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ADMINISTRATION'S PROPOSED TAX DEDUCTION FOR HEALTH INSURANCE SERIOUSLY FLAWED

by Edwin Park

In an attempt to revive its proposal to establish a new standard tax deduction for the purchase of health insurance, the Administration has injected the proposal into the congressional debate over renewing and strengthening the State Children's Health Insurance Program (SCHIP).

The Administration has threatened to veto the bipartisan SCHIP bill approved by the Senate Finance Committee by a 17-4 vote, as well as the SCHIP bill expected to come to the House floor the week of July 30, which would provide health coverage to between 4 million and 5 million uninsured children. The Administration has sharply criticized these bills as a move to "government-run" health care[1] and argued that its standard deduction would be a far better approach to providing health insurance to uninsured individuals.

Proposed as part of the Administration's fiscal year 2008 budget, the standard deduction would replace the current tax exclusion for contributions an employer makes for an employee's health coverage. The proposal has attracted little support on Capitol Hill, in part because of concerns that it would cause many people in poorer health to lose their health coverage by weakening the employer-based insurance system — the source of most Americans' coverage —

KEY FINDINGS

- The Administration is seeking to revive congressional interest in its proposed tax deduction for the purchase of health insurance by presenting it as a better way to expand health coverage than the SCHIP bills now before Congress.
- The Administration plan, however, would do little to help most of the uninsured buy coverage, since they owe little or no federal income tax.
- In addition, the plan would weaken employer-based coverage by eliminating the tax advantage for employer-sponsored health plans, but would provide no alternative way to "pool" healthier and sicker workers to keep coverage affordable for all.
- In addition, workers who face higher health premiums even though they are not enrolled in an overly generous health plan, such as many people who work for small businesses, could face a tax increase under the plan. Also, the value of the standard deduction would erode substantially over time. These factors would make it more difficult for many people to afford health insurance.

[1] For an analysis of the Administration's claims about the children's health insurance bills and why they do not withstand scrutiny, see Robert Greenstein, "The Administration's Dubious Claims About the Emerging Children's Health Insurance Legislation: Myths and Realities," Center on Budget and Policy Priorities, revised July 20, 2007.

without putting a viable alternative to pool risk in its place. In recent weeks, some influential members of Congress who are sympathetic to the proposal have observed that it is too controversial to be considered by Congress this year, particularly as part of the SCHIP bills.[2]

Some members of Congress may offer amendments on the Senate and House floors to substantially scale back the SCHIP bills (and thus reduce the number of uninsured children who would gain coverage) and substitute the Administration's tax deduction proposal or some variant of it. Also, the Administration could offer at some point to withdraw its veto threat in return for inclusion of its tax deduction or a similar proposal in the final SCHIP legislation.

The Administration's tax deduction proposal, however, is seriously flawed, as this analysis explains. In addition, the Congressional Budget Office has estimated that the tax deduction proposal would result in fewer than 500,000 uninsured children gaining coverage.[3]

The Administration's Proposal

Today, individuals do not pay taxes on their employer's contributions toward their health insurance. This exclusion is worth the most to high-income people, who pay taxes at higher rates and often have more extensive coverage. Low- and moderate-income individuals, who have more difficulty affording insurance, get little or no tax break because they either pay taxes at low rates or owe no income tax. And individuals who do not have access to employer-based insurance do not benefit at all.

Under the Administration's proposal, the current tax exclusion would be eliminated starting in 2009, and individuals with employer-based insurance would have their taxable income increased by the amount of their employer's contribution for their health plan.[4] However, they would be allowed to claim a standard deduction of $7,500 for single coverage or $15,000 for family coverage. Individuals who purchase health insurance through the individual market would be able to claim the same standard deduction.

If the employer's contribution were less than the standard deduction, the employee's taxable income — and hence his or her taxes — would be reduced. If the employer's contribution exceeded the standard deduction, the employee's taxes would go up. The amount of the standard deduction would be increased each year by the annual increase in the Consumer Price Index.

The Treasury Department projects that the proposal, which would eliminate all other tax preferences for health insurance and out-of-pocket health care costs except for Health Savings Accounts, would reduce revenues by $32.7 billion over ten years. The Joint Committee on Taxation disagrees, estimating that the proposal would *increase* federal revenues by $333 billion over ten years.

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[2] See, for example, Fawn Johnson, "Leavitt Reinforces Veto Threat of SCHIP Bill," *Congress Daily*, July 18, 2007.

