REACHING THE UNINSURED:
ALTERNATIVE APPROACHES TO EXPANDING HEALTH INSURANCE ACCESS

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EXECUTIVE SUMMARY

The lack of affordable and accessible health insurance remains a major problem for millions of Americans. Without health insurance, many people forego needed health care and suffer adverse health consequences. This has economic consequences as well. This report evaluates three major policy options to make health insurance more affordable. The key findings are:

- **While there are multiple barriers to coverage, lack of affordability remains the primary reason why 44 million Americans lack health insurance.** Though 82 percent of the uninsured are in working families, 56 percent of the uninsured have incomes of less than 200 percent of poverty. Low-wage jobs are less likely to offer health care coverage—and, when offered, often have unaffordable premiums. However, low-incomes are not the only barrier to coverage. Many Americans with incomes well above poverty—such as people who have lost access to employer-based coverage; the near-elderly and people with chronic illness—have difficulty obtaining quality insurance at a reasonable price.

- **Lack of health insurance has economic and health consequences.** Studies show that people without health insurance are less likely to seek health care, resulting in worse health. For example, uninsured pregnant women who fail to get adequate prenatal care have newborns that are at a 31 percent greater risk of being born with adverse health outcomes. In addition, uninsured people often incur higher-than-necessary costs. One study found that expanding Medicaid led to a 22 percent decrease in avoidable hospitalizations of participants. The costs associated with lack of insurance are passed on to the public at large.

- **Tax deductions will do little to improve coverage.** Studies indicate that extending tax deductibility to individually purchased policies would do very little to expand insurance coverage—considerably less than tax credit or direct subsidy programs would. The simulated plans reviewed in this study suggest that the proportion of participants who would be newly insured under a tax deduction plan would be about one-third the proportion of participants who would be newly insured under a tax credit plan. The proportion of participants who would be newly insured under a tax deduction plan would be about one-tenth the proportion of participants who would be newly insured under a direct provision plan. Because tax deductions disproportionately help people with higher incomes, these plans would benefit predominantly middle and upper-income households who already purchase coverage, but would only modestly improve the affordability of insurance for most uninsured people, and thus lead to very few newly insured.

- **While more effective than deductions, tax credits are not the most efficient way to expand coverage.** In contrast to tax deductions that disproportionately benefit those with higher incomes, tax credits provide the same benefit to all eligible taxpayers who take advantage of them. Thus, they are more likely than deductions to help the low-income

uninsured. To expand coverage to significant numbers of uninsured, tax credits must be refundable, since many uninsured have little to no tax liability, and they must be large enough to cover most of the premium costs for the low-income. However, such large, refundable tax credits could also encourage people who currently have group insurance to switch into the more expensive individual market. Therefore, tax credits are less efficient – the cost per newly insured person is higher than direct provision programs narrowly targeted at the uninsured.

- **Refundable tax credits can complement direct insurance programs and also address the inequity in the current tax treatment of health insurance.** Quality individual health insurance purchased with a refundable tax credit equal in value to the employer deduction could eliminate the current tax advantage enjoyed by those who have employer-provided group insurance. In addition, the Administration has proposed allowing tax credits to be coupled with public program expansions to make such expansions more affordable – i.e. allowing the application of tax credits towards coverage through Medicare, Medicaid or SCHIP buy-ins or through individual health insurance with reforms. However, as stated above, by themselves, tax credits are not the most efficient means of providing affordable insurance to uninsured Americans.

- **Direct provision of health insurance through public programs is the most efficient way of targeting low-income families.** Simulation results indicate that direct provision of health insurance, such as the proposed plan to insure parents of children in SCHIP and Medicaid, effectively reaches the uninsured at a relatively low cost for the benefits provided to the newly insured. The costs are relatively low not only because of lower administrative costs, but also because there is less "crowd-out" of current employer-based coverage in direct insurance programs than in tax credit proposals. The simulation reviewed in this paper suggests that over two-thirds of the participants would be newly insured. This proportion of newly insured participants is between seven and ten times the proportion of newly insured participants for the simulated tax deductions. Thus, this is the best first step in expanding health coverage to the uninsured.

