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

by Edwin Park

Executive Summary

As part of its fiscal year 2004 budget, the Administration has proposed to provide a refundable tax credit to individuals and families for the purchase of health insurance in the individual health insurance market. This proposal is the chief component of a series of budget proposals related to the uninsured.

The tax credit would be available for the purchase of health insurance in the individual market for individuals and families who do not participate in employer-based coverage or public health insurance programs. The credit would equal up to \$1,000 for individuals and up to \$3,000 for families with children, with the full credit being available to individuals with incomes of less than \$15,000 per year and families with incomes below \$25,000. The tax credit would phase down as income rose 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. According to the Joint Committee on Taxation, the proposal would cost \$64 billion over 10 years (the Administration estimates the cost at \$89 billion). The proposal accounts for a large percentage of the new federal resources the Administration is proposing for the uninsured.

While the tax credit would result in some currently uninsured individuals gaining insurance, the proposal is highly controversial. It poses substantial risks. In particular, the tax credit could materially weaken the employer-based health system through which the vast majority of insured Americans obtain their health insurance coverage and could cause some currently insured people — particularly people who are older or are in poorer health — to lose insurance altogether or to have to pay exorbitant amounts to retain insurance.

This analysis examines the Administration's tax credit proposal. It considers how the credit would affect the two pillars of group health insurance in the United States — employer-based average and public coverage through programs such as Medicaid and SCHIP. The analysis finds that the tax credit proposal would pose significant risks, including the following:

- **The availability of the tax credit could lead some employers to cease providing coverage to their workers and could induce many new employers not to offer coverage.** Analysts from M.I.T., the Kaiser Family Foundation, and the Urban Institute have found 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 now get a tax credit to purchase coverage in the individual market. Substituting the purchase of health

insurance in the individual market for group coverage through an employer, however, would seriously disadvantage older and less healthy workers. In most states, insurers can vary premiums for health insurance policies offered in the individual market on the basis of age and medical history and can refuse to cover people entirely. Many older and less healthy workers would generally have to pay far more than the amount that the tax credit would provide to secure coverage in the individual market or would not be able to obtain coverage at all because of their health status.

- **The tax credit could institute an “adverse selection” cycle that substantially increases the costs of employer-based coverage.** Aggravating this problem is the fact that under the Administration’s proposal, workers whose employers do offer coverage and require their employees to pay a share of the premium would be able to opt out of employer-based coverage and instead use their tax credits to purchase insurance in the individual market. Such a move could be attractive to young, healthy employees; they may be able to purchase individual policies for which the tax credit could cover up to 90 percent of the cost, which often would be a larger percentage of the cost than their employer would cover. But if these young and healthy workers opt out of employer coverage, the pool of workers remaining in employer plans would become older and sicker, on average, which in turn would drive up the costs of employer-based insurance and further raise the amounts that both employers and the employees remaining in these plans must pay for insurance.

This phenomenon — known as “adverse selection” — could then induce additional younger, healthier workers to abandon employer-based coverage and use their tax credits instead, because the departure of the first wave of younger, healthier employees would have caused premiums for employer-based coverage to rise. In this way, a vicious cycle could be set in motion. The increase in premiums for employer-based coverage that ultimately could occur could induce many employers either to cease offering health insurance or to increase substantially the amounts their employees must pay for insurance. The end result would likely be that many older and less healthy individuals would eventually lose their employer-based coverage and become uninsured or underinsured or have to pay exorbitant amounts for decent coverage.

Intensifying the risk that many firms might not offer coverage is the recent return of a high rate of inflation in health care costs, which are now rising at double-digit rates. As a result, fewer firms, especially those of smaller size, are offering health insurance coverage to their employees. Institution of the tax credit could provide a further incentive for some employers seeking to cut costs to drop or not to institute coverage for their workforce.

