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## **ADMINISTRATION'S PROPOSED TAX CREDIT FOR THE PURCHASE OF HEALTH INSURANCE COULD WEAKEN EMPLOYER-BASED HEALTH COVERAGE**

By Edwin Park

### **Executive Summary**

As part of its fiscal year 2005 budget, the Administration has again proposed to provide a refundable tax credit to individuals and families for the purchase of health insurance in the individual health insurance market. The tax credit would be available to individuals and families who do not participate in employer-based coverage or public health insurance programs and would equal up to \$1,000 for individuals and up to \$3,000 for families with children. The full credit would be available to individuals with incomes below \$15,000 per year and families with incomes below \$25,000. The tax credit phases down as income rises above these levels and would phase out entirely when income reached \$30,000 for individuals and \$60,000 for a two-parent family of four.

The Administration estimates the cost of the tax credit proposal to be \$70.1 billion over 10 years, while the Joint Committee on Taxation estimates the cost at \$61.4 billion. But in an unusual development, the Administration's budget provides no significant new resources for the tax credit. Instead, the Administration calls for nearly 90 percent of the cost of the credit to be offset through cuts in other programs.

The budget contains no specific proposal regarding what cuts to make to finance the tax-credit proposal, even as it indicates that the tax-credit proposal should not be enacted unless offsetting savings are found. This enables the Administration to claim it is offering a proposal to cover some of the uninsured while also maintaining that deficits would be cut in half by 2009 under its budget — and to do so without subjecting itself to criticism for proposing specific cuts in popular programs to come up with the savings to finance the tax credit.

This treatment of the tax credit's financing raises questions about the seriousness of the Administration's commitment to the tax-credit proposal. It virtually assures there will be no action on the tax-credit proposal this year.

Before proceeding to an analysis of the tax-credit proposal, one other aspect of it should be noted. When President Bush first unveiled the tax-credit proposal in the 2000 election campaign, he proposed a tax credit of \$1,000 a year for individuals. Four years later, the proposed tax credit for individuals is still \$1,000. Yet health insurance premium costs increased more than 40 percent between 2000 and 2003 and are rising further in 2004.<sup>1</sup>

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<sup>1</sup> Kaiser Family Foundation and Health Research and Educational Trust, "Employer Health Benefits: 2003 Annual Survey," September 2003. The Administration did increase the value of the tax credit it is proposing for two-parent

The proposed tax credit for individuals thus has eroded substantially in value over the past four years and would cover a much smaller share of the cost of health insurance premiums today than it would have covered when President Bush first unveiled the proposal. The failure to raise the credit amount for individuals in the face of rapidly rising health insurance premium costs raises additional questions about the Administration's commitment to the proposal.

### **Issues Regarding the Proposal**

The key issues regarding the proposal remain the same as in past years. The tax credit would result in some currently uninsured individuals gaining insurance. However, the proposal also could materially weaken the employer-based health system through which the vast majority of insured Americans obtain health insurance coverage. It could cause significant numbers of people currently insured through an employer to lose insurance altogether or to have to pay exorbitant amounts to retain it, as a result of employers responding to the tax credit by dropping employer-based coverage or reducing employer contributions for insurance premiums.

This analysis examines the tax-credit proposal. It considers how the proposed credit would affect the two pillars of group health insurance in the United States today — employer-based coverage and public coverage through programs such as Medicaid and SCHIP. The analysis finds that the proposal could have the following troubling effects.

- **The availability of the tax credit would lead some employers to cease providing coverage to their workers or, in the case of new employers, not to offer coverage in the first place.** A series of studies by analysts from M.I.T., the Kaiser Family Foundation, and the Urban Institute have concluded that enactment of a tax credit of this nature would encourage some firms not to offer health insurance coverage to their employees, because the firms would know their workers could get a tax credit to purchase coverage in the individual insurance market. This effect would be greatest among smaller firms with large numbers of low- and moderate-income workers.

Jonathan Gruber of M.I.T., one of the nation's leading health economists, recently conducted an in-depth analysis of the Administration's proposal. Gruber estimates that the availability of the tax credit would cause employers that currently insure approximately 2.3 million workers to drop coverage.<sup>2</sup> Gruber also found that the net effect of some currently *uninsured* people gaining coverage and some currently *insured* people losing coverage would be a net reduction in the number of uninsured people of approximately 1.8 million. This is only a modest improvement given the tax-credit's substantial cost and suggests that the proposed credit would not be an efficient way to reduce the ranks of the uninsured.

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families with two children from \$2,000 in its fiscal year 2002 budget to \$3,000 in its fiscal year 2003 budget. The value of the tax credit for families has remained at \$3,000 in both the fiscal year 2004 and fiscal year 2005 budgets.

<sup>2</sup> Kaiser Family Foundation, "Coverage and Cost Impacts of the President's Health Insurance Tax Credit and Tax Deduction Proposals," March 2004. Further information was provided by Professor Gruber to CBPP.

- **Establishing the credit would lead, for some workers, to the replacement of group coverage provided through an employer with individual health insurance secured in the individual market, a change likely to be harmful to older and less healthy workers.** In most states, insurers can vary the premiums that they charge for health insurance policies offered in the individual insurance market on the basis of age and medical history. Insurers also can simply refuse to cover people who have significant medical problems. The individual market thus is unfavorable for older and less healthy workers. To secure coverage in the individual market, many such workers would have to pay premiums that far exceed the amount of the tax credit. Some of these workers likely would not be able to obtain coverage in the individual market because of their health status. Professor Gruber estimates that of the 2.3 million workers who would lose employer-based coverage as a result of their employer's dropping coverage in response to the tax credit, slightly more than half — about 1.2 million — would become uninsured.
- **The tax credit could institute an “adverse selection” cycle that substantially increases the costs of employer-based coverage.** Under the tax-credit proposal, low- and moderate-income workers whose employers offer coverage but require their employees to pay a significant share of the premium costs could opt out of employer-based coverage and use their tax credits to purchase insurance in the individual market instead. Such a move could be attractive to young, healthy employees, for whom policies may be available in the individual market at modest cost. Since the tax credit would cover 90 percent of the cost of insurance up to the dollar limit of the credit, some young, healthy employees may be able to purchase policies in the individual market and have the tax credit cover a larger share of the cost than the share of premium costs that their employer plan covers.

Gruber's analysis indicates that if the proposed tax credit is established, nearly one million people would voluntarily switch from employer-based coverage to coverage in the individual market. If these largely young and healthy workers opted out of employer coverage, however, the pool of workers remaining in employer plans would become older and sicker, on average. That would drive up the cost-per-covered-worker that these firms face in providing employer-based insurance, which in turn would cause the amounts that workers in employer-based plans must pay for coverage to increase.

This phenomenon, known as “adverse selection,” could induce more young, healthy workers to abandon employer-based coverage and use the tax credit in the individual market instead, since the departure of the first wave of younger, healthier employees would have caused premiums for employer-based coverage to rise. This could lead to a vicious cycle under which growing numbers of healthier workers abandon employer-based coverage, those remaining in such coverage become an increasingly less healthy group, and premiums for employer-based coverage continue to climb.

