative to Republican economic stimulus packages would have provided tax credits or other forms of public subsidy to help qualified dislocated workers who are not eligible for COBRA health insurance continuation coverage or cannot afford it to buy into Medicaid on a temporary basis.³³ Some Democrats have supported the use of tax credits for pre-Medicare retirees to buy into Medicare.³⁴

All of these "buy-in" proposals face similar design issues: Perhaps the most important is minimizing the effects of adverse selection on both the enrollees in the plan being bought into and the tax-credit-eligible enrollees. Selection is influenced by participation rules, the enrollment process, benefit design, and perhaps most of all, by premiums. Should the coverage offered to tax-credit-eligible individuals be the same as or different from the coverage offered by the public program? How should the premium for the coverage be determined? For example, should the premium charged to these individuals reflect the cost of the broader pool of insureds (for example, all Medicaid or Medicare beneficiaries) or just the pool of tax credit recipients? Who would administer the program for this new pool of insured? Should measures be taken to protect the private carriers from losing business to the public program buy-in option?

Proposals that would give individuals tax credits to purchase Medicaid or SCHIP also raise questions about substitution of federal dollars for state dollars. As suggested earlier, states could be required to maintain their current level of Medicaid spending, as has been done with respect to other policy changes. For example, when SCHIP was enacted, states

Tax credits could be designed to subsidize public insurance coverage, such as Medicaid, SCHIP, or a publicly sponsored insurance program.

were prohibited from substituting the newly available SCHIP dollars for their existing Medicaid commitments.³⁵

SUBSTITUTION

As noted earlier, some of the “tax expenditure” for a new health insurance credit would go to subsidize people who already have coverage. To reduce this “substitution” effect, some proposals would make a credit available only to people who have been without insurance for some period. However, a rule of this kind would be difficult to enforce and, again, raises equity questions. Why should a new buyer receive a subsidy while people at the same income level who have been paying for coverage all along receive no subsidy? Most proposals, then, allow existing buyers of nongroup coverage to claim the credit. There has been much more concern about the potential effects of a credit on the employer market.

One reason that most nonelderly people obtain health insurance through the workplace is that tax subsidies are available for employer coverage but usually not for individually purchased coverage. An individual health insurance tax credit would not just reduce the relative advantage of employer coverage; for some people, it could make nongroup coverage more attractive. In 2001, the average worker with employee-only coverage was contributing \$360 a year toward the cost of his or her premiums.³⁶ If workers eligible for, say, a \$1,000 credit could find a nongroup plan for less than \$1,360, they might be better off dropping the employer coverage. An employer that had many such workers might do better to offer higher wages or other benefits instead of health insurance.

How likely is this scenario? Probably it depends on the size of the credit and whether the credit is available to the middle- and higher-income families who are currently more likely to have employer coverage. Recent attempts to model the effects of various credit proposals have projected modest immediate reductions in employer coverage—drops in the range of 1 to 4 percent.³⁷

Some proposals would seek to preclude coverage-shifting by making people who are offered employer coverage ineligible for an individual credit. (A similar rule currently applies to the health insurance deduction for the self-employed.) Again, a rule of this kind is hard to enforce through the tax code, and would, in any event, not address the long-range incentives for workers to shift to jobs with higher wages and no health plan.

Another option would be to allow the credit to be used for the employee’s share of group premiums. This would remove the incentive for coverage-shifting and would also encourage take-up of coverage by lower-income workers who are currently not participating in their employers’ plans. However, it could also mean that a very large share of the new expenditure would go to currently insured people.

An individual health insurance tax credit would not just reduce the relative advantage of employer coverage; for some people, it could make nongroup coverage more attractive.

Finally, some proposals would completely equalize the tax treatment of individual and employer coverage. For example, an income-based credit might be used for coverage in either setting, while employer contributions would be taxable income for employees. Proponents of this approach point out that the current exclusion of employer contributions favors workers in the higher-income tax brackets because the exclusion or deduction reduces their tax bill by more. Moreover, the current system locks most people into plans selected by their employers, when workers might prefer to choose their own benefits or delivery system.

Opponents of equalized treatment contend that it would destabilize the employer market and potentially increase the number of uninsured people. For example, it could be that younger and healthier workers would be more likely to shift to the nongroup market because they could find better prices. Higher-risk workers would be left behind in a steadily deteriorating risk pool. As prices rose, employers would face greater incentives to drop coverage or shift the costs to workers.