- **Older and sicker individuals likely would be unable to secure adequate health insurance in the individual market without paying exorbitant amounts.** The individual market is generally unregulated. Under the

Administration's proposal, a family containing older or sick members could find itself excluded from coverage in the individual market or charged premiums that are unaffordable, even with a \$3,000 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. They may require high deductibles, impose significant cost-sharing, and provide minimal benefits.

The Administration says its proposal responds to this concern by allowing tax-credit recipients to buy coverage through high-risk pools and private purchasing pools. The success and scope of these mechanisms, however, has been quite limited. Even with some federal and state funding, participation is often low, premium costs are substantial, and the health insurance benefits provided can be restricted to a fairly narrow range of services. Moreover, policies available through high-risk pools often impose high deductibles and cost-sharing or exclude coverage of pre-existing conditions for a lengthy period of time.

The Administration's proposal would permit states to allow certain individuals also to use their tax credits to buy into comprehensive public coverage. It is uncertain, however, how many states would elect this option and open their Medicaid and SCHIP managed care plans to tax-credit recipients. Because the people most in need of buys-in to public coverage tend to be sicker, high-risk individuals unable to obtain coverage in the individual market, adding these individuals to the current Medicaid and SCHIP managed care pools (which primarily enroll relatively healthy families and children) could increase 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 family insurance in the non-group 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 receives a \$3,000 tax credit would have to expend 15 percent or more of its gross income to purchase insurance at this price. Furthermore, more recent studies have found that with a \$1,000 tax credit for individuals, older individuals may have to spend one-third of their income to purchase comprehensive health insurance in the individual market. In some higher-cost geographic areas, premiums could consume still-greater percentages of an individual's or family's income. Studies indicate that such expenditure levels are substantially beyond what most low- and moderate-income families can afford. In addition, the value of the tax credit is likely to erode over time. The Administration's proposal would index the full credit amount annually by inflation, not by increases in health costs. As a result, in some years, insurance premiums could increase by more than two and a half times faster than increases in the value of the tax credit.

- **The tax credit would not be a cost-effective and well-targeted approach to reduce the ranks of the uninsured, since the large majority of those who would use the credit already have insurance.** 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 already are insured. As a result, relatively little of the benefit of the credit would go to reducing the ranks of the uninsured. Instead, a large share of the credit's substantial cost would go either to provide people who already are insured with another tax cut or to shift 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 severe budget deficits, some states have begun cutting eligibility for working parents and children under Medicaid and the State Children's Health Insurance Program. Because the tax credit is targeted in part at the same low- and moderate-income adults and children served by these public programs, states may have another inducement to reduce Medicaid and SCHIP coverage. States could decide that beneficiaries could instead go out and use the tax credits to purchase health insurance in the individual market. After all, unlike public programs that require states to contribute a portion of the costs, the tax credit would be fully funded by the federal government. As a result, beneficiaries who now have access to affordable and comprehensive public coverage through Medicaid or SCHIP could be placed into the individual market and become uninsured or face much higher out-of-pocket costs and significantly reduced benefits.
- **Some individuals and families may be unable to take advantage of the tax credit because of timing problems for "advance payment" of the credit.** To ensure that people can take advantage of the tax credit, the Administration proposal allows the credit to be available at the time that insurance premium payments are due, rather than at the end of the year when income tax returns are filed. Insurers would discount premiums paid by tax-credit recipients and be reimbursed for the discount by the federal government. Eligibility would be based on the taxpayer's prior-year tax return. However, the incomes of low- and moderate-income fluctuate substantially during the course of a year. As a result, some taxpayers may be presumed to be ineligible because their prior-year income was too high to qualify for the credit, even though they may have since lost their jobs or had their work hours reduced.

Description of Administration Health Insurance Tax Credit Proposal

As part of its fiscal year 2004 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.¹ Two-parent families with two or more children could receive a tax credit of up to \$3,000 annually to pay for health insurance primarily in the individual market, so long as the subsidy does not exceed 90 percent of the premium cost. 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 altogether to such families when their incomes reached \$60,000.² For individuals, the subsidy would begin to phase out 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 2004.