The increase in premiums for employer-based coverage that ultimately could result eventually could induce substantial numbers of employers — particularly smaller firms with many lower-wage workers — to cease offering health insurance or to increase markedly the amounts that their employees must pay for insurance. A substantial number of older and less healthy individuals eventually could lose employer-based coverage as a result and become uninsured or underinsured or have to pay exorbitant amounts for decent coverage.

- **Older and sicker individuals would encounter difficulty in obtaining adequate, affordable coverage in the individual market.** The individual market is generally unregulated. A family containing older or sick members could find itself excluded from coverage in the individual market or be charged premiums that are unaffordable despite the proposed tax credit. Alternatively, such a family could be offered a plan that is affordable but does not provide coverage for a variety of significant medical conditions. Many plans in the individual market do not offer comprehensive coverage; such plans can require high deductibles, impose substantial cost-sharing, and/or provide limited benefits.

A study published in *Health Affairs* found that deductibles average \$1,550 for insurance plans available in the individual market and that such plans cover 63 percent of medical costs, on average, as compared to 75 percent under group insurance plans. Of particular concern, a Commonwealth Fund analysis found that older individuals with coverage through the individual market were twice as likely as those with employer-based coverage to fail to see a doctor when a medical problem developed or to skip medical tests or follow-up treatment.

The Administration maintains that its proposal addresses the problems of older and less healthy workers by allowing individuals to use their tax credits to buy coverage through high-risk pools and private purchasing pools. The success and scope of such mechanisms, however, has been limited. Even with some federal and state financing, participation in these pools is low, premium costs can be quite high, coverage for pre-existing conditions can be excluded for significant periods of time, and the health insurance benefits provided can be restricted to a fairly narrow range of services. Policies available through high-risk pools also often impose high deductibles and cost-sharing on enrollees.

The Administration's proposal also would permit states to allow certain individuals to use their tax credits to "buy into" comprehensive *public* coverage provided through managed-care options under programs such as Medicaid. It is unclear, however, whether many states would open their Medicaid and SCHIP managed care plans to tax-credit recipients. The people most in need of buy-ins to public coverage tend to be sicker, high-risk individuals who are unable to obtain coverage in the individual market. Adding these individuals to Medicaid and SCHIP managed care pools, which primarily enroll relatively healthy families and children, could increase state Medicaid and SCHIP costs.

- **The tax credit would be of inadequate size to make health insurance affordable for many low- and moderate-income families.** Health insurance can be expensive. According to the General Accounting Office, the mid-range premium for comprehensive family insurance in the individual market exceeded \$7,300 in 1998. Even without factoring in the increases in health insurance premium costs since 1998, a family with income of \$25,000 that received a \$3,000 tax credit would have to spend 15 percent or more of its gross income to purchase insurance at this price. Some more recent studies have found that with a \$1,000 tax credit for individuals, older individuals could have to spend one-third of their income to purchase comprehensive health insurance in the individual market. In some higher-cost geographic areas, premiums for comprehensive coverage could consume even larger percentages of an individual's or a family's income.

To be sure, low- and moderate-income individuals and families in relatively good health could use the tax credit to purchase less comprehensive health insurance that has significantly lower premium costs. Such insurance generally carries much higher deductibles and cost-sharing charges, however, and covers fewer services. Some low- and moderate individuals who purchase such insurance could encounter difficulty in affording the higher out-of-pocket costs required to access various health care services under such plans.

In addition, a number of studies indicate that with a tax credit of this size, health insurance costs for most uninsured low- and moderate-income families would remain beyond what such families could afford. Also of note, early reports show that the vast bulk of the individuals eligible for a federal health insurance tax credit enacted as part of trade legislation in 2002 continue to be uninsured, largely because health insurance remains unaffordable for them despite the tax credit. Although this trade-related tax credit has been touted by the Administration as evidence that a health insurance tax credit can enable people to purchase coverage, participation in the trade tax credit has been minimal; as of November 2003, only about 7,100 individuals nationwide — about three percent of the population eligible for the tax credit — were using it to buy insurance.

Furthermore, the affordability problems associated with the proposed tax credit included in the Administration's budget would grow more serious over time. The maximum tax-credit amounts (\$1,000 for an individual and \$3,000 for a married couple with two children) would be increased each year by the percentage increase in the medical component of the Consumer Price Index, rather than by the actual percentage increase in health insurance premium costs. The medical component of the CPI does not keep pace with health insurance premium increases because, among other factors, it does not reflect changes in the utilization of health services. In some recent years, insurance premiums have risen more *than three times as fast* as increases in the medical component of the CPI. The tax credit consequently would cover a steadily smaller share of insurance premium costs with each passing year. It thus would become less effective over time in helping the uninsured purchase coverage.

This problem is not easy to solve. Making the credit larger could make health insurance in the individual market more affordable for some individuals who would be eligible for the tax credit. But such a step also would have a significant side-effect — it would increase the likelihood that the tax credit would weaken the employer-based health insurance system. A larger tax credit would induce more employers to stop offering health insurance coverage for their workers. It also would induce more young, healthy individuals to leave employer-based coverage and switch to the individual market, thereby exposing older and sicker workers who remained in employer-based coverage to a greater risk of large premium increases.

- **The tax credit would not be a cost-effective and well-targeted approach to reduce the ranks of the uninsured, as the large majority of those who would use the credit are people who already are insured.** Analysts from M.I.T. and the Kaiser Family Foundation have estimated that under this or similar tax credit proposals, *more than two-thirds* of those using the tax credit would be people who are already insured. (The Administration itself has estimated that about two-thirds of tax-credit participants would previously have had insurance.) According to the analysis conducted by Jonathan Gruber of M.I.T., only 3.1 million of the 10.3 million people expected to use the tax credit — about 30 percent — would previously have been uninsured.

Gruber's analysis also finds that because the tax credit would cause some employers to drop coverage (and other employers to reduce their contributions toward the premium cost of employees' health insurance), an estimated 1.3 million people who currently have coverage through their employers would lose coverage and join the ranks of the uninsured. With 3.1 million of the uninsured gaining coverage and 1.3 million people who currently have insurance becoming uninsured, the net reduction in the number of uninsured people would be 1.8 million. This is a modest gain, given the tax credit's \$60 billion-to-\$70 billion ten-year cost.

As a result, less than 18 percent of the credit's cost would go to reducing the ranks of the uninsured. The other 82 percent of the cost would go to providing another tax cut to people who already are insured or to shifting people from their current insurance arrangements, primarily through employer-sponsored coverage, to different insurance arrangements.

- **Establishment of the tax credit could encourage states to scale back Medicaid and SCHIP coverage for families with children.** Facing budget deficits, many states have instituted cuts over the past two years that have narrowed eligibility for parents and children for Medicaid and the State Children's Health Insurance Program. Because the proposed tax credit would be targeted in part at the same low- and moderate-income adults and children as those whom these public programs serve, it could provide states with further inducement to scale back Medicaid and SCHIP coverage. States could decide that beneficiaries could use the tax credits to purchase health insurance in the individual market instead. After

all, unlike public programs that require states to contribute a portion of the costs, the tax credit would be funded in full by the federal government.