REACHING THE UNINSURED:
ALTERNATIVE POLICIES TO EXPAND HEALTH INSURANCE COVERAGE

1. INTRODUCTION

This report documents a serious policy issue—the lack of health insurance for tens of millions of Americans. Without health insurance, many Americans forego needed health care and suffer adverse health consequences. This has economic consequences as well. The lack of insurance is particularly prevalent among low-wage working Americans and their families, because many of their employers do not offer health coverage, and many of these families cannot afford individual insurance coverage. With regular jobs and incomes above the poverty level, however, many of these hard-pressed families do not qualify for existing government insurance programs, such as Medicaid. A number of policy proposals, including alternative tax treatments (such as tax deductions and tax credits) direct provision of health insurance to specific groups in need of coverage, and allowing individuals to "buy-in" to government insurance programs such as Medicare have been suggested to address the rising numbers of the uninsured. Recent studies that have simulated the effects of some of these proposals indicate that certain types of programs may be more efficient and effective than others in increasing health insurance coverage.

2. HEALTH INSURANCE COVERAGE AND THE CONSEQUENCES OF BEING UNINSURED

A. The Scope of the Problem

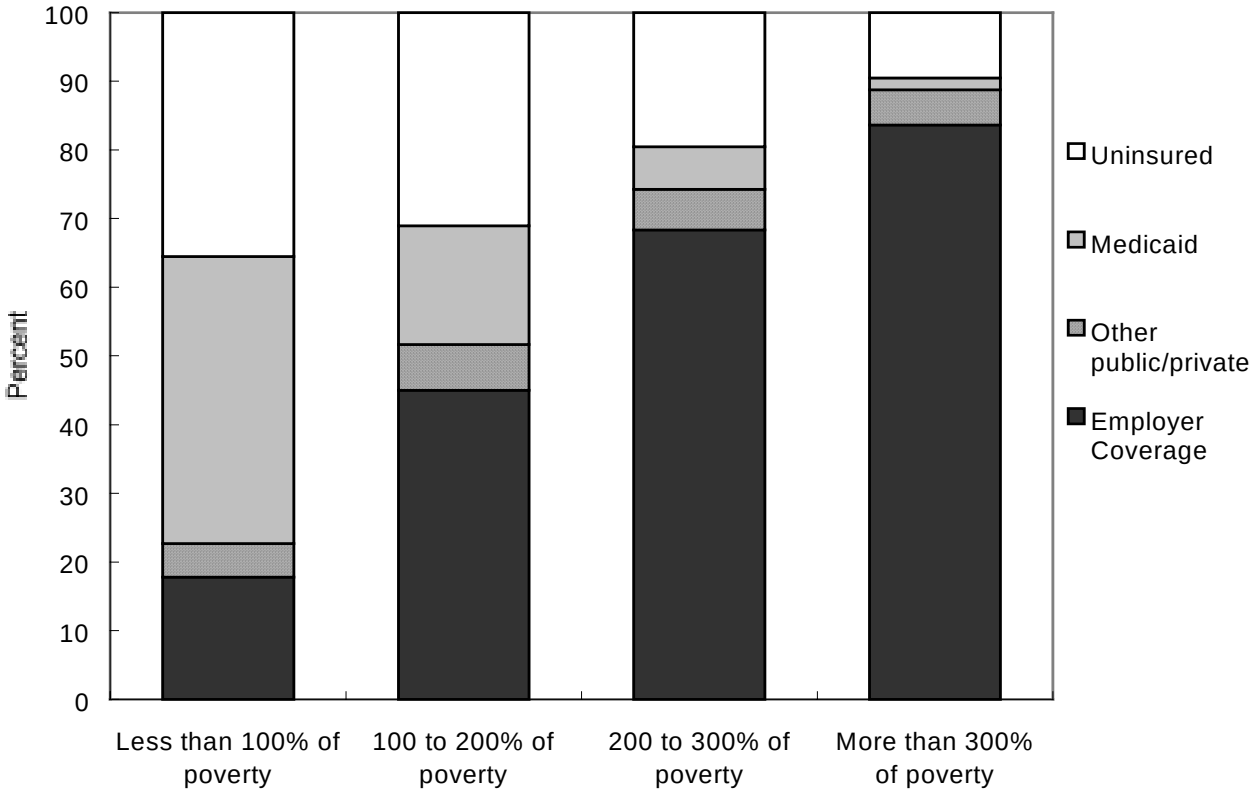
In 1998, about 1 in 6 Americans—an estimated 44.3 million individuals—went without health insurance for the entire calendar year.[1] Despite a robust economy and low unemployment rates, the number of uninsured increased from about 31 million in 1987.[2] The lack of coverage is not solely a function of employment status, because over 80 percent of the non-elderly uninsured either work or live in families with a worker.[3] Instead, many of these workers find that insurance is either unavailable from their employer or is simply unaffordable. They also find that while they cannot afford insurance, their effort to earn a living makes them ineligible for existing government programs (like Medicaid) that provide insurance for the poorest Americans.[4]

