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Revised February 5, 2002

HEALTH INSURANCE PROPOSALS IN ADMINISTRATION'S BUDGET COULD WEAKEN THE EMPLOYER-BASED HEALTH INSURANCE SYSTEM

by Edwin Park

The Administration's fiscal year 2003 budget released on Monday includes a number of health insurance initiatives, for which the budget allocates substantial resources. Both the principal such initiative and one other significant initiative, however, would be of questionable effectiveness and could materially weaken the conventional employer-based health system through which the large majority of insured Americans obtain health coverage. The two proposals that would pose risks to the employer-based insurance system are:

- A refundable tax credit for the purchase of private health insurance for individuals and families not covered by employer-based coverage, a proposal that would cost $89 billion over 10 years and would account for the vast majority of the new resources the Administration is proposing in the health insurance area; and

- An expansion of Medical Savings Accounts, which are tax-advantaged personal savings accounts used by individuals covered by high-deductible health insurance policies. The budget allots $5.7 billion over 10 years to this proposal.

The Administration also is proposing to extend for four years the time during which states can use funds provided to them under the State Children's Health Insurance Program (to prevent these funds from reverting to the Treasury) and to extend for one year the Transitional Medical Assistance (TMA) program, which provides health insurance to many families that leave welfare for work. These proposals are welcome, but each of them is likely to be inadequate. Because of insufficient federal funding, the number of people insured through SCHIP is currently projected to drop by 900,000 between 2003 and 2006. The Administration SCHIP proposal does not provide any additional federal resources beyond the extension of expiring funds, and would not by itself be sufficient to avert all of this large enrollment decline.

The proposal to extend Transitional Medical Assistance for only one year is puzzling, since this is a well-established program that is an integral part of welfare reform and has been in existence since 1988. The Administration had been expected to propose continuing this program for the same duration of time for which it is proposing to extend the welfare block grant. Since it is virtually unthinkable that Transitional Medical Assistance will be allowed to die after a year, the Administration's failure to include in the budget an extension for TMA for more than one year appears to be a budget gimmick designed to make federal expenditures appear lower in years after fiscal year 2003 than they actually will be.

Tax Credit for the Purchase of Health Insurance in the Individual Market

The Administration is proposing to provide a refundable tax credit to individuals and families not participating in employer-based health insurance or public health insurance. 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 non-group 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 health insurance purchased through private purchasing pools or state high-risk pools where such pools exist). The credit would not be available to families with incomes above $60,000, and the subsidy would begin to phase down once a family's income reached $25,000. (Similarly, individuals making $30,000 would not be eligible for the credit, with the subsidy beginning to phase out when an individual's income reached $15,000.)

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.

- **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 have written that enactment of a tax credit of this nature would 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. 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. As a result, policies offered in the individual market are most attractive to the young and healthy. If employers that 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. Moreover, the individual market often denies insurance entirely to people with certain health conditions.

  Aggravating this problem is the fact that under the Administration's proposal, some workers whose employers do 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 instead to purchase insurance in the individual market. Such a move could be attractive to young, healthy employees; they could purchase policies for which the tax credit would cover 90 percent of the cost, which often would be a larger percentage than their employer would cover. But if these 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. This phenomenon — known as "adverse selection" — could then induce additional younger, healthier workers to abandon employer-based coverage and use their tax credit 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 in many areas. Institution of the tax credit could provide a rationale for some employers seeking to cut costs to drop or not to institute coverage.

- **The tax credit would not be a cost-effective way 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., the Kaiser Family Foundation, and the Joint Committee on Taxation have estimated that under 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.

- **Older and sicker individuals likely would be unable to access adequate health insurance in the individual market without paying exorbitant amounts.** The individual market is generally unregulated. As a recent Kaiser Family Foundation study found, older and sicker people often are unable to obtain coverage in the non-group market. They either are not offered a policy or are offered insurance at prices they cannot afford. Under the Administration's proposal, a family containing older or sick members could find itself excluded

How A Tax Credit for Health Insurance In the Individual Market Could Undermine Employer-Based Coverage: A Simplified Example

Assume a company provides a comprehensive health insurance plan to its two employees. John is a 28 year-old man with a healthy family of three. The cost of a family coverage plan for John through the employer-based system would be $3,000. Mary is a 45 year-old woman with a family of three that has a history of chronic, serious medical problems. The cost of a plan for Mary is $12,000. However, because both workers are in the same health insurance pool, the health insurance cost through the company averages to $7,500 a year. Since the company subsidizes 80 percent of the cost of health insurance, it would contribute $6,000 per year for the cost of health insurance and the workers would pay $1,500 a year.