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 credit and be reimbursed by the federal government. States would also have the option of letting certain tax-credit recipients purchase coverage in their Medicaid or SCHIP managed care plans (or through their state employees' health plan if no managed care plans are available), 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 induce new employers not to offer coverage.

Analysts from M.I.T., the Kaiser Family Foundation, and the Urban Institute all have concluded that enactment of a tax credit of this design could encourage firms not to offer health insurance coverage to their employees because firms would know their workers could now get a tax credit to purchase coverage in the individual market.³ Research that Professor Jonathan Gruber of M.I.T. conducted in analyzing the Administration's tax credit proposal from last year, which is nearly identical to this year's proposal, found the proposal would lead employers to

¹ U.S. Department of Treasury, *General Explanations of the Administration's Fiscal Year 2004 Revenue Proposals*, February 3, 2003.

² For families with one adult and two children, the credit would not be available if the family's income exceeds \$40,000.

³ 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 Approaches Make: Comparing Proposals to Expand Health Insurance*, Kaiser Family Foundation, October 1999; Leonard E. 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.

Table 1
Projected Effects of Last Year's 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 | 2.4 million |
| Number who would become uninsured | 1.4 million (58%) |
| Number who would be forced into the individual market | 1.0 million (42%) |
| Number of individuals who would voluntarily leave employer-based coverage to use tax credits in the individual market | 1.5 million |
| * Jonathan Gruber, Written Testimony before the Subcommittee on Health, House Ways and Means Committee, February 13, 2002. | |

drop coverage for 2.4 million people — 1.4 million of whom would become uninsured and one million of whom would switch to the individual market (see Table 1).⁴

Substituting the purchase of health insurance in the individual market for group coverage through an employer would be troublesome. It could seriously disadvantage older and less healthy workers, many of whom would not be able to obtain coverage in the individual market or could obtain coverage only at exorbitant 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 and can refuse to cover people entirely. If employers who otherwise would offer coverage decline to do so because of the availability of a tax credit of this nature, the consequences could be serious for many older and less healthy workers, who generally would have to pay far more than the tax credit would provide to secure coverage in the individual market, if they were able to secure coverage at all. The individual market often simply denies insurance to people with certain health conditions.

Aggravating this problem is the fact that under the Administration's proposal, some workers whose employers offer coverage and ask their employees to pay a share of the premium could opt out of employer-based coverage and use the tax credits to purchase insurance in the individual market instead. Such a move could be attractive to young, healthy employees. Because such workers represent a low risk, the policies they could buy in the individual market with the help of a tax credit may 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

⁴ Jonathan Gruber, Written Testimony before the Subcommittee on Health, House Ways and Means Committee, February 13, 2002.

limited coverage.⁵ The tax credit could cover 90 percent of the cost of inexpensive coverage that some young, healthy workers might obtain, while employers pay an average of three-quarters of the cost of job-based health insurance.⁶ Young and healthy workers thus could find it financially advantageous to opt out of employer coverage and move into the individual market. Professor Gruber's research analyzing the Administration's proposal from last year indicated that under the proposal, approximately 1.5 million people would voluntarily switch from their current group policies to individual market policies (see Table 1).⁷

But if these workers — largely those who would get the lowest cost policies in the individual market — opt out of employer coverage, the pool of workers remaining in employer plans would become older and sicker on average, which in turn would drive up the costs of employer-based insurance. This phenomenon is known as “adverse selection.” Once adverse selection starts and the cost of employer-based insurance begins to rise, additional younger, healthier workers would be induced to abandon employer-based coverage and use their tax credits instead, because they now could do better in the individual market using the tax credits.

In this way, a vicious cycle — sometimes called an insurance death spiral — could be set in motion. The increase in premiums for employer-based coverage that ultimately could occur could induce many employers either to cease offering health insurance or to increase substantially the amounts their employees must pay for insurance. The end result would likely be that many older and less healthy individuals would eventually lose their employer-based coverage and become uninsured or underinsured (if their employer dropped coverage) or have to pay very large amounts to retain decent coverage.