[3] Letter from Peter Orszag to Senator Max Baucus, Chairman of the Senate Finance Committee, Congressional Budget Office, July 24, 2007.

[4] Under the Administration's proposal, employers would still be able to deduct contributions made on behalf of their employees' health coverage when figuring the firm's taxes.

The Weaknesses of the Proposal

Health policy analysts agree that reforming the tax exclusion for employer-sponsored health insurance should be part of any broader health-care reform effort. For example, the exclusion could be replaced with a refundable tax credit that (unlike the existing exclusion) is not regressive and provides at least as much help to low- and moderate-income individuals, who are least able to afford coverage, as to people at higher income levels. Nevertheless, the Administration's proposed tax deduction likely would do more harm than good, for the following reasons:

- it would give little help to most of the uninsured;
- it would significantly weaken employer-based coverage without providing a viable pooling alternative to employer-based coverage;
- it would mean higher taxes (and less ability to afford coverage) for workers who face higher health premiums *not* because they have elected an overly generous health care plan, but because they are employees of small businesses, firms with older and less healthy workforces, or firms located in geographic areas with high health-care costs; and
- its value would erode substantially over time.

The rest of this paper examines these points in detail.

1. It would give little help to most of the uninsured.

As many as 55 percent of the uninsured would not benefit from the standard deduction because they do not earn enough to owe federal income tax.[5] (Their payroll taxes would decline under the plan, but that would generally be offset by reduced Social Security benefits when they retired, since Social Security benefits are based on the amount of a worker's wages that are subject to the payroll tax.[6])

Most of the remaining uninsured individuals — more than six of every seven — are in the 10 percent or 15 percent tax bracket.[7] Their tax benefits would be modest: $750 for an individual and $1,500 for a family for people in the 10 percent bracket, and $1,125 and $2,250 for individuals and families, respectively, in the 15 percent bracket.[8] These amounts are well below the average cost of employer-based insurance ($4,242 for individual coverage and $11,480 for family coverage in 2006, according to the Kaiser Family Foundation and the Health Research Educational Trust).[9]

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[5] Sherry Glied and Dahlia Remler, "The Effect of Health Savings Accounts on Health Insurance Coverage," The Commonwealth Fund, April 2005. See also Jonathan Gruber, "Tax Subsidies for Health Insurance: Evaluating the Costs and Benefits," Kaiser Family Foundation, January 2000.

[6] Len Burman, *et al.*, "The President's Proposed Standard Deduction for Health Insurance: An Evaluation," Tax Policy Center, February 14, 2007.

[7] Glied and Remler, *op cit.*

[8] These individuals would also have their payroll taxes reduced by $1,147 for individual coverage and $2,295 for family coverage. As noted, however, their future Social Security benefits would be reduced as well.

[9] Kaiser Family Foundation and Health Research Educational Trust, "Employer Health Benefits: 2006 Annual Survey," September 2006.

Comparable coverage in the individual market tends to cost even more than employer-based coverage because of higher administrative costs[10] and insurers' ability to charge higher premiums based on individuals' health status and other risk factors.

In short, the modest tax subsidies that low- and moderate-income people who are uninsured would receive from the Administration's plan would likely be too small to enable a large share of them, particularly those with the lowest incomes, to afford health coverage.

2. It would significantly weaken employer-based coverage.

While highly imperfect, the employer-based health insurance system is the principal means for "pooling" healthy and sick workers together so insurers can offset the high cost of covering sick people with the low cost of covering healthy people, keeping premiums more affordable for everyone. The tax exemption for employer-sponsored insurance is designed to support this pooling mechanism.

A wide body of health economics research has concluded that tax incentives for the purchase of health insurance in the individual market, such as the Administration's proposal, would likely encourage some employers to stop offering health insurance to their employees or not to offer it in the first place.[11] Since individuals could claim the standard deduction whether they obtain their coverage through their employer or on their own, some employers would conclude they did not need to provide coverage. Smaller employers, whose workforces consist to a substantial degree of low-income workers and who are the least likely to offer health insurance today, would be the firms most likely to take this step.