If John instead buys health insurance for his family in the individual market, he might be able to purchase a policy that costs $3,600. (This is a little more than the cost of a plan in the employer-based system, since individual insurance is usually more expensive than employer-based coverage for the same level of coverage.) Because he and his family are in excellent health, they can obtain a policy in the individual market. Under the Administration's proposal, with a tax credit of $3,000, John can save $900 a year by dropping his employer-sponsored plan and buying a plan in the individual market. (His net cost is $3,600 minus $3,000, or $600, while he currently pays $1,500 for his employer-based plan.)

But if John drops out of his employer's plan, then only Mary is left in her company's health insurance pool and the average cost of insurance for the firm rises from $7,500 to $12,000. If the company continues to subsidize 80 percent of the costs of health insurance,, the employer contribution toward her insurance would rise to $9,600 because John is no longer available to bring the average cost of insurance down. Accordingly, Mary's premium would rise from $1,500 to $2,400. It is likely that Mary would be unable to afford this higher premium and continue to participate in her employer's health insurance plan. She and her family could be eligible for a $3,000 tax credit to buy health insurance in the individual market. However, because of her family's medical history, she may be denied coverage entirely or face unaffordable premiums, even with the tax credit.

On the other hand, Mary's company may be unable to increase its contribution to the costs of health insurance. It might balk at increasing the company contribution by $3,600 per year (making it more likely that Mary would be unable to afford the employee contribution) or decide against offering health insurance altogether, knowing that Mary has the tax credit available to purchase coverage in the individual market.

In this very simple example, John has used his tax credit to buy insurance in the individual market but since he already had insurance, there is no net reduction in the number of uninsured people. On the other hand, it became much harder for Mary and her family to retain their job-based insurance once John was no longer part of her insurance pool. She might end up losing her coverage because her company's premiums became too expensive or her company decided to no longer offer health insurance. Because of her family's medical history, Mary may be unable to find affordable insurance in the individual market and she and her family could become uninsured.

from coverage 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 medical conditions. Many plans in the individual market do not offer comprehensive coverage; they may require high deductibles and provide modest benefits. The Administration purports to respond to this concern by allowing tax credit recipients to buy coverage through high risk pools and private purchasing pools. However, the success and scope of these mechanisms has been limited. Even with some state funding, participation is often low, and the health insurance benefits provided can be restricted to a fairly narrow range of benefits or impose high deductibles and cost-sharing. The proposal would permit certain individuals to use their tax credits to buy into comprehensive public coverage, but it is uncertain how many states would elect this option and open their Medicaid and SCHIP managed care plans to tax-credit recipients.

- **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 $30,000 that receives a $3,000 tax credit would have to expend 10 percent to 15 percent or more of its gross income to purchase insurance at this price. In some high-cost geographic areas, premiums could consume still-greater percentages of family income. Studies indicate that such expenditure levels are beyond what most low- and moderate-income families can afford.

Expansion of Medical Savings Accounts

Established under a limited demonstration project scheduled to expire at the end of this year, MSAs are tax-advantaged personal savings accounts available to the self-employed and employees at small businesses who are covered by high-deductible health insurance policies. Funds in MSAs may be used to pay for a wide range of out-of-pocket health care costs. They also may be retained in the MSA accounts and placed in investment vehicles such as stocks and bonds, with the investment earnings accumulating tax-free in the accounts. The funds may be withdrawn for *non*-medical purposes upon retirement. As a result, MSAs can be used as a tax shelter.