Intensifying the risk that many firms might not offer coverage is the recent return of a high rate of inflation in health care costs. The average cost of employer-based coverage rose 12.7 percent between 2001 and 2002, the largest increase since 1990. Among small firms with fewer than 50 workers, health insurance premiums increased by more than 14 percent. Due in part to these premium increases (and in part to financial pressures resulting from the economic slump), the number of smaller firms with fewer than 200 workers that offer health coverage declined from 67 percent in 2000 to 61 percent in 2002.⁸ Institution of the tax credit could

⁵ 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 median individual market premium for 27 year-old males in 17 geographic markets was 78 percent 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.

⁶ Kaiser Family Foundation and Health Research and Educational Trust, *Employer Health Benefits: 2002 Annual Survey*, September 2002.

⁷ While claiming only minimal employer dropping under the Administration's proposal from last year (without providing an actual estimate), the Treasury Department's 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 uncertain whether these estimates represent recipients over the course of a year or at a point in time.) Testimony of Mark McClellan before the Senate Health, Education, Labor and Pensions Committee, March 12, 2002.

⁸ Kaiser Family Foundation and Health Research and Educational Trust.

Table 2
Projected Effects of Last Year's Administration Tax Credit Proposal
in Reducing the Number of Uninsured

| | |
|--|-------------------|
| Projected number of total participants in the tax credit | 10.5 million |
| Number of participants who would previously have had health insurance coverage | 7.2 million (69%) |
| Number who would previously have been uninsured and would gain coverage | 3.3 million (31%) |
| Number who would previously have had employer-based coverage but would become uninsured | -1.4 million |
| Net gain in coverage | 1.9 million |
| * Jonathan Gruber, Written Testimony before the Subcommittee on Health, House Ways and Means Committee, February 13, 2002. | |

provide a further rationale for employers seeking to cut costs to drop or not to institute health coverage.

On balance, M.I.T. professor Jonathan Gruber found that 10.5 million people would take up the tax credit under the proposal the Administration offered last year (see Table 2). Of those, fewer than one-third — 3.3 million people — would previously have been uninsured. The other 7.2 million people who would use the tax credit would do so either to secure a tax subsidy for individual insurance they already had or to change their existing insurance arrangements. Because the credit would cause significant churning in employer-provided insurance, an estimated 1.4 million people who currently have employer-based coverage would lose it and join the ranks of the uninsured. The net reduction in the number of uninsured would have been only 1.9 million people, a relatively small number considering the tax credit's \$64 billion ten-year cost.⁹

Limited Access in the Individual Market

The Administration envisions that most tax-credit recipients would primarily use the credit to purchase health insurance in the individual market. Many of the uninsured face significant barriers, however, to obtaining insurance in the individual market. More than one

⁹ Gruber, Written Testimony, February 13, 2002.

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.¹⁰

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.¹¹ These are some of the people for whom insurance in the individual market may be either expensive or unavailable. Only a small segment of the uninsured population — 15 percent — are young adults aged 19-34 who do not have children and lack problematic health conditions.¹²

As noted, these sicker and older individuals who constitute such a large percentage of the uninsured would likely be unable to access adequate health insurance in the individual market without paying exorbitant amounts. The individual market is largely unregulated. It 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 that does not necessarily mean an affordable plan.¹³ Another Commonwealth Fund study found that among adults aged 19-64 who sought coverage in the individual market and who were in poorer health or suffered from chronic conditions, 62 percent found it very difficult or impossible to find a plan they could afford with the coverage they needed.¹⁴

A Kaiser Family Foundation study examined the response that hypothetical families and individuals applying for coverage in the individual health insurance market would meet; the hypothetical applicants were structured to test the medical underwriting process through 60 applications in eight geographic markets. The study found that older and sicker people, even those with relatively mild conditions, are often unable to obtain comprehensive coverage in the individual market.¹⁵

These findings indicate that under the Administration’s proposal, a family containing older or sick members could find itself excluded from coverage or charged premiums that are

¹⁰ CBPP analysis of 1997 Health Interview Survey.