As a result, some beneficiaries who now have access to affordable and comprehensive group coverage through Medicaid or SCHIP could be forced into the individual market and either become uninsured — because they cannot afford coverage with the tax credit or are denied coverage due to their health status — or be left with substantially scaled-back insurance that requires them to pay much higher out-of-pocket costs while providing narrower coverage.

- **Some individuals and families may be unable to take advantage of the tax credit due to timing problems regarding “advance payment” of the credit.** Low-income families would have difficulty paying health insurance premiums over the course of the year and then waiting until the tax filing season the following year to get financial assistance through the tax credit. To address this problem, the Administration’s proposal would allow the credit to be available at the time that monthly insurance premium payments are due, rather than at the end of the year when tax returns are filed. Insurers would discount the premiums charged to tax-credit recipients and be reimbursed for the discount by the federal government. This is known as “advance payment” of the credit.

In concept, this should facilitate use of the tax credit. In practice, the advance payment mechanism may have serious inadequacies. In implementing the health insurance tax credit currently available to workers who have lost their jobs due to trade, the Internal Revenue Service is requiring individuals eligible for “advance payment” of that credit to pay themselves at least one month’s full premium up-front. The full cost of one month’s premium can be out of reach for many low-income uninsured families. This appears to be one of the reasons that use of the health tax credit established for workers displaced by foreign trade has been so minimal.

In addition, under the Administration’s proposed tax credit, eligibility for the advance payment option would be based on a taxpayer’s *prior-year* tax return. The incomes of low- and moderate-income families often fluctuate substantially from year to year. Many low-income taxpayers would be ineligible for advance payment because their prior-year income would be too high, even though they have since lost their jobs or had their work-hours reduced. This problem would be particularly acute during economic slumps.

In short, the Administration’s proposed tax credit for the purchase of health insurance suffers from serious flaws. The chief concerns are that the proposed tax credit would encourage employers — particularly those that are smaller and whose workforces contain a large share of low-wage workers — to cease offering health insurance to their employees (or in the case of new employers, not to offer health insurance in the first place), that the credit would leave the uninsured to the vagaries of the unregulated individual health insurance market, and that for many families, insurance in the individual market would remain unaffordable despite the tax credit.

## Description of the Tax Credit Proposal

As part of its fiscal year 2005 budget, the Administration is proposing to provide a refundable tax credit to individuals and families under age 65 who do not participate in employer-based health insurance or public health insurance programs.<sup>3</sup> Two-parent families with two or more children could receive a tax credit of up to \$3,000 a year to pay for health insurance primarily in the individual market, as long as the subsidy did not exceed 90 percent of the premium cost.<sup>4</sup> Individuals could receive a credit of \$1,000. The tax credit also could be used for individual health insurance purchased through private purchasing pools or state high-risk pools where such pools exist.

The subsidy would begin to phase down once a family's income reached \$25,000 (for a family of four with two children) and would cease being available to such families when their incomes reached \$60,000.<sup>5</sup> For individuals, the subsidy would begin to phase down when an individual's income reached \$15,000 and be unavailable to those making \$30,000 or more. The tax credit would be available starting in tax year 2005.

Under the proposal, the credit could be issued in advance, rather than waiting until a family or individual filed a tax return after the year was over. Insurers would reduce the premium cost by the size of a family's tax credit and be reimbursed for the tax-credit amount by the federal government. States also would have the option of letting certain tax-credit recipients purchase coverage in Medicaid or SCHIP managed care plans (or through the state employees' health plan, if the state does not use managed care plans in its Medicaid and SCHIP programs), but there would be no requirement that states do so.

## Likely Weakening of the Employer-Based Health Insurance System

The principal concern with the Administration's tax-credit proposal is that the availability of the tax credit could lead some employers to cease providing coverage to their workers and could induce new employers not to offer coverage.

In separate studies, analysts from M.I.T., the Kaiser Family Foundation, and the Urban Institute have concluded that enactment of a tax credit of this design could encourage some firms (especially smaller firms whose workforces consist primarily of low-income workers) not to offer health insurance coverage to their employees, since firms would know that a substantial share of their workers could get a tax credit to purchase coverage in the individual market.<sup>6</sup> The

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<sup>3</sup> U.S. Department of Treasury, "General Explanations of the Administration's Fiscal Year 2005 Revenue Proposals," February 2, 2004.

<sup>4</sup> Under the Administration's proposal, each adult in a family would be eligible for a credit of \$1,000, and each child (up to a maximum of two children) would be eligible for a credit of \$500. This results in a maximum tax credit of \$3,000 for a two-parent family with two children.

<sup>5</sup> For families with one adult and two children, the credit would not be available if the family's income exceeds \$40,000.

<sup>6</sup> Jonathan Gruber, "Tax Subsidies for Health Insurance: Evaluating the Cost and Benefits," National Bureau of Economic Research, February 2000; Judith Feder, Cori Uccello, and Ellen O'Brien, "The Difference Different



most current study is one that Jonathan Gruber of M.I.T., one of the nation's leading health economists, conducted for the Kaiser Family Foundation. This study was released in March 2004. The Gruber study specifically examines the tax-credit proposal in the Administration's fiscal year 2005 budget.

- Gruber's analysis finds that the proposed tax credit would lead employers to drop coverage for an estimated 2.3 million people. An estimated 1.2 million of these individuals would become uninsured. Another 860,000 would secure coverage in the individual health insurance market, while 240,000 would enroll in Medicaid (see Table 1).<sup>7</sup>
- Gruber estimates that another 150,000 workers would become uninsured because they would drop out of employer-based coverage in response to action by their employers to reduce contributions to workers' premiums. (Some employers would scale back their contributions to workers' health insurance premium costs, reasoning that the tax credit is available for low and moderate income workers who are unable to afford the increased share of premium costs they would have to pay for employer-based coverage.)

Substituting health insurance in the individual market for group coverage through an employer would be troublesome for many workers. Such a change would tend to disadvantage older and less healthy workers, many of whom would not be able to obtain coverage in the individual market or would be able to secure coverage only at a very high cost. In most states, insurers can — and do — vary premiums for health insurance policies offered in the individual market on the basis of age and medical history. Leonard Burman, co-director of the Urban Institute-Brookings Tax Policy Center, has warned that the loss of employer-sponsored coverage that would result from a tax credit of this nature “could be particularly devastating to old and unhealthy workers who would face prohibitively high health insurance premiums in the private non-group market.”<sup>8</sup> Insurers in the individual market also can simply refuse to provide coverage to people whom they believe would be expensive to insure.