ADMINISTRATION OF TAX CREDITS

There are certain administrative issues associated with implementation that accompany any new federal policy to expand health insurance coverage, and how these issues are addressed can have significant implications for how many people take advantage of the new subsidies. The more complex the system, the longer it will take and more difficult it will be to obtain significant participation rates among the targeted populations. In addition, participation will depend on the degree of effort invested in educating the public on the new program in terms of who is eligible, what the mechanics are for receiving the subsidies, and what types of coverage the subsidies may be used for.

Administration of a tax credit subsidy for health insurance requires determination of individuals' eligibility status and some mechanism to make the subsidy dollars available to those eligible for the purchase of the coverage. If advance funding is provided, there may or may not also be the need to have a reconciliation process whereby actual income is compared to estimated income to determine if an adjustment in the subsidy amount is necessary (either recoupment of excess subsidy funds or provision of additional subsidy funds in cases where income was overestimated).

The most direct way to provide tax credits is simply to use the existing tax filing system. There would be no need to determine eligibility in advance. Individuals would self-determine their eligibility status based on their expected income for the year, and any other criteria relevant to the policy on credits (for example, unemployment status and lack of access to employer coverage). Eligible individuals would receive the applicable amount of reimbursement for their health insurance expenses by claiming the credit when filing their tax returns for the previous year. Individuals who wished some advancement of the credit could

The way administrative issues are addressed during implementation can have significant implications for how many people take advantage of the new subsidies.

adjust their tax withholding to provide additional net income. Reconciliation would be unnecessary since the individual's exact income and eligibility status would be known at the time the claim for the credit was made. However, such an approach has drawbacks, because individuals who would most likely be eligible under any health insurance tax credit approach will have relatively low incomes. In addition to not having much discretionary income to pay premiums, they may not be knowledgeable or comfortable enough with the tax system to understand the consequences or mechanics of withholding.³⁸ And they may not understand how tax credits work, that, for example, they may be available to individuals who do not itemize their returns or that credits are refundable to the extent they exceed total tax liability.

Differing methods for determining probable eligibility and advancing credits are contained in the various tax credit proposals. Often, government agencies that are familiar with qualifying individuals for government programs based on income are used. The exact method proposed often corresponds directly to the characteristics of the target population. For example, proposals to extend tax credits to unemployed or displaced workers may call for the state unemployment offices to perform this function. Other proposals assign this function to state Medicaid programs, especially those proposals that would allow the credit to be used to buy into coverage under state Medicaid or SCHIP programs. One large drawback of using such existing government agencies is the stigma that is attached to government assistance. Many low-income working individuals may be discouraged from taking advantage of the credits if they must interact with government "welfare" agencies. Indeed, reducing the barriers imposed by the welfare stigma is one reason many states have opted to implement SCHIP programs separate from Medicaid.³⁹

There are also various proposals for how the transfer of subsidy funds would be made for payment of the health insurance premiums. Few proposals would advance cash to the individual to use for premium payments. Instead, individuals, once qualified to receive an advance credit, would receive some form of certification that could be used like a voucher to present to the insurer. The insurer would then be paid the subsidy amount on behalf of the individual. The insurer might directly receive payment from the Department of the Treasury, or some other mechanism to provide the funds may be specified. For example, in some proposals, the insurer may deduct the relevant sums from its payroll tax payment obligations. Many proposals simply leave the issue of how vouchers for advance payment would work up to the secretary of health and human services to define through regulations. However payments are made, insurers, or employers in the case of COBRA premiums, are concerned that they be timely; they do not want to have to float the subsidy amounts while waiting for payment by the government.

Making advance payments based on assumptions about income eligibility raises issues of reconciliation after the fact. Individuals who qualify

for advancement of the credits may have changes in circumstances that change their eligibility status. In such cases, the government may be making advance payments to ineligible individuals and some process for recoupment is necessary. Or, if the credits are graduated based on income, some individuals may, in fact, have less income than they anticipated and therefore qualify for larger subsidy payments than they obtained on an advance basis.

Some people think the amounts involved are trivial, especially if eligibility is determined in advance using the prior year's tax return, and that having any kind of reconciliation will scare off potential participants. One way to deal with this problem is simply to establish time-limited eligibility based on information available at the time and not provide for reconciliation after the fact. This approach would require that eligibility be reviewed on a more frequent basis and thus poses an administrative burden. Other proposals provide for reconciliation through the annual tax filing process. However, especially in the case of low-income individuals, individuals may not have realized that their eligibility changed or terminated mid-year and that they are now liable to refund some or all of the advanced subsidies. They may not have available resources to do this.