¹¹ Elisabeth Simantov, Cathy Schoen and Stephanie Bruegman, *Market Failure? Individual Insurance Markets for Older Americans*, Health Affairs July/August 2001.

¹² CBPP analysis of 1997 Health Interview Survey.

¹³ Lori Achman and Deborah Chollet, *Insuring the Uninsurable: An Overview of State High-Risk Health Insurance Pools*, The Commonwealth Fund, August 2001.

¹⁴ Lisa Duchon and Cathy Schoen, *Experiences of Working-Age Adults in the Individual Market*, The Commonwealth Fund, December 2001.

¹⁵ 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.

unaffordable, even with a tax credit. Alternatively, such a family could be offered a plan that is affordable but does not provide coverage for a variety of medical conditions.

In the individual insurance market, even if a plan is theoretically available in a geographic area, there is no guarantee that a family would be able to find, apply for and enroll in such a plan. Once a family has applied to one plan and has been rejected, that unfavorable application result must be reported on subsequent applications and also is made available to other insurers via an industry-wide database. These results can then 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 must generally submit a payment equal to one month's base premium (unadjusted for age and health status) for each plan application, in order to start the medical underwriting process. Such a payment would often be impracticable to the low and moderate-income families to which the tax credit proposal is targeted.¹⁶

Even individuals and families who find an affordable health insurance policy may find that it becomes unaffordable over time. For example, renewal premium rates often rise significantly after an individual passes age 40.¹⁷ Some insurers also impose "re-underwriting," by which premiums are adjusted annually based on the person's current health status and health care utilization from the year before.¹⁸ As a result, even once-affordable individual insurance can become prohibitively expensive after an individual becomes sick. Because 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 impose higher deductibles and cost-sharing, provide fewer benefits, and cover a significantly smaller share of health care than employer-based health insurance policies do. For example, many individual market plans require high deductibles of \$1,000 or more — on average, deductibles are set at \$1,550 in the individual market — and cost-sharing requirements are significant. Individual market plans also often do not cover the broad range of benefits available in comprehensive employer-based coverage. Plans available in the individual market may not cover preventive benefits or mental health services and may set limits on prescription drug coverage. A recent study by the Commonwealth Fund found that individual market plans rarely include maternity benefits.¹⁹ On average, individual market plans cover only

¹⁶ Karen Pollitz and Larry Levitt, *Explaining the Findings of a Study About Medical Underwriting in the Individual Market*, Kaiser Family Foundation, May 2002.

¹⁷ Karen Pollitz and Richard Sorian, *Ensuring Health Security: Is the Individual Market Ready for Prime Time*, Health Affairs (Web Exclusive), October 23, 2002.

¹⁸ 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.

¹⁹ Sara Collins, Stephanie Berkson and Deirdre Downey, *Health Insurance Tax Credits: Will They Work for Women*, The Commonwealth Fund, December 2002.

63 percent of medical costs, as compared to 75 percent under group insurance plans. Half of people buying individual policies are covered for just 30 percent of their health care bills.²⁰

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 coverage are *twice as likely* as those with employer-based coverage to fail to see a doctor when a medical problem has developed or to skip medical tests or follow-up treatment.²¹ Another study concluded that so-called “bare-bone” health plans, comparable to some of those found in the individual market, could leave low-wage individuals and families with catastrophic costs well in excess of their annual income.²²

In response to such concerns, the Administration would allow tax-credit recipients to buy coverage through high-risk pools or other private purchasing pools. According to the Commonwealth Fund and other researchers, however, the success and scope of these mechanisms has been limited.²³ While more than half the states operate high-risk pools, participation is low — only 105,000 people participated nationwide in 1999. Such pools themselves often impose high premiums, deductibles and other cost-sharing that substantially limit their affordability.