The loss of employer-based coverage would create serious problems for many workers, especially those in poorer health. In most states, companies selling insurance in the individual market vary premiums substantially based on a person's health, as well as other "risk factors" like age and gender. For individuals with medical problems, insurers often charge very high amounts, refuse coverage for these individuals' medical conditions, or refuse to sell them insurance altogether.[12]

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[10] Between 25 percent and 40 percent of the premium cost of individual market insurance goes to administrative costs, as compared to about 10 percent among large group plans. Jon Gabel, *et al.*, "Individual Insurance: How Much Financial Protection Does It Provide?" *Health Affairs*, Web exclusive, April 17, 2002.

[11] See, for example, Jonathan Gruber, "The Cost and Coverage Impact of the President's Health Insurance Budget Proposals," Center on Budget and Policy Priorities, February 15, 2006; Leonard Burman and Jonathan Gruber, "Tax Credits for Health Insurance," Tax Policy Center, June 2005; Jonathan Gruber, "Tax Policy for Health Insurance," Working Paper 10977, National Bureau of Economic Research, December 2004; Leonard Burman, *et al.*, "Tax Incentives for Health Insurance," 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; Linda Blumberg, "Health Insurance Tax Credits: Potential for Expanding Coverage," Urban Institute, August 2001; and Judith Feder, Cori Uccello, and Ellen O'Brien, "The Difference Different Approaches Make: Comparing Proposals to Expand Health Insurance," Kaiser Family Foundation, October 1999. The Administration has itself acknowledged that tax incentives could have this adverse effect on employer-based coverage. Council of Economic Advisers, "Health Insurance Tax Credits," February 13, 2002.

[12] For a discussion of the flawed individual market, see Edwin Park, "Administration's Proposed Tax Credit for the Purchase of Health Insurance Could Weaken Employer-Based Health Coverage," Center on Budget and Policy Priorities, revised April 6, 2004.

For example, a Commonwealth Fund survey found that *71 percent* of individuals in poorer health who sought coverage in the individual market found it very difficult or impossible to find a plan they could afford; one-third were rejected outright or charged a higher premium for their pre-existing conditions.[13] Workers in poor health whose employers drop coverage as a result of the standard deduction could find themselves unable to secure adequate coverage on their own. Many could end up uninsured or underinsured.

In fact, three independent analyses have concluded that the standard deduction would result in substantial declines in employer-based coverage:

- The Congressional Budget Office (CBO) estimates that 7.8 million workers now receiving insurance through their employer would lose such coverage, and 1.5 million of them would end up uninsured.[14]

- In estimates conducted for The Commonwealth Fund, the Lewin Group projected that 12.1 million individuals would lose employer-sponsored insurance, with 2.3 million ending up without coverage.[15]

- The Joint Committee on Taxation (JCT) expects 6 million people would lose employer-sponsored health insurance, with 500,000 becoming uninsured.[16]

The standard deduction also could drive up the cost of employer-based coverage — leading even more employers to drop coverage over time — by provoking a process known as "adverse selection." Healthier employees would be the ones most likely to find that with the standard deduction, they could buy a policy in the individual market that is less expensive than staying in their employer-based plan, since the premiums for the latter reflect the higher cost of the less healthy individuals with whom they are pooled. As healthy individuals opt out of employer-sponsored insurance, the pool of workers remaining in employer plans would become sicker, on average. That, in turn, would drive up the cost of the employer-sponsored plans, raising the premiums for workers remaining in those plans and inducing even more of the healthy workers to abandon them.

Adverse selection could lead to a vicious cycle in which growing numbers of healthier workers drop employer-sponsored insurance, those who remain in such coverage become an increasingly less healthy group, and the premiums for employer-based coverage steadily mount. As JCT notes, if adverse selection occurs, "this cycle could continue to the point where the employer [or employers drop their] health plan due to insufficient enrollment."[17]

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[13] Sara Collins, *et al.*, "Squeezed: Why Rising Exposure to Health Care Costs Threatens the Health and Financial Well-Being of American Families," The Commonwealth Fund, September 2006.

[14] Congressional Budget Office, "Appendix C: The President's Proposal for a Standard Tax Deduction for Health Insurance," in "An Analysis of the President's Budgetary Proposals for Fiscal Year 2008," March 2007.

[15] John Sheils and Randy Haught, "President Bush's Health Care Tax Proposal: Coverage, Cost and Distributional Impacts," The Lewin Group, January 2007. See also Sara Collins, Karen Davis, and Jennifer Kriss, "An Analysis of Leading Congressional Health Bills, 2005-2007: Part I, Insurance Coverage," The Commonwealth Fund, March 2007.