### **“Adverse Selection”**

Adding to this problem, some workers whose employers offer coverage would likely opt out of employer-based coverage and to use their tax credits to purchase insurance in the individual market instead. Such a move could be attractive to young, healthy employees. Such workers represent a low risk, so the policies they could purchase in the individual market

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Approaches Make: Comparing Proposals to Expand Health Insurance,” Kaiser Family Foundation, October 1999; Leonard Burman, Cori Uccello, Laura Wheaton and Deborah Kobes, “Tax Incentives for Health Insurance,” Urban/Brookings Tax Policy Center, May 2003; Leonard Burman and Amelia Gruber, “First Do No Harm: Designing Tax Incentives for Health Insurance,” *National Tax Journal*, May 2001; and Linda Blumberg, “Health Insurance Tax Credits: Potential for Expanding Coverage,” Urban Institute, August 2001. The Administration also acknowledges that some tax credits could have this adverse effect on employer-based coverage. Council of Economic Advisers, “Health Insurance Tax Credits,” February 13, 2002.

<sup>7</sup> Kaiser Family Foundation, “Coverage and Cost Impacts of the President's Health Insurance Tax Credit and Tax Deduction Proposals,” March 2004. Further information was provided by Professor Gruber to CBPP.

<sup>8</sup> Burman, Uccello, Wheaton and Kobes, *op. cit.*

**Table 1**  
**Projected Effects of Fiscal Year 2005 Administration Tax Credit Proposal**  
**on Employer-Based Health Insurance**

Number of individuals who would lose employer-based coverage because their employers would not offer coverage	2.27 million
Number who would become uninsured	1.17 million (51.5%)
Number who would be forced into the individual market	860,000 (37.9%)
Number who would become eligible for Medicaid	240,000 (10.6%)
Number of individuals who would lose employer-based coverage and become uninsured due to reduced employer premium contributions	150,000
Number of individuals who would voluntarily leave employer-based coverage to use tax credits in the individual market	960,000
* Kaiser Family Foundation, "Coverage and Cost Impacts of the President's Health Insurance Tax Credit and Tax Deduction Proposals," March 2004. Further information was provided by Professor Gruber to CBPP.	

with the help of a tax credit could cost them less than their share of the cost of premiums for employer-provided coverage (especially if they choose an individual policy that provides more limited coverage).<sup>9</sup> The proposed tax credit could cover 90 percent, up to the dollar limit of the credit, of the cost of inexpensive, less comprehensive coverage that young, healthy workers might be able to obtain in the individual market. By contrast, employers cover an average of about 75 percent of the cost of employer-based health insurance, and a substantial number of employers cover smaller percentages than that.<sup>10</sup> Gruber's research indicates that under the

<sup>9</sup> Jon Gabel, Kelly Dhont and Jeremy Pickreign, "Are Tax Credits Alone the Solution to Affordable Health Insurance," The Commonwealth Fund, May 2002. This study found that the cost of the median individual-market premium for 27 year-old males in 17 geographic markets was 78 percent of the cost of the median employer-based premium. For 27-year old females, however, the median individual-market premium exceeded the median premium for an employer-based plan.

<sup>10</sup> Kaiser Family Foundation and Health Research and Educational Trust, *op. cit.*

Administration's proposal, an estimated 960,000 people would voluntarily switch from their current group policies to individual market policies (see Table 1).<sup>11</sup>

If these younger, healthier workers opted out of employer coverage, the pool of workers remaining in employer plans would become older and sicker, on average, which would drive up the cost-per-covered-worker of employer-based insurance. This phenomenon is known as "adverse selection." Once it started and the premium costs associated with employer-based coverage began to rise, additional younger, healthier workers would likely be induced to abandon employer-based coverage and use their tax credits in the individual market. As premiums for employer-based coverage rose, more workers would be able to do better by using their tax credits in the individual market.

A vicious cycle could thus be set in motion. The increase in premiums for employer-based coverage that ultimately would result could induce substantial numbers of employers either to cease offering health insurance altogether or to increase substantially the amounts that their employees must pay for insurance. The end result would likely be that a substantial number of older and less healthy individuals eventually would either: 1) lose their current employer-based coverage and become uninsured or underinsured (because they were forced into the individual health insurance market as a result of employer dropping); or 2) have to pay very large premium and other out-of-pocket costs to retain decent coverage through their employer.

The return in the past few years of a high rate of inflation in health-care premium costs accentuates the risk that fewer firms would offer coverage if the tax credit were approved. The average cost of employer-based coverage rose 13.9 percent between 2002 and 2003, the largest increase since 1990. Among smaller firms with fewer than 200 workers, health insurance premiums increased 15.5 percent in 2003. In the face of these rising health care costs, employer-based coverage has been weakening, a trend that is likely to continue for at least several years. Due to both premium increases and financial pressures on employers resulting from the economic slump, the percentage of firms with fewer than 200 workers that offer health coverage declined from 68 percent in 2000 to 65 percent in 2003.<sup>12</sup> Institution of the proposed tax credit could provide further inducement for employers seeking to cut costs to drop, or not to institute, health insurance coverage.

### **Overall Impact on the Number of Uninsured**

Overall, Professor Gruber found that 10.3 million people would take up the tax credit, but that fewer than one-third of the participants — 3.1 million — would previously have been uninsured (see Table 2). The other 7.2 million people who would use the tax credit would do so to secure a tax subsidy for individual insurance they already have or to change their existing

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<sup>11</sup> Although the Administration has claimed that the number of employers dropping coverage under its proposal would be minimal (without providing any estimate), Treasury Department estimates show that about 2.5 million tax credit recipients would be individuals who otherwise would have been covered through employer-based health insurance. (It is unclear whether these estimates represent the number of recipients over the course of a year or the number at a point in time.) Testimony of Mark McClellan before the Senate Health, Education, Labor and Pensions Committee, March 12, 2002.

<sup>12</sup> Kaiser Family Foundation and Health Research and Educational Trust, *op. cit.*

**Table 2**  
**Projected Effects of Fiscal Year 2005 Administration Tax Credit Proposal**  
**in Reducing the Number of Uninsured**

Projected number of total participants in the tax credit	10.3 million
Number of participants who would previously have had health insurance coverage	7.16 million (69.6%)
Number who would previously have been uninsured and would gain coverage	3.13 million (30.4%)
Number who would previously have had employer-based coverage but would become uninsured as their employers dropped coverage or reduced their premium contributions.	-1.32 million
Net gain in coverage	1.82 million
* Kaiser Family Foundation, "Coverage and Cost Impacts of the President's Health Insurance Tax Credit and Tax Deduction Proposals," March 2004. Further information was provided by Professor Gruber to CBPP. Numbers may not add due to rounding.	

insurance arrangements. At the same time, an estimated 1.3 million people who currently have employer-based coverage would lose it as a result of the tax credit and join the ranks of the uninsured. The net reduction in the number of uninsured hence would be 1.8 million people, a modest number considering the tax credit's \$60 billion-to-\$70 billion ten-year cost.<sup>13</sup>

The credit thus is likely to be an inefficient and wasteful way to reduce the ranks of the uninsured. The lion's share of the tax credit's substantial cost would go to provide a new tax cut to people who already buy insurance in the individual market or to shift people from their current insurance arrangements (primarily through employer-based coverage) to different insurance arrangements.