For example, in one-fifth of the states with high-risk pools, premiums for older enrollees were at least \$10,000.²⁴ High-risk pools also tend to provide limited benefits. For example, they often exclude mental health and maternity care or set a cap on the amount of prescription drugs costs they will cover. Participants also face a pre-existing condition exclusion for some period of time in all states with these pools, sometimes for as long as a year, even though the pre-existing condition is often the reason the individual otherwise is unable to obtain coverage in the individual market. Several states have closed enrollment or impose waiting lists for their high-risk pools, often because of a lack of adequate funding. While Congress recently provided modest funds for states to establish or expand their high-risk pools as part of the trade bill enacted last year, those funds are likely to be insufficient to improve significantly the affordability and benefits provided to individuals through these pools.

The Administration also suggests that certain low-income individuals would be permitted to use their tax credits to buy into comprehensive public coverage. It is uncertain how many states would elect this option — there would be no requirement that states do so — and open

²⁰ 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.

²¹ Simantov.

²² Sherry Glied, Cathi Callahan, James Mays and Jennifer Edwards, *Bare-Bones Health Plans: Are They Worth the Money*, The Commonwealth Fund, May 2002.

²³ 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.

²⁴ Chollet, October 23, 2002.

their Medicaid and SCHIP managed care plans to tax-credit recipients. The people most in need of these buy-ins to public coverage would tend to be sicker, high-risk individuals who cannot otherwise obtain coverage in the individual market. Adding these individuals to the current Medicaid and SCHIP managed care pools (which now consist primarily of parents and children, who constitute a relatively young group) could raise Medicaid and SCHIP costs significantly.

Inadequate Size of the Tax Credit

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 family insurance in the individual market exceeded \$7,300 in 1998.²⁵ 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 receives the full \$3,000 tax credit would have to spend \$4,300 out-of-pocket for health insurance premiums to purchase a policy with a \$7,300 premium cost (\$7,300 minus \$3,000). That would constitute more than 17 percent of the family's gross income. The family would have additional out-of-pocket costs through deductibles and co-payment before it could receive any benefit from having the insurance.

In addition, a 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 to be approximately \$6,100.²⁶ Thus, with a tax credit of \$1,000, a 55 year-old with 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 still more, if he or she were not excluded entirely from the individual market.

In some high-cost geographic areas, premiums could consume even larger percentages of family income. For example, premiums for a healthy 55 year-old were more than \$9,500 in the Los Angeles-Long Beach, California area.²⁷ 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. One study determined that premiums set at or above five percent of income discouraged most low-income families from enrolling in health insurance.²⁸

²⁵ 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).

²⁶ Gabel, Dhont and Pickreign.

²⁷ Gabel, Dhont and Pickreign. *See also* Collins, Berkson and Downey, which found that individual market premiums for women varied significantly across geographic areas.

²⁸ Leighton Ku and Teresa Coughlin, *Use of Sliding Scale Premiums in Subsidized Insurance Programs*, Urban Institute, March 1, 1997.

Furthermore, the value of the tax credit is likely to erode over time. The Administration's proposal would index the full credit amount annually by the medical care portion of the Consumer Price Index for All Urban Consumers (CPI-U). In 2002, the medical care inflation rate was five percent.²⁹ Assuming that individual health insurance plan premiums rise at double-digit rates comparable to the increase in premium rates charged for employer-based coverage, insurance premiums could increase *more than two and a half times faster* than the value of the tax credit increases in some years.

Some supporters of the Administration's tax-credit proposal have argued that family coverage in the individual market is more affordable than studies by the General Accounting Office and other researchers have found. They cite a study by an online health insurance broker finding that the average premium cost was between \$3,600 and \$4,500 for families of three that succeeded in obtaining coverage in the individual market through the broker.³⁰ Similarly, a trade association of health insurers issued a study finding that premiums for individuals ages 50-64 who purchased coverage ranged from \$2,749 to \$3,642.³¹

These figures are likely to be skewed downward, however, by the lower health risks associated with the relatively healthy individuals who actually succeeded in finding insurance that they could afford in the individual market and went ahead and purchased it, as well by the higher deductibles and cost-sharing and less-generous benefits that many of these policies provide. It should be noted that the average cost figures cited in these studies do *not* represent the average premium offer made and that applicants who sought but ultimately turned down health insurance in the individual market because the premiums were too high are not factored into these figures. Furthermore, the experience of individuals and families that applied for but were denied coverage based on their medical conditions also is not reflected in the figures. Nor do these studies include information on the benefits provided under the individual policies that were purchased and how those benefits compare to the comprehensive coverage typically offered through employer-based plans.