The lack of health insurance in the United States is strongly related to income (Chart 1). In families with income below the poverty line, 43 percent of adults did not have health insurance. In contrast, in families with income greater than 300 percent of poverty, only 9 percent of adults are uninsured. Fifty-six percent of uninsured nonelderly people are in families with incomes below 200 percent of poverty. The source of coverage also varies with income. More than 80 percent of families with incomes over 300 percent of poverty receive health care

[1] Jennifer A. Campbell, *Health Insurance Coverage: 1998,* U.S. Census Bureau, Current Population Reports, P60-208 (Washington: U.S. Government Printing Office, 1999).
[2] Ibid.
[3] Kevin Quinn, *Working without Benefits: The Health Insurance Crisis Confronting Hispanic Americans* (New York: The Commonwealth Fund, 2000).
[4] Catherine Hoffman and Alan Schlobohm, *Uninsured in America: A Chart Book,* 2nd ed. Kaiser Commission on Medicaid and the Uninsured (Menlo Park: The Henry J. Kaiser Family Foundation, 2000).

coverage through an employer. For families below the poverty line, meanwhile, Medicaid is the source of coverage for nearly a third of all families.

Chart 1. Health Insurance Coverage of Non-elderly People by Family Income, 1998



Source: US Census Bureau tabulations (August 2000)

Overall, the vast majority of Americans who have health insurance receive it through their employers. The percentage of workers insured through the workplace has generally declined since the late 1970s, with low-wage workers being the hardest hit. This decline is due in part to firms' restricting eligibility to exclude many part-time and temporary workers from health insurance coverage.[5] The effect of this decline is magnified by the increasing use of temporary workers. The employer-based system means that young adults have a particularly high risk for non-coverage because they are more likely to hold part-time and temporary jobs. Too old to be covered by their parents' plans but too young to be established in jobs providing health insurance, 30 percent of those aged 19 to 29 are uninsured.[6] Affordable access can also be a problem for the near elderly (those aged 55-64) in the individual insurance market. As health status generally declines with age, insurance may be more important for the near elderly. At the same time, exclusions for pre-existing conditions and high premiums related to expected costs

[5] Ellen O'Brien and Judith Feder, *Employment-Based Health Insurance Coverage and Its Decline: The Growing Plight of Low-Wage Workers*, Kaiser Commission on Medicaid and the Uninsured (Menlo Park: The Henry J. Kaiser Family Foundation, 1999).

[6] Kevin Quinn, Cathy Schoen, and Louisa Buatti, *On their Own: Young Adults Living without Health Insurance* (New York: The Commonwealth Fund, 2000). The authors find that 80 percent of adults aged 19 to 29 take up employer-provided insurance, when it is offered, compared with 84 percent of 30-to-64 age group.

can restrict access and affordability for the early retirees who are no longer covered by employment-based health insurance. Employees of small businesses (less than 100 employees) are also less likely to have insurance: one-fourth of small business employees are uninsured, compared to one-eighth of the employees in firms with 100 or more workers. Racial and ethnic minorities are less likely to be insured than whites, because members of minority groups are less likely to have employer-sponsored health insurance coverage, as they are disproportionately likely to work in low-wage jobs. Approximately 12 percent of non-Hispanic whites, 22 percent of blacks, 35 percent of Hispanics, and 21 percent of Asians and Pacific Islanders were uninsured in 1998.[7]

B. An Investment in Health

Because lack of insurance leads to a host of adverse health consequences and higher medical costs, health insurance, although seemingly expensive, may be a good investment for society. Uninsured people experience worse health problems and thus increase the cost of care to society. One study valued the increase in longevity and improved quality of life between 1970 and 1990 at $77,000, while the increase in medical spending per person was only $25,000. While much of this increase in longevity and quality of life may be due to non-medical reasons, such as better nutrition or more exercise, if even a third of the improvement is due to medical spending, the investment is worthwhile.[8] Public investment in health insurance might extend the benefits of longevity and quality of life to more people. In addition, if individuals can be treated routinely, they may maintain better health at a lower cost.

The health effects

Uninsured Americans are more than three times as likely to delay seeking care, and between three and five times less likely to obtain medical/surgical care, dental care, or prescription drugs.[9] Additionally, people who lack insurance coverage often require medical attention for medical complications that could have been prevented by earlier treatment. Thus, they are often hospitalized for conditions that might have been avoided altogether.[10] Uninsured people are often diagnosed at later stages of diseases, when the chance of recovery is diminished. Moreover, failure to receive routine care has far reaching consequences. For example, uninsured pregnant women receive prenatal care later in their pregnancy and make fewer doctor visits than the privately insured. As a result, their newborn infants are at a 31 percent greater risk of being born with adverse health outcomes, including low birth-weight, which is a major cause of physical disability, mental retardation, and other costly health problems (see Box 1).[11]

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[7] Hoffman and Schlobohm, *Uninsured in America*.