Despite the findings of an array of analyses by respected research institutions that widespread use of MSAs could destabilize the health insurance market (findings the demonstration project has failed to dispel), the Administration is proposing a package of MSA changes that have long been pushed by insurance companies that sell MSA policies and

conservative policy institutions. The Administration proposes to repeal most current protections and limitations on MSAs, to make MSAs more lucrative as tax shelters for affluent, healthy individuals (and hence more attractive to such individuals), and to allow unlimited expansion of MSAs across the country. The risks of such a course are great.

- **Widespread use of MSAs could jeopardize coverage for substantial numbers of Americans in conventional health insurance by causing premiums for conventional insurance to rise markedly.** Research by the RAND Corporation, the Urban Institute, and the American Academy of Actuaries has found that premiums for conventional insurance could *more than double* if MSA use becomes widespread. This is because of the extensive "adverse selection" in the health insurance market that would likely ensue. If MSAs become broadly available, substantial numbers of healthy, affluent individuals may opt for them in lieu of conventional, employer-based group insurance policies. As a result, those remaining in group insurance would be less healthy, on average, and premiums for conventional group insurance would have to increase.

  High deductible policies and MSAs are most attractive to younger, healthy individuals, because such individuals do not expect to incur significant health costs and thus can anticipate accumulating significant amounts in their tax-advantaged MSA accounts. MSAs can be particularly attractive to higher-income individuals, a group that also tends to be in better health than people with lesser incomes, since they can benefit handsomely from the tax sheltering advantages of MSAs, which are worth the most to those in higher tax brackets. The attraction of MSAs to healthy, affluent individuals would be significantly enhanced under the Administration's proposal, which would alter the rules governing MSAs in ways that would make the accounts more lucrative as tax shelters.

  The increase in premium costs that would be expected to result if use of MSAs becomes widespread and significant numbers of healthy individuals withdraw from employer-based plans could lead many employers either to cease offering coverage or to raise the percentage of premium costs that their employees must pay. Such steps would make insurance less affordable and likely cause more people to become uninsured.

- **The Administration's proposal would make MSAs more attractive as a tax shelter to healthy, affluent individuals by removing or weakening many safeguards Congress enacted to prevent MSAs from turning into a significant tax shelter opportunity.** MSAs are similar to tax-deductible Individual Retirement Accounts in that the deposits an individual makes in these accounts are tax deductible and the earnings that accumulate in the accounts are tax-free. (The funds in the account are never taxed as long as they either remain in the account or are withdrawn for medical purposes; the funds are subject to taxation if

withdrawn for non-medical purposes, just as funds in tax-deductible IRAs are subject to taxation when they are withdrawn.) MSAs differ, however, from IRAs in one key respect — there are no income limits on MSAs that prevent wealthy people from making tax-deductible contributions to them. Indeed, the higher an individual's income, the greater the tax benefit an MSA provides. By opening MSAs for widespread use and eviscerating a number of the current limitations and safeguards on MSAs, the Administration's proposal would essentially enable high-income individuals to circumvent the IRA income limits by using MSAs for the same purpose — as tax shelters to accrue substantial assets over time on a tax-advantaged basis. As noted above, at retirement, funds can be withdrawn from MSAs penalty-free for *non*-medical purposes.

Other Health Insurance Proposals

The Administration's fiscal year 2003 budget also includes several other health insurance purposes. These proposals are more beneficial.

The first such proposal would extend until 2006 the availability of more than $3 billion in funds that have been provided to states under the State Children's Health Insurance Program (SCHIP) but have not yet been spent. Under current law, states that receive unspent SCHIP funds that have been reallocated from other states must return those funds to the U.S. Treasury if they do not use them within a certain period of time, usually one year. Because of a mismatch between the time when the unspent funds have been reallocated to states and the time when a number of the states that have received these funds will need them, some states will not be able to use all of the reallocated funds within the required timeframe. Some $700 million of these funds are expected to revert to the Treasury at the end of this fiscal year, and an additional $2.3 billion are expected to revert at the end of fiscal year 2003. Yet state SCHIP programs will badly need these funds in years after that.

An analysis the Office of Management and Budget conducted last year projected that if more SCHIP funds are not made available, states will act within a few years to reduce by 400,000 the number of children they insure through SCHIP. In the budget released today, OMB has updated this analysis and now projects that in the absence of more federal SCHIP funds, enrollment will be reduced by 900,000 between 2003 and 2006.