### **Limited Access in the Individual Market**

The Administration envisions that most tax-credit recipients would use the credit to purchase health insurance in the individual market. But many of the uninsured face significant barriers to obtaining insurance in that market.

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<sup>13</sup> Kaiser Family Foundation, "Coverage and Cost Impacts of the President's Health Insurance Tax Credit and Tax Deduction Proposals," March 2004.

More than one quarter of all uninsured adults suffer from serious medical conditions such as cancer, heart disease or diabetes. Over half — 53 percent — have a history of serious medical conditions, smoke, or are obese.<sup>14</sup>

In addition, among lower-income uninsured adults over age 50, some 39 percent report a limited disability, and 66 percent have been diagnosed with a chronic condition. Among all uninsured people aged 50-64, some 64 percent report at least one chronic condition.<sup>15</sup>

For such people, insurance in the individual market may be expensive or unavailable. Only a small segment of the uninsured population — 15 percent — are young adults aged 19-34 who neither have children nor any problematic health condition.<sup>16</sup>

The sicker and older individuals who constitute a large percentage of the uninsured often are unable to access adequate health insurance in the individual market without paying exorbitant sums. The individual market is largely unregulated and generally permits individual medical “underwriting” — that is, insurers can vary premiums based on age and medical history and can deny coverage entirely. According to a study by the Commonwealth Fund, only 16 states require that insurers offer a plan to most applicants in the individual market (and this does not necessarily mean an affordable plan).<sup>17</sup> Another Commonwealth Fund study found that among adults aged 19-64 who sought coverage in the individual market and were in poorer health or suffered from chronic conditions, 62 percent found it very difficult or impossible to find a plan they could afford that provided the coverage they needed.<sup>18</sup>

In addition, a Kaiser Family Foundation study examined the response that hypothetical families and individuals applying for coverage in the individual health insurance market would get from insurers. The study considered 60 applications for coverage in eight geographic markets. It found that even people with relatively mild health conditions often are unable to obtain comprehensive coverage in the individual market.<sup>19</sup>

These findings suggest that under the Administration’s proposal, a family containing older or sick members could find itself excluded from coverage in the individual market or be charged premiums that are unaffordable, despite the tax credit. For example, a recent study estimated that adults in poor health participating in tax credits similar to those proposed by the Administration’s would face premiums 50 percent higher than adults in excellent health. Similar

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<sup>14</sup> CBPP analysis of 1997 Health Interview Survey, *op. cit.*

<sup>15</sup> Elisabeth Simantov, Cathy Schoen and Stephanie Bruegman, “Market Failure? Individual Insurance Markets for Older Americans,” *Health Affairs*, July/August 2001.

<sup>16</sup> CBPP analysis of 1997 Health Interview Survey, *op. cit.*

<sup>17</sup> Lori Achman and Deborah Chollet, “Insuring the Uninsurable: An Overview of State High-Risk Health Insurance Pools,” *The Commonwealth Fund*, August 2001.

<sup>18</sup> Lisa Duchon and Cathy Schoen, “Experiences of Working-Age Adults in the Individual Market,” *The Commonwealth Fund*, December 2001.

<sup>19</sup> Karen Pollitz, Richard Sorian and Kathy Thomas, “How Accessible is Individual Health Insurance for Consumers in Less-than-Perfect Health?”, *Kaiser Family Foundation*, June 2001.

premium cost differences in comparing the premiums faced by older tax credit participants ages 55-64 and those faced by younger adults ages 19-29.<sup>20</sup>

Alternatively, such a family might be offered a plan that is affordable but does not provide coverage for a variety of medical conditions. The study also indicates that even families of average age and health may face difficulties in obtaining affordable and comprehensive coverage in the individual market.

In addition, even if a plan is theoretically available in an area through the individual insurance market, there is no guarantee that a family will be able to find, apply for, and enroll in such a plan. Once a family has applied to one plan and been rejected, the unfavorable application result must be reported on subsequent applications and is made available to other insurers via an industry-wide database. Those results can be used to deny the family's subsequent applications. While a family may be able to bypass this system by applying for multiple plans at the same time, applicants generally must submit a payment equal to one month's base premium (unadjusted for age and health status) for *each* plan application. Making multiple payments would generally be impracticable for the low- and moderate-income families on which the tax-credit proposal is targeted.<sup>21</sup>

Furthermore, some individuals and families who find a health insurance policy in the individual market that they can afford may find the policy becomes unaffordable over time. Renewal premium rates often rise significantly after an individual passes age 40.<sup>22</sup> Some insurers also adjust premiums annually based on the person's current health status and health care utilization over the past year.<sup>23</sup> Even once-affordable individual insurance can become prohibitively expensive after an individual becomes sick. And as a result of poor health status, such an individual may then be unable to secure another affordable policy in the individual market.

Many plans in the individual market also impose higher deductibles and cost-sharing and cover a significantly smaller share of health care costs than employer-based health insurance typically does. For example, deductibles for coverage through the individual market average \$1,550. Cost-sharing requirements are usually quite substantial, as well.<sup>24</sup>

### **More Limited Coverage**

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<sup>20</sup> James Reschovsky and Jack Hadley, "The Effect of Tax Credits for Nongroup Insurance on Health Spending by the Uninsured," *Health Affairs* (Web Exclusive), February 25, 2004.

<sup>21</sup> Karen Pollitz and Larry Levitt, "Explaining the Findings of a Study About Medical Underwriting in the Individual Market," Kaiser Family Foundation, May 2002.

<sup>22</sup> Karen Pollitz and Richard Sorian, "Ensuring Health Security: Is the Individual Market Ready for Prime Time," *Health Affairs* (Web Exclusive), October 23, 2002.

<sup>23</sup> Pollitz and Sorian; Chad Terhune, "Is All Fair in Health and Insurance," *Wall Street Journal*, July 30, 2002; Families USA, "Protecting Consumers from Unfair Rate Hikes: The Need for Regulation of Health Insurance Renewal Premium Increases," November 2002.

<sup>24</sup> Jon Gabel, Kelly Dhont, Heidi Whitmore and Jeremy Pickreign, "Individual Insurance: How Much Financial Protection Does It Provide," *Health Affairs* (Web Exclusive), April 17, 2002.

Individual market plans frequently also do not provide the broad range of benefits available in comprehensive employer-based coverage. Plans available in the individual market may not cover preventive or mental health services and may set limits on prescription drug coverage. A study by the Commonwealth Fund found that individual-market plans rarely include maternity benefits.<sup>25</sup> On average, individual market plans cover 63 percent of medical costs, as compared to 75 percent under group insurance plans. Half of people buying policies in the individual market are covered for just 30 percent of their health-care bills.<sup>26</sup>

People enrolled in individual insurance may delay treatment because of potential out-of-pocket costs or because benefits are not covered. One study found that older individuals with individual-market coverage are twice as likely as those with employer-based coverage to fail to see a doctor when a medical problem develops or to skip medical tests or follow-up treatment.<sup>27</sup> Another study concluded that “bare-bones” health plans comparable to some of those found in the individual market could leave low-wage individuals and families with costs in excess of their annual incomes.<sup>28</sup>

### **High-Risk Pools**

In response to such concerns, the Administration would allow tax-credit recipients to buy coverage through high-risk pools or other private purchasing pools. Unfortunately, the success and scope of these mechanisms has been limited.<sup>29</sup> Although more than half the states operate high-risk pools, participation is very low; only 105,000 people nationwide purchased insurance through these pools in 1999. Such pools themselves often impose high premiums, deductibles and other cost-sharing that substantially limit their affordability.