[16] Joint Committee on Taxation, "Estimating the Revenue Effects of the Administration's Fiscal Year 2008 Proposal Providing a Standard Deduction for Health Insurance: Modeling and Assumptions," March 20, 2007.

[17] *Op cit.*

The last workers remaining in the employer's plans would tend to be those in poorest health. They would be the ones least able to obtain coverage in the individual market — and most likely to end up uninsured if their employer dropped coverage.

3. It would provide no viable pooling alternative to employer-based coverage.

Even with the standard deduction, many individuals in poorer health are unlikely to be able to obtain affordable health insurance in the individual market. As a result, CBO has concluded, "the uninsured people who would acquire health insurance under [the Administration's] proposal would also have better health status, on average, than the uninsured population at large . . . [because] premiums in the nongroup market are generally lower for people with lower expected health care costs."[18]

The Administration has acknowledged this problem and argues that its "Affordable Choices" initiative — which would allow states to divert to other purposes the federal funds currently used to support hospitals that care for the uninsured — would address it.[19] The Administration proposes to allow states to convert these funds to subsidies that uninsured people could use to pay for "basic private coverage," principally in the individual market.[20]

Virtually no analysts believe that Affordable Choices represents an adequate solution to this serious problem, for several reasons:

- Under the Affordable Choices proposal, states would receive *no* new federal funds. Safety net hospitals would need to continue to serve large numbers of uninsured people, and it is difficult to see how states could afford to divert a large portion of these funds away from them.

- The Administration argues that states might redirect some of the diverted funds to state "high-risk pools," which sell coverage to people who are unable to purchase insurance in the individual market due to their health status. But high-risk pools have largely been failures. Rather than pool sick people with healthier ones, they pool sick people with even sicker ones who cost even more to insure. Indeed, to keep the cost of these pools from spiraling out of control, many states have had to restrict enrollment, set premiums at very high levels that far exceed what many families can afford, and scale back the scope of the coverage provided.[21]

- The funds that states would be permitted to reallocate under Affordable Choices are distributed very unevenly across states. Many states get few of those funds and thus would have few funds to divert.[22]

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[18] Congressional Budget Office, *op cit*.

[19] See, for example, The White House, "Press Briefing on the President's State of the Union Health Care Initiative," January 22, 2007.

[20] For an analysis of the Affordable Choices proposal, see Judy Solomon, "President's 'Affordable Choices' Initiative Provides Little Support for State Efforts to Expand Health Insurance Coverage," Center on Budget and Policy Priorities, April 3, 2007.

[21] See, for example, Deborah Chollet, "Expanding Individual Health Insurance Coverage: Are High-Risk Pools the Answer?" *Health Affairs*, Web exclusive, October 23, 2002.

[22] Solomon, *op cit*.

If the Administration wishes to move away from the current employer-based health insurance system, as its standard deduction would do, it must provide a viable alternative method of pooling risk. Such approaches could include allowing individuals to buy into Medicare or the Federal Employees Health Benefits Program (FEHBP), which serves federal workers and members of Congress, and/or substantially increasing federal and state regulation of the non-group market so insurers cannot turn away (or charge unaffordable amounts to) people who are sicker or older. The Administration's plan would do none of those things.[23]

Converting the Standard Deduction Into a Refundable Credit Would Improve the Proposal, But Still Leave It Fundamentally Flawed

A number of health policy analysts have recommended that a refundable tax credit be substituted for the Administration's standard tax deduction. Unlike the deduction, such a tax credit would provide the same level of assistance to low-income individuals — including those with no tax liability — as to higher-income individuals. This would be more efficient and equitable.[*]

The Administration appears willing to consider converting the standard deduction to a refundable credit of about $2,500 for individual coverage and $4,500 for family coverage.[**] Without other major changes, however, the Administration's proposal would remain seriously flawed.