- **While helpful, the Administration's proposal appears inadequate to avert the reduction in the number of people SCHIP insures.** When Congress created the SCHIP program in 1997, it wrote into the law a 26 percent reduction in federal SCHIP funding for fiscal year 2002 and the two years after that. (This was done to help balance the budget by 2002 under the CBO projections in use at the time the SCHIP legislation was written.) States can ease the effects of this funding reduction by using unspent SCHIP funds from the program's earlier years, when

the program got off to a slow start and many states amassed unspent funds. States' ability to do so is hampered, however, by the fact that about $3 billion in unused SCHIP funds are scheduled to revert to the Treasury in the next two years rather than to be retained by states and used in years after that. As a result, as just noted, OMB projects substantial cutbacks in SCHIP enrollment a few years from now. Extending the availability of these unused SCHIP funds for several years, as the Administration is proposing, would help. If the SCHIP funds are targeted on the states that most need the funds to avert enrollment declines, the funds could avert a substantial share of the cutback in children's coverage that otherwise would occur.

At the same time, SCHIP funding is likely to be insufficient over the long term even if the availability of these $3 billion in funds is extended. This is in part because a number of states have acted or have announced plans to use SCHIP funds to cover other uninsured groups in addition to children, such as the parents of low-income children eligible for Medicaid or SCHIP and some poor adults without children. Indeed, the Administration has been encouraging states to use SCHIP funds during the current recession to expand coverage to the unemployed. (OMB projects enrollment this year that is 1.4 million higher than it projected last year, partly because of recent SCHIP expansions that cover parents.) Even with the extension of the availability of these $3 billion in funds, a number of states eventually are likely to have insufficient federal SCHIP funding to sustain enrollment.

The Administration could have proposed in its budget to increase overall SCHIP funding, as bipartisan "FamilyCare" legislation introduced by Senators Kennedy and Snowe would do. That legislation would provide additional SCHIP funds to states both to expand coverage to uninsured low-income parents whose children are in Medicaid or SCHIP (the vast bulk of whom are low-income working parents) and to enable states to continue reaching more of the low-income children who remain uninsured, rather than cutting back on the number of children and parents that SCHIP covers. The Administration has elected instead to place no new resources in SCHIP and to concentrate new health insurance resources in the tax credit described above. The Administration's budget contains $89 billion over ten years for the tax credit.

As noted above, the second helpful proposal would extend for one year the Transitional Medical Assistance (TMA) program. TMA is scheduled to expire at the end of the current fiscal year.

- **The TMA program would be extended for only one year.** Because health insurance constitutes a key work support that, like child care, helps facilitate entry into the workforce, TMA is an essential element in helping people leave welfare

for work. While a one-year extension of TMA would be useful, it is unclear why the Administration is not proposing a multi-year extension. The reason may be that the Administration did not wish to show in its budget the costs of operating TMA over a longer period of time. In other words, this appears to be a budget gimmick, since it is difficult to believe that either the Administration or Congress would contemplate terminating this program a year from now. The proposal to extend for just one year an established and widely supported program to help welfare recipients go back to work is ironic, given that the Administration is proposing to make permanent a number of tax cuts that primarily affect upper-income taxpayers and do not expire until 2010.

- **Also of note, the Administration's proposal does not include improvements in TMA that would have only a modest cost but could increase the program's effectiveness.** Partly because of rigid federal rules that govern TMA, many working-poor families either fail to receive TMA despite being eligible for it or are disqualified for it for reasons that are difficult to justify. For example, if a family is on welfare and Medicaid for at least three months before it works its way off welfare, the family qualifies for TMA. But if a family enrolls in a welfare-reform "work first" program and goes to work before being on welfare and Medicaid for three months, it is *in*eligible for TMA. Other overly rigid federal TMA rules impose reporting and paperwork requirements that can be onerous for poor families and state agencies alike. There is broad support for according states more flexibility to make these rules more reasonable and thereby to increase the chances that low-income families will remain insured when they leave welfare for work. Despite the Administration's support for the principles of state flexibility, supporting work, and reducing the ranks of the uninsured, it has not included funds in the budget for TMA reform measures that would enable more of these families to obtain insurance.