[8] David M. Cutler and Elizabeth Richardson, *Your Money and Your Life: The Value of Health and What Affects It*, Working Paper W6895 (Boston: National Bureau of Economic Research, 1999). These values are in constant 1990 dollars.

[9] *No Health Insurance? It's Enough to Make You Sick—Scientific Research Linking the Lack of Health Coverage to Poor Health* (Philadelphia: American College of Physicians-American Society of Internal Medicine, 1999).

[10] Joel S. Weissman, Constantine Gatsonis, and Arnold M. Epstein, "Rates of Avoidable Hospitalization by Insurance Status in Massachusetts and Maryland," *Journal of the American Medical Association* 268.17 (1992).

[11] *No Health Insurance? It's Enough to Make You Sick—Scientific Research Linking the Lack of Health Coverage to Poor Health* (Philadelphia: American College of Physicians-American Society of Internal Medicine, 1999).

Box 1. The Value of Prenatal Care

Prenatal care is currently underused, limiting its ability to cost-effectively improve infant health. Innovations in neonatal care have dramatically increased the life expectancy of low-birth-weight infants, counteracting in part the lack of pre-natal care. But this care has a high price tag. Intensive neonatal care for a low birth-weight infant can cost more than $2,000 per day and more than $100,000 over the course of treating one infant.[12] By increasing prenatal care coverage, we may be able to take advantage of preventive medical care, resulting in healthier infants at lower costs. At a relatively low cost of about $400-$500 per woman, prenatal medical screening and appropriate care could reduce the incidence of low birth-weight by about 20 percent.[13]

Access to prenatal care is often a problem for low-income and uninsured women. Almost 60 percent of uninsured women do not begin prenatal care until after their first trimester. Among uninsured women, almost 70 percent reported difficulty paying for prenatal care. Additionally, a full 15 percent of uninsured mothers were refused prenatal care when looking for a provider. Evidence suggests that increased eligibility for medical care decreased the number of women who went without prenatal care and the number of women who delayed prenatal care beyond the first trimester.[14] To the extent that cheaper prenatal care can substitute for much more expensive neonatal care, the overall costs of achieving improved infant health outcomes might be reduced.

The health benefits of routine preventive care measures are evident in the rapid progress made in treating cardiovascular disease over the last 50 years. Although heart disease remains the leading cause of death for Americans, cardiovascular disease mortality has fallen dramatically.[15] Part of this decline is due to advances in medical technology, but much of it is because of increased prevention. Less than half of the decline in cardiovascular disease mortality can be attributed to medical technological advances for post–heart attack treatment. Better preventive care, rather than responsive medical care, has accounted for most of the decline. Almost a third of the reduction in heart disease was due to reducing risk factors in individuals diagnosed with coronary disease.[16] Access to early diagnosis and medical care is an effective method of treating cardiovascular disease.

The economic cost

Lack of health insurance for the poor may be costly. The uninsured more often obtain care in the emergency room than in a physician's office, and emergency room care is more expensive than office visits. Further, because of inadequate care, the health problems of the uninsured are often more severe and hence more expensive to treat. Evidence indicates that

[12] David M. Cutler and Ellen Meara, *The Technology of Birth: Is It Worth It?,* Working Paper W7390 (Boston: National Bureau of Economic Research, 1999).
[13] Janet Currie and Jeffrey Grogger, *Medicaid Expansions and Welfare Contractions: Offsetting Effects on Prenatal Care and Infant Health?,* Working Paper W7667 (Boston: National Bureau of Economic Research, 2000).
[14] Ibid.
[15] Based on Centers for Disease Control calculations for the entire U.S. population in 1997. Heart disease is estimated to have killed 726,974 people that year.
[16] Calculations based on MG Hunink, L Goldman, AN Tosteson, MA Mittleman, PA Goldman, LW Williams, J Tsevat, and MC Weinstein, "The Recent Decline in Mortality from Coronary Heart Diseases, 1980-1990: The Effect of Secular Trends in Risk Factors and Treatment," *Journal of the American Medical Association 277.7* (1997).

Medicaid expansions are associated with significant increases in primary care utilization and reductions in expensive avoidable hospitalizations. One recent study found that increases in Medicaid eligibility were associated with a 22 percent decline in avoidable hospitalizations.[17]

Lack of insurance creates a public cost. The costs of hospital care for people who cannot pay are often absorbed by providers, passed on to the insured through higher cost health care and health insurance, or paid by taxpayers through higher taxes to finance public hospitals and public insurance programs.