It also should be noted that while a credit larger than that which the Administration has proposed could make health insurance in the individual market more affordable for some tax-credit recipients, it would intensify the likelihood of adverse effects on the employer-based system and the magnitude of such effects. A larger credit would make it more attractive for employers to cease offering health insurance coverage and would increase the probability that more young, healthy individuals would opt to leave employer-based coverage.³²

²⁹ Bureau of Labor Statistics, "Another Rise in Medical Care Inflation," April 16, 2003.

³⁰ eHealthInsurance, *The Cost and Benefits of Individual and Family Health Insurance Plans* (June 2001). Based on the study's cost-per-member-per-month estimates.

³¹ Health Insurance Association of America, *HIAA Study: Individual Medical Expense Insurance Affordable, Serves Young and Old*, 2002.

³² Burman and Gruber.

Lack of Cost-Effectiveness and Targeting

The proposed tax credit is not likely to be a cost-effective way to reduce the ranks of the uninsured, since the large majority of those who would use the credit are expected already to have insurance. Analysts from M.I.T. and the Kaiser Family Foundation have estimated that under the Administration's proposal from last year and under similar such tax credits, more than two-thirds of those using the tax credit would be people who already are insured.³³ Even the Administration's own estimates of its proposal from last year, issued by the Treasury Department, indicate that nearly two-thirds of tax-credit recipients would already have health insurance.³⁴

As noted above, Jonathan Gruber of M.I.T. analyzed the President's proposal from last year and projected that 10.5 million persons would take up the tax credit. Only 3.3 million people of these 10.5 million would previously have been uninsured, and employer-dropping would cause 1.4 million people who formerly had employer-based coverage to lose that coverage and become uninsured. The net reduction in the number of uninsured would be 1.9 million, or just 18 percent of the total number of tax-credit users.³⁵

As a result, the credit is likely to be an inefficient and wasteful way to attempt to reduce the ranks of the uninsured. A large share of the credit's substantial cost would go either to provide people who already are insured in the individual market with a tax cut or to shift people from their current insurance arrangements (primarily through employer-sponsored coverage) to different insurance arrangements.

Likely Weakening of State Medicaid and SCHIP Programs

Another concern with the Administration's tax-credit proposal is its potential effect on actions by states. As with employers, the availability of the tax credit may encourage states to scale back eligibility for Medicaid and SCHIP.

The tax credit is targeted to the same low-income individuals and families who currently are served or could be served by those public programs. For *families of four*, income eligibility for the full tax credit would be capped at \$25,000 per year. This constitutes 136 percent of the poverty line. Forty 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 have been less generous with eligibility for working parents in such families — income eligibility for parents in the median state is only 69 percent of the poverty line — as of 2001,

³³ Gruber, Written Testimony; Feder, Uccello and O'Brien.

³⁴ McClellan.

³⁵ Gruber, Written Testimony.

some 20 states including the District of Columbia did cover working parents up to 100 percent of the poverty line or higher.³⁶

State budget deficits, as well as health-care cost inflation, are leading some states to scale back eligibility for Medicaid and SCHIP. The latest estimates indicate that states are facing total budget shortfalls of \$70 billion to \$85 billion for the 2004 fiscal year, which begins July 1 in most states. This is on top of \$50 billion in deficits already closed and \$25.7 billion in shortfalls that have subsequently arisen in the current fiscal year.³⁷ Several states have reduced Medicaid and SCHIP eligibility for working parents. Some states also are considering cuts in SCHIP eligibility for children.³⁸

A number of states have avoided cutting eligibility up to this point, but the availability of the tax credit could provide a further rationale for states to shrink Medicaid and SCHIP. States could decide that more low-income families and children should seek health coverage in the individual market with a tax credit. 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 fully funded by the federal government.