- The credit would be too small to make insurance affordable for a large number of the uninsured. For example, it would leave individuals and families responsible for 40-60 percent of the cost of an average employer-based plan. Increasing the size of the credit could make coverage more affordable, but it could also increase the likelihood that employers would no longer offer health insurance to their workers.
- Like the deduction, the tax credit could lead to adverse selection, as described on pages 5-6.
- Like the deduction, the tax credit would encourage some employers to stop offering coverage, leaving workers to use the credit to find coverage on their own in the individual market.
- Even though it would weaken the employer-based insurance system, the tax credit would *not* be paired with an alternative effective pooling mechanism, such as a buy-in to Medicare or FEHBP and/or stronger regulation of the individual market, as explained on pages 6-7. Individuals in poorer health would have difficulty finding affordable plans with comprehensive benefits in the individual market.
- The value of the tax credit would steadily erode over time as health insurance costs outpaced inflation. (The credit, like the standard deduction, would presumably be adjusted each year only by increases in the general inflation rate, rather than by increase in health-care costs.) Over time, this would increasingly affect access to health insurance among low-income individuals, people in poorer health, workers in small businesses, and individuals living in high-cost geographic areas.

[*] See, for example, Burman, *et al.*, *op cit*, and Henry Aaron, "Three Steps to Better Healthcare," *Los Angeles Times*, February 10, 2007.

[**] The White House, "Press Briefing on Health Care by Senior Administration Officials," June 27, 2007.

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[23] In fact, the Administration separately supports legislation that would substantially *weaken* existing state regulation of the individual market by permitting insurers licensed in one state to offer health insurance in all other states even if they do not comply with those states' insurance regulations, including rating rules governing how much insurers may vary premiums based on health status and other risk factors.

4. It would disproportionately affect workers who face higher health premiums, such as employees of small businesses, less healthy workers, and workers in geographic areas with high health-care costs, making it more difficult for them to their afford health insurance.

Under current law, 100 percent of an employer's contribution to the cost of health insurance is tax exempt. The Administration says this exemption creates a bias toward expensive "first dollar" health plans that facilitate the use of unnecessary health care services, and that replacing it with a standard deduction of $7,500 for individual coverage and $15,000 for family coverage would discourage use of these "overly generous" plans.[24]

Because the level of the deduction would initially be set above the average cost of employer-sponsored health insurance, the White House has emphasized that only the enrollees in 20 percent of the nation's employer-based health plans would face a tax increase under its plan.[25] In addition, the Administration has implied that only individuals with very generous plans would be affected by the "cap" that its standard deduction would effectively place on how much of an employer's contribution for health insurance would be tax exempt.[26]

The Urban Institute-Brookings Tax Policy Center and The Commonwealth Fund have both pointed out, however, that this cap would hit many individuals who do *not* have overly generous policies — namely, many individuals who work for small firms, firms with workforces that are older or in poorer-than-average health, or firms located in geographic areas with high health-care costs.[27] The reasons are as follows:

- Employees of small businesses tend to pay more for employer-sponsored health care. Workers' health premiums average 18 percent more for the *same* health plan in firms with fewer than ten employees than in firms with at least 1,000 workers, all other things being equal. (This is primarily due to small-group plans' higher administrative costs, which are related to marketing and medical underwriting.[28])

- In many states, firms with a disproportionate number of older and sicker workers are likely to be charged significantly higher premiums for health policies.[29]

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[24] U.S. Department of Treasury, "General Explanations of the Administration's Fiscal Year 2008 Revenue Proposals," February 2007.

[25] The White House, *op cit*.

[26] The White House, "Affordable, Accessible, and Flexible Health Coverage," January 25, 2007.

[27] Burman, *et al.*, *op cit* and Karen Davis, "The 2007 State of the Union Address: The President's Health Insurance Proposal Is Not a Solution," The Commonwealth Fund, January 2007.

[28] Jon Gabel, *et al.*, "Generosity and Adjusted Premiums in Job-Based Insurance: Hawaii Is Up, Wyoming Is Down," *Health Affairs*, May/June 2006.

[29] Davis, *op cit*. See also Mary Beth Senkewicz, "Senate Bill Would Preempt States' Small Group Rating Rules," Center on Budget and Policy Priorities, April 26, 2006.

Expanding Public Programs Is Considered the Most Efficient and Best-Targeted Way to Provide Health Insurance to More of the Uninsured

As CBO director Peter Orszag and other leading health experts have explained, under the fragmented U.S. health insurance system, virtually any effort to cover more of the uninsured — including the creation of tax deductions or credits for the purchase of insurance in the individual market — would result in some "crowd-out" (i.e., in the substitution of one type of health insurance for another).