3. OVERVIEW OF CURRENT FEDERAL HEALTH INSURANCE POLICIES

There are several ways whereby the Federal government traditionally seeks to improve the public's access to health insurance. One approach is through provisions in the U.S. tax code that lower the price of insurance. A second is by providing free or low-cost health insurance through public programs. A third method is through laws and regulations enhancing access to insurance. This section provides a brief overview of these approaches.

The current tax system encourages health insurance by allowing income exclusions and deductions for health insurance expenses. Employer-provided health insurance has long had a tax preference, originating during World War II when the IRS ruled that increased health benefits were outside the limits of federal wage controls.[18] Eventually, the exemptions were codified by Congress. This status continues today.[19] One study estimates that the tax exemptions (including both the income and payroll tax exemptions) will cost the Federal government approximately $125.6 billion in lost tax revenues in 2000.[20]

There are some inequities inherent in the current system. The system provides a tax subsidy that varies directly with the tax rate of the individual or family receiving coverage—the higher the tax rate, the higher the implicit tax subsidy (see Chart 2). For individuals who are in the highest federal income tax bracket, the tax policy reduces the relative "price" of health insurance compared to other goods that must be purchased with after-tax dollars by 39.6 cents on the dollar. In contrast, for those with low incomes—who are in a low tax bracket—the current

[17] Leemore Dafny and Jonathan Gruber, *Does Public Insurance Improve the Efficiency of Medical Care? Medicaid Expansion and Child Hospitalizations*, Working Paper W7555 (Boston: National Bureau of Economic Research, 2000).

[18] Jon Gabel, "Job-Based Health Insurance, 1997-1998: The Accidental System Under Scrutiny," *Health Affairs*, Vol 18, No 6 (1999).

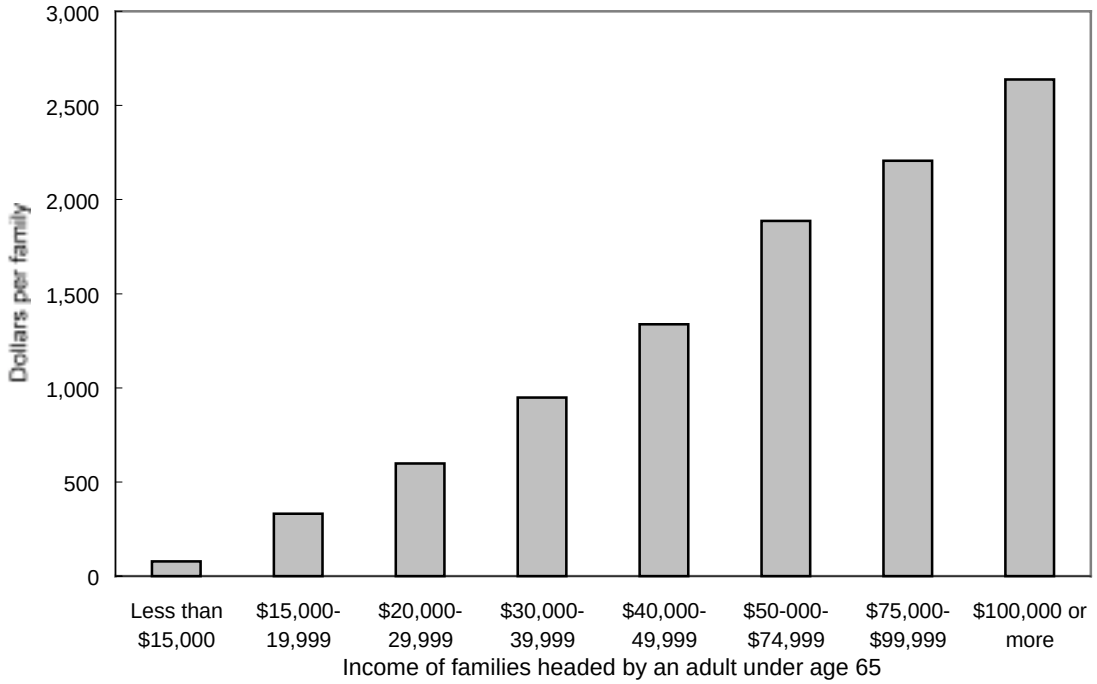
[19] Other tax provisions include: itemized deductions for any medical spending above 7.5 percent of adjusted gross income; flexible spending plans (Section 125) that allow employees' shares of premiums to be made on a pre-tax basis; a phased-in deduction for self-employed workers; and a demonstration of Medical Savings Accounts for some self-employed and workers in small businesses.