Providing adequate information and communication about any new federal policy to encourage health insurance coverage is essential to achieving significant participation. This may be even more true of tax policy, which can be arcane and confusing. Higher-risk individuals who have had difficulty obtaining affordable coverage in the existing market might find their way to the program on their own. Attracting a sufficient mix of lower-risk people to permit real pooling might require an information campaign that not only highlights the mechanics of the program but also persuades people of the importance of being insured.

ENDNOTES

1. Under Medicaid, tax credits would have been available to individuals purchasing qualified health insurance plans, phasing down with increased income. See Karen Davis. *National Health Insurance. Benefits, Costs, and Consequences* (Washington, D.C.: Brookings Institution, 1975).

2. This measure was part of the Omnibus Budget Reconciliation Act of 1990 (P.L. 101-508). Originally sponsored by Sen. Lloyd Bentsen (D-Tex.), then chair of the Senate Finance Committee, it provided a refundable tax credit for low-income families who bought health insurance coverage that included qualifying children. Eligible families could elect to receive advance payments of the credit to enable them to buy insurance in the year they needed it instead of having to await the refund in the following year. The complexity of the credits and their low subsidy amounts (the maximum was \$451 in 1992) may have discouraged their use, and problems arose with respect to the marketing of policies that did not qualify for the credit. Even though the credit phased down as income increased, participation in the program increased markedly with family income. The credits were therefore probably replacing existing sources of coverage for many of its recipients as much as encouraging new coverage. The EITC-Health Insurance tax credit was repealed by the Omnibus Budget Reconciliation Act of 1993 (P.L. 103-66). U.S. House, Committee on Ways and Means, *Report on Marketing*

Abuse and Administrative Problems Involving the Health Insurance Component of the Earned Income Tax Credit (Ways and Means Committee Print:103-14, June 1, 1993).

3. The President's Comprehensive Health Care Reform, February 6, 1992. For more information, see Congressional Research Service, *The President's Health Care Reform Proposal* (CRS Report for Congress 92-285 EPW, March 5, 1992).
4. COBRA was enacted in April of 1986 as P.L. 99-272. Employers with 20 or more employees that sponsor group health insurance plans must offer plan participants the option of remaining with the group plan in the event of certain events. Such events include job loss or a change in family status that would otherwise result in the loss of coverage.
5. See H.R. 2250, introduced by Rep. John Cooksey (R-La.) in the 107th Congress.
6. See, for example, Leonard E. Burman and Amelia Gruber, "First, Do No Harm: Designing Tax Incentives for Health Insurance," *National Tax Journal*, 53 (2000), no. 3: 473-493; Richard E. Curtis, Edward Neuschler, and Rafe Forland, "Private Purchasing Pools to Harness Individual Tax Credits for Consumers," *Inquiry*, 382, no. 2 (Summer 2001): 159-176; Lynn Etheredge, "Health Insurance Tax Credits for Workers: An Efficient and Effective Administrative System," Health Insurance Reform Project, Washington, D.C., March 1999; Jon R. Gabel, Kelley Dhont, and Jeremy Pickreign, "Are Tax Credits Alone the Solution to Affordable Health Insurance," Commonwealth Fund, New York, May 2002; Sherry Glied, "Challenges and Options for Increasing the Number of Americans with Health Insurance," *Inquiry*, 38, no. 2 (Summer 2001): 90-105; Jonathan Gruber and Larry Levitt, "Tax Subsidies for Health Insurance: Costs and Benefits," *Health Affairs*, 19, no. 1 (January/February 2000): 72-85; Leslie Jackson and Sally Trude, "Stand-Alone Health Insurance Tax Credits Aren't Enough," Issue Brief No. 41, Center for Studying Health System Change, Washington, D.C., July 2001; Mark V. Pauly and Bradley Herring, "Expanding Coverage via Tax Credits: Trade-offs and Outcomes," *Health Affairs*, 20, no. 1 (January/February 2001): 9-26; Lawrence Zelenak, "A Health Insurance Tax Credit for Uninsured Workers," *Inquiry*, 38, no. 2 (Summer 2001): 106-120.
7. These estimates are based on the March 2001 Current Population Census (CPS) of the Bureau of the Census. In 2000, 38.7 million people were without coverage for the full year, or 15.9 percent of the under age 65 population. See <http://www.census.gov/hhes/hlthins/hlthin00/hlt00asc.html>.
8. Cathy Schoen and Catherine DesRoches "Uninsured and Unstably Insured: The Importance of Continuous Insurance Coverage," *Health Services Research* 35, no.1 (April 2000), part 2: 187-206.
9. Some employers may also set up "premium-only plans" for their employees in which the employee's share of premium payments is made through a salary reduction arrangement and are not counted as taxable income to the employee.
10. Adjusted gross income is total income minus all the above-the-line deductions, such as the deduction for IRA contributions and the self-employed health insurance deduction.
11. Of itemizers with incomes below \$20,000, an estimated 57 percent took the medical expense deduction in 2001, compared to just 3 percent of itemizers with incomes over \$100,000. U.S. Congress, Joint Committee on Taxation, *Estimates of Federal Tax Expenditures for Fiscal Years 2002-2006* (Washington, D.C., January 17, 2002).
12. U.S. Office of Management and Budget, *Budget of the United States Government: Analytical Perspectives, Fiscal Year 2003* (Washington D.C.: 2002). The congressional Joint Committee on Taxation provides much lower estimates of the tax expenditure for the employer exclusion, in part because it assumes that, in the absence of the exclusion, taxpayers would have more expenses subject to the medical expense deduction.
13. For the HIAA/Families USA proposal, see Charles N. Kahn III and Ronald F. Pollack, "Building a Consensus for Expanding Health Coverage," *Health Affairs*, 20, no. 1 (January/February 2001): 40-48.
14. There have also been proposals that would replace the 7.5 percent threshold with a lower percentage, such as 2 percent.
15. See, for example, Pauly and Herring, "Expanding Coverage," and Gruber and Levitt, "Tax Subsidies."