Public programs also suffer from such substitution effects. However, Jonathan Gruber of M.I.T., a leading health economist whose work on crowd-out in SCHIP is frequently cited by the Administration, has concluded that "public insurance expansions like SCHIP remain the most cost-effective means of expanding health insurance coverage. I have undertaken a number of analyses to compare the public sector costs of public sector expansions such as SCHIP to alternatives such as tax credits. I find that the public sector provides much more insurance coverage at a much lower cost under SCHIP than these alternatives. Tax subsidies mostly operate to 'buy out the base' of insured without providing much new coverage."[*]

[*] Letter from Jonathan Gruber to Representative John Dingell, Chairman of the House Energy and Commerce Committee, March 2007.

- Health insurance premiums vary across localities, states, and regions.[30] The premiums for the same plan may be below the effective cap that the standard deduction would create in one region of the country but above the effective cap in another region.

5. Its value would erode substantially over time.

Under the Administration's proposal, the size of the standard deduction would be adjusted annually by the Consumer Price Index (CPI). The CPI has historically risen at a much slower rate than health-care costs and health insurance premiums. For example, employer-sponsored insurance premiums rose by an average of 11 percent annually between 2000 and 2006, while the CPI averaged only 2.7 percent.[31]

JCT expects this trend to continue. Between 2009 and 2017, JCT expects premiums in employer-based health insurance to increase by about 7 percent per year, while the CPI would increase by about 2.2 percent annually.[32]

As a result, over time the value of the standard deduction would steadily shrink relative to the cost of insurance. The Administration itself acknowledges that after ten years, about 60 percent of current employer-based health plans would have costs above the level of the standard deduction — which means the enrollees in these plans would face a tax increase.[33] That is why the

[30] See Agency for Healthcare Quality and Research, "City vs. City: When It Comes to Health Insurance Costs, Geography Matters," December 21, 2006 and Gabel, *et al.*, *op cit*.

[31] Kaiser Family Foundation and Health Research Educational Trust, *op cit*.

[32] Joint Committee on Taxation, *op cit*.

[33] Burman, *et al.*, *op cit*.

Administration's proposal would produce revenue increases in later years, as more and more health premiums become taxable.

As a consequence, fewer individuals would be able to afford comprehensive health coverage over time. CBO estimates that under the proposal, typical health insurance benefits are projected to decline by 15 percent by 2010.[34] Similarly, JCT projects that employer-based plans would become "leaner," ultimately leading 17 million more individuals to enroll in high-deductible health insurance plans that qualify for a Health Savings Account.[35]

This could pose a particular problem for low-income individuals in poorer health. Research has shown that high deductibles and co-payments can lead to a deterioration in such individuals' health, as they forgo medically necessary services they have difficulty affording.[36]

As noted above, this also would disproportionately harm people who work for small firms, firms with older or less healthy workforces, and firms located in geographic areas with high health-care costs. Over time, such people would increasingly be forced into stingier plans or be unable to afford insurance altogether.

Conclusion

Although reforming the tax exclusion for employer-sponsored health insurance is an essential element of broader health-care reform, the Administration's standard deduction proposal is poorly designed. To become workable, the proposal would need to be revamped to provide viable mechanisms to pool risk in the non-group market and to prevent the value of the deduction from eroding over time.

As noted M.I.T. health economist Jonathan Gruber has observed, "If you're going to blow up the employer-based system you need somewhere else where people can go. [President] Bush doesn't do that, and that's the fundamental flaw. Overall [the President] has raised an important issue, but he chose to do it in a dangerous context."[37]

In short, the Administration's proposal is "not ready for prime time." It surely ought not to be used to impede passage of legislation that would bring coverage to as many as 5 million low-income children who otherwise will remain among the ranks of the uninsured.

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[34] Congressional Budget Office, *op cit*.

[35] Joint Committee on Taxation, *op cit*.

[36] See, for example, Leighton Ku, "Charging the Poor More for Health Care: Cost-Sharing in Medicaid," Center on Budget and Policy Priorities, May 7, 2003, and Julie Hudman and Molly O'Malley, "Health Insurance Premiums and Cost-Sharing: Findings from the Research on Low-Income Populations," Kaiser Commission on Medicaid and the Uninsured, March 2003.

[37] Economic Research Institute on the Uninsured, "On My Mind: Conversations with Economists, Universal Coverage Rx: Tax Code Changes, Money, Insurance Pools and a Mandate, Interview with Jonathan Gruber, Ph.D., Professor of Economics at the Massachusetts Institute of Technology," February 2007, available at www.umich.edu/~eriu/forthemedia/interviews_gruber.html.