[20] John Sheils, Paul Hogan, and Randall Haught, *Health Insurance and Taxes: The Impact of Proposed Changes in Current Federal Policy: Prepared for The National Coalition on Health Care (*Washington, DC: The Lewin Group, Inc., 1999). This estimate also includes the foregone tax revenue due to the exclusion of income from Social Security and Medicare hospitalization insurance taxes.

tax reduces the relative "price" of health insurance by only 15 cents on the dollar or not at all, if no taxes are owed by the individual.[21]

A second inequity arises for those who do not get health insurance through their workplace, but who purchase insurance in the individual market. Because the exemption only applies to employer-provided group insurance, their subsidy, if any, is much smaller. [22]

Chart 2. Average Federal Tax Benefit from Health Insurance Exemption, 2000



Source: John Sheils, Paul Hogan and Randall Haught, "Health Insurance and Taxes: The Impact of Proposed Changes in Current Federal Policy," October 1999, The Lewin Group, Inc.

Note: Calculations incorporate likelihood of receiving employer-provided health benefits and the value of the tax benefit of employer-provided health insurance

With the introduction in 1965 of Medicare and Medicaid to provide health insurance for elderly and low-income Americans, the government began to provide health insurance directly. Over 32 million elderly and 4 million disabled received basic medical insurance through Medicare Part B in 1998.[23] Medicaid offers federal assistance to States that provide medical care to low-income Americans. Historically, eligibility for Medicaid was linked to eligibility for cash welfare. Beginning in the late 1980s, Medicaid has shifted toward a more general health insurance program that includes low-income working people.[24] The 1996 Personal Responsibility and Work Opportunity Reconciliation Act, particularly, allowed Medicaid

[21] The exclusion from the employer and employee shares of the Social Security tax and state and local income taxes further reduces the after tax price (in the case of high income earners only the Medicare tax would typically apply). However, future Social Security benefits may also be reduced.

[22] The tax code includes a phased-in deduction for self-employed individual insurance purchases. See footnote 21.

[23] These statistics for Medicaid, SCHIP and Medicare are based on publicly available estimates by the Health Care Financing Administration.

[24] Lara Shore-Sheppard, Thomas Buchmueller, and Gail Jensen, "Medicaid and Crowding out of private insurance; a re-examination using firm level data." *Journal of Health Economics,* 19 (2000), 61-91

coverage to low-income families. Medicaid served over 41 million people in 1998. In 1997, the State Children's Health Insurance Program (SCHIP) was created to target the growing number of uninsured children in families that have too much income to be eligible for Medicaid but too little to afford private insurance. SCHIP provides states with funding to provide health insurance through Medicaid, a non-Medicaid program, or a combination of both. Combined, these programs insure over 74 million Americans – but through strict eligibility rules, leave out many of the uninsured. For example, people age 62 are not eligible for Medicare, and the uninsured parents of children enrolled in SCHIP are not eligible themselves. (The Administration's budget includes a proposed expansion of SCHIP.)

Federal and state governments have enacted policies to improve access and affordability to private health insurance. Two Federal health-care initiatives were designed to make it easier for workers with health-care coverage to maintain that coverage when they are in-between jobs. The health continuation rules enacted under COBRA (Consolidated Omnibus Budget Reconciliation Act of 1986) enable workers to purchase continued coverage for a limited time when they change jobs or lose eligibility for health insurance. The Health Insurance Portability and Accountability Act (HIPAA) of 1996 was designed to extend individuals' ability to maintain private health insurance by limiting exclusions for pre-existing conditions in employer health plans and for workers converting to individually purchased insurance. State regulation of the insurance market is varied. Eight states require guaranteed issue of all products in the individual insurance market; another five states require guaranteed issue of a standard product only. Fifteen states limit rating in the individual market; two require pure community rating.

4. CONSIDERATIONS IN ASSESSING PROPOSALS TO EXTEND COVERAGE

While the current system of tax incentives and direct provision programs assists millions of Americans in obtaining health insurance, there are many who remain uninsured because they either are ineligible or do not take advantage of them. A number of proposals have been considered to extend coverage to the uninsured. Prior to discussing individual proposals, it is useful to lay out the basic economic issues that are important in assessing the various proposals.