The existence of the tax credit also could discourage states from reversing these cuts once state budgets recover. Similarly, the tax cut could deter states from continuing, after their budgets recover, to expand Medicaid or SCHIP coverage so those programs cover more low-income working families and children, as states were doing before the economic downturn 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 otherwise could 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. In particular, the public programs are open to any eligible individual, irrespective of age or medical history. And both the Medicaid and SCHIP programs place limits on premiums, deductibles and cost-sharing to ensure that participating low-income families and

³⁶ Donna Cohen Ross and Laura Cox, *Enrolling Children and Families in Health Coverage: The Promise of Doing More*, Kaiser Commission on Medicaid and the Uninsured, June 2002. Some states have subsequently scaled back eligibility for working parents as a result of state budget cuts.

³⁷ Iris Lav and Nicholas Johnson, *State Budget Deficits for Fiscal Year 2004 are Huge and Growing*, Center on Budget and Policy Priorities, Revised January 23, 2003; National Conference of State Legislatures, *State Budget Update: February 2003*, February 4, 2003.

³⁸ Leighton Ku, Melanie Nathanson, Edwin Park, Laura Cox and Matt Broaddus, *Proposed State Medicaid Cuts Would Jeopardize Health Insurance Coverage for One Million People*, Center on Budget and Policy Priorities, Revised January 6, 2003.

individuals can afford out-of-pocket costs. For example, cost-sharing for children enrolled in SCHIP may not exceed five percent of family income.³⁹

The public programs also provide comprehensive benefits that meet the needs of older and sicker families and individuals. Both programs establish federal benefits standards intended to provide comprehensive health insurance coverage. Under Medicaid, states must provide certain minimum benefits. Under SCHIP, separate state insurance programs must generally provide a benefits package that is equivalent to one of several benchmarks, including the Blue Cross-Blue Shield Standard Option under the Federal Employees Health Benefits Plan (FEHBP).

Beneficiaries who could 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 could face significantly higher out-of-pocket costs and receive coverage for fewer medical conditions than is the case under their current Medicaid and SCHIP coverage.

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 at 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 in the following year to be reimbursed through a tax credit.⁴⁰ 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 directly and be reimbursed for the price reduction by the federal government. Eligibility for the advance credit would be based on the taxpayer's prior-year tax return.

Basing eligibility for an advance credit on the prior-year's tax return would pose problems, however, for many families. The incomes of many low- and moderate-income families fluctuate significantly during the course of a year, due to changes in family situation, job losses or changes, overtime pay and other variables. A taxpayer with low-income may have prior-year income too high to qualify for advance payment of the credit in the current year. This would be a particularly large problem during an economic downturn. It also would represent a problem for individuals whose work hours have been reduced considerably; such workers might no longer qualify for health insurance coverage through their employer but be unable to get an advance credit. Such individuals, having to meet other financial obligations with a reduced income, would be unlikely to be able to purchase health insurance with their own funds and wait for a reimbursement after the end of the year.

³⁹ If a family has two or more children enrolled in SCHIP, aggregate cost-sharing for the family for all of the children may not exceed five percent of income.

⁴⁰ Blumberg.

Conclusion

The Administration's proposal to provide tax credits for the purchase of health insurance in the individual market is a deeply flawed approach to addressing the problem of the uninsured. The principal concern with the proposal is that the tax credit poses a threat to the employer-based health insurance system through which the vast majority of Americans obtain health coverage. While this proposal may provide meaningful health insurance to some currently uninsured Americans, many others who now have insurance through their employers could lose their coverage and become uninsured. Others forced into the individual market who are able to access a plan may end up with significantly higher premiums, deductibles and cost-sharing, and coverage for fewer medical conditions and treatments than under their current employer-based plans.

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