High-risk pools also tend to provide limited benefits; they often exclude mental health and maternity care and/or set a cap on the amount of prescription drug costs they cover. In every state with these pools, participants also face a pre-existing condition exclusion for some period of time — sometimes for as long as a year — even though the pre-existing condition is often the reason that the individual is unable to obtain coverage in the individual market in the first place. In addition, several states have closed enrollment or imposed waiting lists for their high-risk pools, often because of a lack of adequate funding. Congress provided modest funds to states in 2003 to establish or expand high-risk pools, but those funds are likely to be insufficient to improve substantially the affordability and benefits of the policies offered through these pools.

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<sup>25</sup> Sara Collins, Stephanie Berkson and Deirdre Downey, “Health Insurance Tax Credits: Will They Work for Women,” The Commonwealth Fund, December 2002.

<sup>26</sup> Gabel, Dhont, Whitmore and Pickreign, *op. cit.*

<sup>27</sup> Simantov, *op. cit.*

<sup>28</sup> Sherry Glied, Cathi Callahan, James Mays and Jennifer Edwards, “Bare-Bones Health Plans: Are They Worth the Money,” The Commonwealth Fund, May 2002.

<sup>29</sup> Achman and Chollet; Deborah Chollet, “Expanding Individual Health Insurance Coverage: Are High-Risk Pools The Answer?,” Health Affairs (Web Exclusive), October 23, 2002. See also Sally Trude and Paul B. Ginsburg, “Tax Credits and Purchasing Pools: Will This Marriage Work?,” Center for Studying Health System Change, April 2001.

Under the Administration's proposal, states also could allow people to use their tax credits to "buy into" comprehensive public coverage. It is uncertain, however, whether many states would elect this option and open their Medicaid and SCHIP managed care plans to tax-credit users. The people most in need of buy-ins to public coverage would tend to be sicker, high-risk individuals who could not otherwise obtain coverage in the individual market. Adding these individuals to the Medicaid and SCHIP managed care pools — which now consist primarily of parents and children, a younger and generally healthier group — could raise state Medicaid and SCHIP costs significantly.

### **Inadequate Size of the Tax Credit**

Another concern is that the tax credit would be too small to make health insurance affordable for many low- and moderate-income families. According to the General Accounting Office, the mid-range premium for comprehensive family insurance in the individual market exceeded \$7,300 in 1998.<sup>30</sup> Even without factoring in the substantial increases in health insurance premium costs that have occurred since 1998, a family of four with income of \$25,000 that received the full \$3,000 tax credit would have to pay \$4,300 out-of-pocket for health insurance premiums to purchase a comprehensive policy with a \$7,300 premium cost (\$7,300 minus \$3,000 equals \$4,300). That would constitute more than 17 percent of the family's gross income. The family would then incur additional out-of-pocket costs for deductibles and co-payments before it could receive any benefit from the insurance.

A recent Commonwealth Fund study examined premiums for individual health insurance policies that provide coverage comparable to what employer-based insurance typically provides. The study looked at premium costs in 17 cities for policies for a single healthy adult aged 55. It found the median annual premium for these policies in 2001 to be approximately \$6,100.<sup>31</sup> With a tax credit of \$1,000, a 55 year-old with annual income of \$15,000 would have to pay \$5,100 — more than one-third of his or her gross income — to obtain such insurance. A less healthy person generally would have to pay even more, if he or she were not excluded entirely from the individual market. Premiums could consume still larger percentages of family income in some high-cost geographic areas. For example, premiums for a healthy 55 year-old were found to exceed \$9,500 in the Los Angeles-Long Beach, California area in 2001.<sup>32</sup> The tax credit would reduce that cost only to \$8,500.

Studies indicate that premium costs of these magnitudes are well beyond what most low- and moderate-income families can afford, because health insurance costs must compete directly with household necessities such as food and housing.<sup>33</sup> One study found that premiums set at or

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<sup>30</sup> U.S. General Accounting Office, "Private Health Insurance: Potential Tax Benefit of a Health Insurance Deduction Proposed in H.R. 2990," GAO/HEHS-00-104R (April 2000).

<sup>31</sup> Gabel, Dhont and Pickreign, *op. cit.*

<sup>32</sup> Gabel, Dhont and Pickreign, *op. cit.* See also Collins, Berkson and Downey, *op. cit.* which found that individual market premiums for women varied significantly across geographic areas.

<sup>33</sup> Reschovsky and Hadley, *op. cit.*



above five percent of income discouraged most low-income families from enrolling in health insurance.<sup>34</sup>

Recent experience with an existing, more generous federal tax credit underscores these concerns.<sup>35</sup> In 2002, as part of major trade legislation, Congress established a new refundable tax credit that covers 65 percent of the cost of health insurance for individuals who either lose their jobs due to trade or are receiving assistance through the Pension Benefits Guaranty Corporation. Early reports indicate that most eligible individuals are not able to pay the remaining 35 percent of the premium cost themselves and remain without health insurance.<sup>36</sup> At the end of November 2003, only about 7,100 individuals nationwide were participating in this tax credit out of an estimated eligible population of 232,000 individuals.<sup>37</sup> This constitutes a participation rate of about three percent.

To be sure, low- and moderate-income individuals and families in relatively good health might be able to use the proposed tax credit included in the Administration's budget to purchase less comprehensive health insurance in the individual market that carries significantly lower premium costs but requires substantially higher deductibles and cost-sharing and includes fewer covered health care services than employer-based coverage typically does. Although such insurance carries significantly lower premium costs than comprehensive coverage, low- and moderate-income individuals who enroll in such plans can encounter difficulty in paying the much higher out-of-pocket costs that such policies can require before various health care services can be accessed.

### **Value of Credit Would Erode Over Time**

Adding to these problems, the value of the new tax credit the Administration is proposing would erode over time. The maximum tax credit (\$1,000 for an individual, \$3,000 for a married couple with two children) would be increased each year by the percentage increase in the medical care component of the Consumer Price Index. The medical component of the CPI rises much more slowly than health insurance premium costs. The medical-care component of the

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<sup>34</sup> Leighton Ku and Teresa Coughlin, "Use of Sliding Scale Premiums in Subsidized Insurance Programs", Urban Institute, March 1, 1997.

<sup>35</sup> This credit is more generous than the credit than would be provided under the tax-credit proposal in the Administration's budget, because it subsidizes a fixed proportion (65 percent) of the premium cost of health insurance *without any dollar limit*, rather than limiting the credit to \$1,000 for an individual, as under the Administration's proposed tax credit. For an analysis of the trade tax credit, see Edwin Park, "Substantial Flaws in Trade Health Insurance Tax Credit Need to be Addressed Before Consideration of An Expansion," Center on Budget and Policy Priorities, revised March 23, 2004.