A. Distributional Effects

Different types of subsidies will have different distributional effects. As described in the previous section, expanding tax deductibility for health insurance premiums will provide more benefit to higher-income people. In contrast, a tax credit directly reduces tax payments by the amount of the credit, and is therefore worth *the same to all taxpayers able to take advantage of it*. To take full advantage of a non-refundable tax credit, however, an individual must pay at least as much in taxes as the amount of the credit. Because almost half of the uninsured do not pay any taxes against which either a deduction or credit can be applied, neither tax deductions nor tax credits reduce the cost of health insurance for this group.[25] If a tax credit is made *refundable*, however, it will reduce the cost of health insurance to all lower-income individuals, because a refundable credit is payable even to those individuals who do not owe any taxes at all.

[25] Jonathan Gruber, *Tax Subsidies for Health Insurance: Evaluating the Costs and Benefits*, Working Paper 7553 (Boston: National Bureau of Economic Research, 2000).

Limiting eligibility for tax credits targets the benefits to specific income groups. Direct government provision of health insurance can also be targeted to specific income levels by eligibility criteria. While Medicare eligibility is not income-related, Medicaid and SCHIP eligibility are.

B. Crowding Out and the "Cost per Newly Insured."

Policies that are designed to extend coverage to those currently uninsured can cause some people who currently have insurance to drop it in favor of government-provided insurance or individually purchased insurance motivated by a tax subsidy. Equivalently, some employers may stop offering coverage (or reduce their contribution) and tell their employees to take advantage of the new government insurance or tax subsidy. *This is known as "crowding out" of existing insurance—when new government subsidized insurance crowds out employer-provided insurance.* It means that government dollars go not just to newly insured; some fraction of the money goes to those who had employer-provided coverage and are now switching to a new government-subsidized plan. If the new subsidy provides a much higher benefit than the value of the tax exclusion, then crowding out can be severe and the cost to the government of each net newly insured person can be pushed up substantially. Moreover, if firms drop coverage, some employees may choose not to purchase individual insurance, leading to a smaller net increase in coverage, or possibly even a net decrease.

Studies of the Medicaid child eligibility expansions of the late 1980s and first half of the 1990s found that about 10 to 20 percent of the increase in Medicaid coverage was due to a reduction in private insurance coverage. Most of these studies examined Medicaid expansions that did not contain anti-crowd-out provisions. Because Medicaid covers mostly low-income people who are less likely to have private insurance, crowding out might be expected to be modest.

To prevent crowding-out, some proposals have excluded eligibility of people who previously had private insurance. However, this penalizes people who had already purchased health insurance in the private market and are not eligible for the new subsidies. The amount of crowding out will likely increase as eligibility for subsidies is extended up the income scale. Crowding out will also likely increase as the generosity of a subsidy increases. Therefore crowding out might be limited by targeting subsidies to the lowest income families, who are unlikely to be covered by health insurance, or by limiting subsidies to relatively modest amounts.

C. Encouraging Participation

Many families do not take advantage of insurance programs that are available to them. For individuals at low-income levels, even modest costs (such as nominal premiums or co-payments) may dramatically decrease enrollment and utilization. This may especially affect families without health-insurance problems, who could risk remaining uninsured to pay for more pressing needs such as food and housing. In addition, a complex application process designed to determine eligibility may have the unintended side effect of dramatically reducing coverage for otherwise qualified individuals. A subsidy that is received only after expenses have been paid may also deter individuals who do not have the funds to pay the insurance premiums up front.

D. Issues with Different Types of Insurance

The type of health insurance that the government subsidizes is important. Traditional employer-based insurance is often called "group" coverage, because a firm's employees form a risk pool of individuals who are all charged the same rate regardless of their individual health status. In contrast, individuals seeking health insurance on their own must purchase insurance in the "non-group" market, where fewer regulatory protections apply. A third option is a public insurance product: either by public provision of insurance, or by a "buy-in" provision. The following are some of the major issues associated with these different types of policies.

Accessibility of insurance

In the non-group market, individuals can face difficulties with access to insurance. Insurers can often vary the benefits package to limit coverage, or exclude individuals with pre-existing conditions from coverage. In many states, insurers can charge different premiums based on the perceived risk of coverage, making health insurance unaffordable for some people. State regulations can address these problems—for example, fifteen states limit rating in the individual market, restricting how much insurers can base premiums on a person's health[26]—but such solutions can lead to adverse selection problems (discussed below). Small businesses can also face accessibility issues. Insurers recalculate premiums each year based on the experience of the firm. Because firms with fewer employees have a small risk pool, a few serious, costly illnesses among employees could significantly increase premiums in subsequent years. These increases could be passed on to the employees, or the firm could drop health insurance coverage. Larger firms, with larger risk pools are less likely to have such access problems. Publicly-provided insurance provides guaranteed issue to those meeting the criteria established by the government.