16. Leighton Ku and Teresa A. Coughlin, "The Use of Sliding Scale Premiums in Subsidized Insurance Programs," Urban Institute, Washington, D.C., March 1, 1997; accessed August 13, 2002, at <http://www.urban.org>.
17. Council of Economic Advisers, *Health Insurance Credits* (Washington, D.C., February 2002); Jon Gabel, Kelley Dhont, Heidi Whitmore, and Jeremy Pickreign, "Individual Insurance: How Much Financial Protection Does It Provide?" Marketwatch, *Health Affairs*, Web Exclusive, April 17, 2002; accessed May 2002, at http://www.healthaffairs.org/WebExclusives/Gabel_Web_Exclusive_041702.
18. Karen Pollitz, Richard Soriano, and Kathy Thomas, *How Accessible is Individual Health Insurance for Consumers in Less-than-Perfect Health?* Henry J. Kaiser Family Foundation, Menlo Park, California, June 2001; accessed August 7, 2002, at <http://www.kff.org/content/2001/20010620a/report.pdf>.
19. Community rating is a method for establishing the price for health insurance premiums. The insurance company sets one rate for each plan for all covered people in the same geographic area, regardless of the individual characteristics of those insured, such as age, sex, vocation, and health condition.
20. U.S. General Accounting Office (GAO), *Private Health Insurance: Access to Individual Market Coverage May Be Restricted for Applicants with Mental Disorders*, GAO Report to Congressional Requesters (GAO-02-339) Washington, D.C., February 2002. Information is based on GAO's analysis of the March 2001 Current Population Survey.
21. Although this latter type of coverage shares some of the advantages of group policies (for example, reduced marketing costs), carriers who write policies through intermediaries such as associations still regard their applicants as individuals and generally underwrite and price their policies accordingly. Gary Claxton, *How Private Insurance Works: A Primer*, Henry J. Kaiser Family Foundation, Menlo Park, California, April 2002; accessed August 7, 2002, at <http://www.kff.org/content/2002/2255/privinsprim.pdf>.
22. Mark V. Pauly and Allison M. Percy "Cost and Performance: A Comparison of the Individual and Group Health Insurance Markets," *Journal of Health Politics, Policy, and Law*, 25, no. 1 (February 2000): 9–26; U.S. House, Committee on Ways and Means, *Private Health Insurance: Options for Reform* (Ways and Means Committee Print:101-35, September 20, 1990).
23. Pollitz, Soriano, and Thomas, *How Accessible*.
24. Under pure community rating, the insurer charges each applicant the same amount for the same policy regardless of the applicant's risk factors. Under modified community rating, the insurer may vary the premium for risk factors such as geography, age, and sex but not health status.
25. In 2001, New Hampshire passed legislation to repeal guaranteed issue and increase rating flexibility. It also established a risk pool, to become operational in July 2002.
26. Major reforms were enacted in Washington in 1993; they included guaranteed issue, modified community rating, and tight limits on waiting periods for preexisting condition exclusions. These reforms encouraged significant numbers of insurers to exit the individual insurance market. Some moderating changes were enacted in 1995, and more have been enacted since that time. Kentucky enacted sweeping health insurance market changes in 1994 and 1996, including guaranteed issue and community rating. Premiums rose significantly for a sizable share of the individual market, and all but one carrier decided to pull out of the market. In 1998, largely in reaction to the market disruptions and instability that had emerged in the wake of the previous reforms, a new law was enacted, largely restoring the state's individual insurance laws to the way that they were prior to 1994. New Jersey has had less difficulties in its efforts to reform its individual insurance market. Prior to 1993, only one health insurance carrier offered policies in the individual market as the insurer of last resort. Other carriers helped to subsidize this insurer's losses through reduced premium taxes and hospital reimbursement rates. For a variety of reasons, this situation became unsustainable; in 1993, the state established the Individual Health Coverage Program (IHCP), known as an insurer "play or pay" program. Under the IHCP, insurers choose to issue individual policies that meet state requirements or help pay for an appropriate share of any losses incurred by those carriers electing to sell in the individual market. Although the IHCP has not produced a dramatic