<sup>36</sup> Robert Pear, "Sluggish Start for Offer of Tax Credit for Insurance," New York Times, January 25, 2004. A forthcoming analysis by the Center will examine the existing health insurance tax credit and its effectiveness in providing health insurance coverage to eligible individuals.

<sup>37</sup> Treasury Department data. The 7,100 figure includes those individuals who participated in the tax credit on an advance payment basis in 2003. It does not include additional individuals who may have elected to receive the tax credit only when they file their 2003 tax return. The tax-credit-eligible population, as estimated by the Treasury Department, includes both Trade Adjustment Assistance recipients and people receiving assistance through the Pension Benefit Guaranty Corporation.

CPI increased only 3.7 percent in 2003, while health insurance premiums for employer-based coverage rose 13.9 percent.<sup>38</sup> A similar pattern has held for a number of years.

The medical portion of the CPI does not keep pace with health insurance premium increases for a number of reasons. For example, the medical-care component of the CPI reflects changes in the prices of certain health care items and services but does *not* reflect changes in the utilization of such services. Utilization significantly affects health insurance premium costs.

Some supporters of the tax-credit proposal have argued that coverage in the individual market is more affordable than the 1998 General Accounting Office study mentioned above and various other studies have found. Those who make this argument often cite a 2001 analysis by an online health insurance broker which reported that the average premium cost for families of three that succeeded in obtaining coverage in the individual market through the broker was between \$3,600 and \$4,500.<sup>39</sup> Similarly, a study issued by a trade association of health insurers reported that premiums for individuals aged 50-64 who purchased coverage in the individual market ranged from \$2,749 to \$3,642.<sup>40</sup>

Such figures are not applicable to this discussion, however, because they are skewed downward by the lower health risks associated with the *relatively healthy individuals who succeeded in finding insurance that they could afford in the individual market and purchased it*. (These lower premium costs also reflect the higher deductibles and cost-sharing and less-generous benefits that many of these policies provide.) The average cost figures cited in these studies do not reflect the average premium offers that insurers made to applicants who sought but ultimately turned down health insurance in the individual market because the premiums were too high. Also not reflected in these figures is the experience of individuals and families that applied for but were denied coverage based on their medical conditions. Nor do these studies include information on the benefits provided under the individual policies that were purchased or how those benefits compare to the comprehensive coverage typically offered through employer-based plans.<sup>41</sup>

A credit larger than that which the Administration has proposed could make health insurance in the individual market more affordable for some tax-credit beneficiaries. But a

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<sup>38</sup> Bureau of Labor Statistics, "Consumer Price Index: December 2003", January 15, 2004; Kaiser Family Foundation and Health Research and Educational Trust.

<sup>39</sup> eHealthInsurance, "The Cost and Benefits of Individual and Family Health Insurance Plans," June 2001. Based on the study's estimate of cost-per-member-per-month.

<sup>40</sup> Health Insurance Association of America, "HIAA Study: Individual Medical Expense Insurance Affordable, Serves Young and Old," 2002.

<sup>41</sup> A recent study projected that the average premium for health insurance purchased in the individual market through a tax credit would be \$2,820 per individual. These estimates, however, assumed that 71.8 percent of participants would be in excellent or good health, 71 percent of participants would be ages 19-44, and that all children in families with incomes below 200 percent of poverty would be covered through Medicaid and SCHIP rather than under the individual market policies. These assumptions likely lowered the estimated average premium cost. Moreover, unlike the studies previously cited, the estimated premium do not reflect the cost of low-deductible comprehensive individual market coverage comparable to the coverage typically offered in employer-based coverage but rather the cost of coverage typically offered in the individual market which tend to have significant deductibles and cost-sharing and cover fewer benefits. Reschovsky and Hadley, *op cit*.

larger credit also would have adverse side effects — it would increase the likelihood of a negative impact on the employer-based system, as it would induce more employers to cease offering health insurance coverage. It also would increase the probability that more young, healthy individuals would opt to leave employer-based coverage.<sup>42</sup>

## Likely Weakening of State Medicaid and SCHIP Programs

Another concern with the Administration's proposal is that the availability of the tax credit may encourage states to narrow eligibility for Medicaid and SCHIP. The tax credit is targeted on some of the same low-income individuals and families who are served or could be served by these programs.

For families of four, income eligibility for the full tax credit would be capped at \$25,000 per year. This equals 133 percent of the poverty line. Thirty-nine states, including the District of Columbia, provide Medicaid or SCHIP coverage to children in families with incomes up to 200 percent of the poverty line. While many states are less generous with eligibility for working parents — the eligibility limit for parents in the median state is only 71 percent of the poverty line — some 16 states covered working parents up to 100 percent of the poverty line or higher, as of April 2003.<sup>43</sup>

State budget deficits and health-care cost inflation have recently led many states to institute eligibility cuts in their Medicaid and SCHIP programs. Over the last two years, states have eliminated Medicaid and SCHIP eligibility for between 1.2 million and 1.6 million low-income people, many of them working parents and children.<sup>44</sup> Several states also have instituted enrollment freezes and waiting lists for children in their SCHIP programs.<sup>45</sup> Temporary fiscal relief that the federal government provided to states starting in mid-2003 has averted or ameliorated more drastic Medicaid and SCHIP eligibility cuts, but states may propose new Medicaid and SCHIP cuts in the year ahead. States face budget shortfalls totaling about \$40 billion for the 2005 fiscal year (which begins July 1 in most states), and the federal fiscal relief ends this summer.<sup>46</sup>

The availability of the tax credit could provide a further rationale for states facing budget shortfalls to cut their Medicaid and SCHIP programs. States could decide that more low-income families and children should seek health coverage in the individual market with a tax credit.

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<sup>42</sup> Burman and Gruber, *op. cit.*

<sup>43</sup> Donna Cohen Ross and Laura Cox, "Preserving Recent Progress on Health Coverage for Children and Families: New Tensions Emerge," Kaiser Commission on Medicaid and the Uninsured, July 2003.

<sup>44</sup> Leighton Ku and Sashi Nimalendren, "Losing Out: States Are Cutting 1.2 to 1.6 Million Low-Income Children from Medicaid, SCHIP and Other State Health Programs," Center on Budget and Policy Priorities, December 22, 2003.

<sup>45</sup> Donna Cohen Ross and Laura Cox, "Out in the Cold: Enrollment Freezes in Six State Children's Health Insurance Programs Withhold Coverage from Eligible Children," Center on Budget and Policy Priorities, revised January 15, 2004.

<sup>46</sup> Nicholas Johnson and Bob Zahradnik, "Projected State Budget Deficits for Fiscal Year 2005 Continue to Threaten Public Services," Center on Budget and Policy Priorities, revised February 6, 2004.

Unlike under Medicaid and SCHIP, states would not have to provide any matching funds for coverage provided with the credit, since the tax credit would be funded in full by the federal government.

The existence of the tax credit also could discourage states from reversing some of the recent Medicaid and SCHIP cuts when state budgets recover. Similarly, the tax credit could deter states from continuing to expand Medicaid or SCHIP coverage after their budgets recover, as states were doing before the economic slump started. Finally, the tens of billions of dollars in federal funds that would be needed to finance the tax credit would take away scarce federal resources that could otherwise be used to shore up Medicaid and SCHIP during tough economic times and to finance future public-program expansions.

Adding to these concerns, coverage secured with a tax credit through the individual market generally is not comparable to the coverage that Medicaid and SCHIP provide. Unlike many policies in the individual market, Medicaid and SCHIP provide accessible, affordable and comprehensive coverage.

The public programs also are open to any eligible individual, irrespective of age or medical history. This guarantee is of particular importance because Medicaid and SCHIP beneficiaries tend to be in poorer health than other individuals. Children enrolled in Medicaid and SCHIP are more likely than children in private insurance to be in fair or poor health, to have chronic conditions or other special health care needs requiring medication, or to suffer from asthma.<sup>47</sup>

Medicaid and SCHIP also place limits on premiums, deductibles and cost-sharing to ensure that participating low-income families and individuals can afford the out-of-pocket costs. For example, cost-sharing for children enrolled in SCHIP cannot exceed five percent of family income.<sup>48</sup> In addition, these programs provide comprehensive benefits that meet the needs of beneficiaries, including older and sicker families and individuals. Both Medicaid and SCHIP include federal benefits standards that provide for comprehensive health insurance coverage. Under Medicaid, states must provide certain minimum benefits. Under SCHIP, separate state health insurance programs must generally provide a benefits package equivalent to one of several benchmarks, such as the Blue Cross-Blue Shield Standard Option under the Federal Employees Health Benefits Plan.

Beneficiaries who lose public program coverage as a result of the tax credit would face the vagaries of the individual market. Those unable to access coverage could become uninsured. Others able to obtain coverage in the individual market could face significantly higher out-of-

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<sup>47</sup> Leighton Ku and Sashi Nimalendran, "Improving Children's Health: A Chartbook about the Roles of Medicaid and SCHIP," Center on Budget and Policy Priorities, January 2004. While on average, children in Medicaid and SCHIP tend to be in poorer health than children in private insurance, adding older and sicker adults to the managed care risk pools under the Administration's proposed buy-in option would likely worsen the average risk in such pools and increase state Medicaid and SCHIP managed care costs as noted.

<sup>48</sup> If a family has two or more children enrolled in SCHIP, aggregate cost-sharing for the family for all of the enrolled children may not exceed five percent of income.

pocket costs and receive substantially more limited coverage for their medical conditions than they currently receive through Medicaid or SCHIP.

### **Timing Problems for Advance Payment of the Credit**

A number of studies have pointed out that to be effective, especially for low-income families, a tax credit must be available at the time that insurance premiums are due, rather than after the end of the year when tax returns are filed. Low-income families on tight budgets would have difficulty paying health insurance premiums during the year and then waiting until the tax-filing season the following winter and spring to be reimbursed through a tax credit.<sup>49</sup> The Administration proposes to address this timing problem by permitting “advance payment” of the tax credit. Insurers would reduce the premiums that tax-credit recipients have to pay and be reimbursed for the price reduction by the federal government.

The proposed advance payment mechanism, however, may not adequately address these timing problems. In implementing the health insurance tax credit that Congress created for individuals who have lost their jobs due to trade, the Administration is requiring individuals to pay at least one month’s full premium costs up-front.<sup>50</sup> The tax credit is then made available in subsequent months on an advance payment basis. This requirement has apparently discouraged enrollment in the credit, as many eligible individuals are likely to have difficulty paying the full cost of the premium even for one month. In addition, if an individual does come up from the initial full-month premium and the credit then kicks in on an “advance basis,” the individual can lose the advance payment for a period of time, and possibly the remainder of the year, if the individual is as little as one day late in paying his or her share of the monthly premium cost.<sup>51</sup> This can deter participation. As noted above, participation in the trade-related health insurance tax credit has been extremely low.<sup>52</sup>

Intensifying these problems is the fact that under the new tax credit the Administration has proposed, eligibility for advance payment of the credit would be based on the taxpayer’s *prior-year* tax return. The incomes of many low- and moderate-income families fluctuate due to changes in family composition, job losses or changes, reductions in overtime pay and other variables. A taxpayer whose income has fallen and now is quite low may have prior-year income too high to qualify for advance payment of the credit. Without advance payment, however, health insurance will generally remain out of reach. This problem could become acute during economic downturns.

Individuals whose work hours have been reduced since the prior year also could face difficulty. Such workers might no longer qualify for health insurance coverage through their

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<sup>49</sup> Blumberg, *op. cit.*

<sup>50</sup> U.S. Department of Treasury, “Health Coverage Tax Credit Program Kit,” June 2003.

<sup>51</sup> U.S. Department of Treasury, “Health Coverage Tax Credit: The August 1, 2003 Implementation,” June 2003. An individual who successfully participates in the trade-related health insurance tax credit cannot obtain retroactive reimbursement for the initial one month’s full premium until he or she files for taxes the following April.

<sup>52</sup> Pear, *op. cit.*

employer but be unable to get advance payment of the tax credit from the IRS because their prior-year income was too high. Such individuals generally would be unable to purchase health insurance with their own funds and wait for a reimbursement after the end of the year.

## Conclusion

The Administration's proposal to provide a tax credit for the purchase of health insurance in the individual market is deeply flawed. The tax credit would pose a significant threat to the employer-based health insurance system through which the vast majority of Americans obtain health coverage. While the proposed credit might provide meaningful health insurance to some currently uninsured Americans, it also would encourage some firms — particularly smaller firms that employ substantial numbers of low- and moderate-income workers — to drop coverage altogether or not to offer it in the first place, thereby causing significant numbers of workers who currently have insurance to become uninsured. In addition, those workers forced into the individual market by the loss of employer-based coverage who *were* able to purchase a plan in the individual market could face significantly higher premium, deductible and cost-sharing charges and receive coverage for fewer medical conditions and treatments than under their current employer-based plans.

The tax credit also is likely to be of inadequate size to make health insurance affordable for many low- and moderate-income families. Increasing the size of the credit, however, would intensify the risks that the credit would weaken the employer-based health insurance system. The tax credit also could encourage states to scale back Medicaid and SCHIP coverage for low-income families with children.

Finally, the proposed tax credit would not be a cost-effective or well-targeted approach to cover more of the uninsured. More than two-thirds of tax-credit participants would be people who already are insured. A large share of the tax credit's cost would go either to provide people who already are insured through the individual market with a tax benefit or to shift people from employer-based coverage to the individual market. If federal policymakers are committed to reducing substantially the ranks of the uninsured, a more effective approach would be to build upon, rather than weaken, the twin pillars of the U.S. health insurance system — employer-based coverage and public programs like Medicaid and SCHIP.

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