improvement in health insurance coverage rates, it has created a more competitive individual insurance market that offers a choice of standardized products at relatively stable premiums.

27. A rating band compresses the degree of price variation that a given insurer may impose on its policyholders.

28. Lynn Etheredge, "A Flexible Benefits Tax Credit for Health Insurance and More," *Health Affairs*, Web Exclusive, March 22, 2001; accessed August 13, 2002, at http://www.healthaffairs.org/WebExclusives/Etheredge_Web_Excl_32201.htm. A state-developed credit adjustment might be preferable to a national one because age factors might not be constant across markets.

29. Glied, "Challenges and Options," 95.

30. Providing for a federal reinsurance mechanism has been considered on and off at least since the Eisenhower administration. In that period, the federal government would have made reinsurance available to certain prepaid health care plans that could not otherwise obtain reinsurance in order to encourage their participation in the market and broaden their benefit offerings. U.S. House, Committee on Interstate and Foreign Commerce, *Health Reinsurance Legislation*, hearings, 83rd Congress, second session (Washington, D.C., March 1954).

31. Lori Achman and Deborah Chollet, *Insuring the Uninsurable: An Overview of State High-Risk Health Insurance Pools* (New York: Commonwealth Fund, August 2001).

32. Money also was included in the fiscal year 2001 appropriations for the Department of Health and Human Services to help finance the Montana risk pool.

33. Employers with 20 or more employees that sponsor group health insurance plans must offer plan participants the option of remaining with the group plan in the event of certain events, such as job loss or a change in family status that would otherwise result in the loss of coverage.

34. See H.R. 1255 and S. 623 introduced in the 107th Congress by Rep. Pete Stark (D-Calif.) and Sen. Jay Rockefeller (D-W.Va.).

35. See section 2015(c)(6)(B) of the Social Security Act.

36. Larry Levitt et al., *Employer Health Benefits: 2001 Annual Survey*, Henry J. Kaiser Family Foundation and Health Research and Educational Trust, Menlo Park, California, 2001; accessed August 13, 2002, at http://www.kff.org/content/2001/3138/EHB2001_fullrpt.pdf.

37. Testimony of Mark McClellan, member, Council of Economic Advisers, before the Senate Health, Education, Labor, and Pensions Committee, March 12, 2002; Glied, "Challenges and Options"; Gruber and Levitt, "Tax Subsidies."

38. A concern with implementation of the earned income tax credit (EITC) is that some of the benefits intended to help low-income families have been diverted to pay for tax preparation, electronic filing, and refund loan fees. See Alan Berube, Anne Kim, Benjamin Forman, and Megan Burns, "The Price of Paying Taxes: How Tax Preparation and Refund Loan Fees Erode the Benefits of the EITC" (Washington, D.C.: Brookings Institution and Progressive Policy Institute, May 2002).

39. Marilyn Ellwood, *The Medicaid Eligibility Maze: Coverage Expands, but Enrollment Problems Persist, Findings from a Five-State Study*, Occasional Paper No. 30, Assessing the New Federalism, Kaiser Commission on Medicaid and the Uninsured, Washington D.C., September 1999; accessed August 7, 2002, at <http://newfederalism.urban.org/pdf/occa30.pdf>.