Adverse selection

Health insurance is based on the premise that, by offering a single rate to a group of individuals, those people who do not have health expenses in a particular year help pay the costs of those people who do experience health-related expenses—people pool their risks. *Adverse selection occurs when low-risk individuals do not believe they benefit from the risk pooling, and therefore leave the risk pool.* As these relatively healthy people leave the original pool, the average cost per person remaining in the pool will increase. When the costs and therefore the premiums for insurance begin to climb, still more people will elect not to purchase health insurance and there can be a spiral of rising premiums and declining enrollments. This could lead to prohibitively high premiums for those still desiring to purchase health-care insurance.

Adverse selection can affect both the group and the non-group markets. The existing tax subsidy for employment-based group health insurance encourages healthy workers to remain in the group pool, because the subsidy for individually purchased insurance is smaller. If alternative subsidies are available for individual insurance, healthy people may decline employer-based coverage for individual coverage priced to suit them. In response to restrictions on individual

[26] Deborah Chollet, "Consumers, Insures, and Market Behavior," *Journal of Health Politics, Policy, and Law*, 25.1 (2000).

rating, healthy people may also leave the individual market and not carry any health insurance. Even if young, healthy individuals find low-premium policies that reflect their lower risk rather than choosing to drop insurance altogether, higher risk people might still face prohibitively high premiums because the market becomes segmented into different risk pools.

Administrative costs

The administrative expense of selling and billing to many individual policyholders is much larger than when a group of people are represented by a benefits manager. This means that administrative costs are often higher in the non-group than in the group market. Estimates of the amount of premiums paid relative to benefits received suggest that non-group insurance is substantially more expensive than group insurance. *Individuals buying insurance in the non-group market pay on average about $1.50 in premiums for each $1 in benefits, a substantially higher ratio than the $1.15 in premiums paid for $1 of benefits in the group insurance market.*[27] Small businesses also face relatively high administrative costs.[28] The administrative cost of Medicare is 3 percent of benefit payments.

5. SIMULATING THE IMPACT OF ALTERNATIVE POLICY PROPOSALS: EXAMPLES FROM THE LITERATURE

Economists have built simulation models that estimate the value and cost of different policy options for extending health insurance coverage. These models include estimates of the effects of some or all of the factors discussed above—such as crowding out and take-up rates. The available simulations suffer from some inevitable limitations. They look at a range of different policies that differ sharply in overall cost and eligibility, and the workings of the models are not terribly transparent. Seemingly small changes in proposals can have a big impact on the estimates. Moreover, some of the simulations present short-term effects, even though the policies are likely to require many years before the full effects on the health insurance market play out. But despite these limitations, the models provide a way to quantitatively compare alternative policy choices that go beyond the more qualitative discussion of issues given above. In this section we will briefly present the simulation results for alternative policies aimed at incrementally expanding coverage.

A. Tax Policies

A simulation model developed by Jonathan Gruber examines the effects of two tax proposals to extend coverage.[29]

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[27]Mark V. Pauly and Allison M. Percy, "Cost and Performance: A Comparison of the Individual and Group Health Insurance Markets," *Journal of Health Politics,Policy and Law*, 25.1 (2000).

[28] If the credit is available to anyone purchasing private insurance, taxpayers may file tax returns solely for the purpose of claiming the new tax credit. That could be costly for the IRS to administer. A solution to this problem could be to limit the credit to working individuals and families with earnings above a *de minimis* amount. Those people almost all file tax returns, and as noted earlier, 80 percent of the uninsured are employed or married to an employed person. However, the restriction would exclude many early retirees and other working-age people who are out of the work force, but ineligible for Medicaid.

[29] Gruber, *Tax Subsidies for Health Insurance: Evaluating the Costs and Benefits.*

- The first proposal is a refundable tax credit of up to $1,000 per individual and $2,000 per family for non-group health insurance.
- The second proposal is a tax deduction for individually purchased health insurance, available whether or not the household itemizes deductions.[30] (Unlike the Patients' Bill of Rights proposal, the deduction would not be available to individuals whose employers contribute to their health insurance, regardless of how small the contribution is.[31])

Each proposal would be fully available to individuals with incomes up to $45,000 and to families with incomes up to $75,000, and phased out to zero by incomes of $60,000 for individuals and $100,000 for families. The results of these simulations are in the table below.[32]

Although Gruber's analysis does take into account the immediate effect of the subsidy on employers' decisions to discontinue coverage or employees opting out of employer plans, it does not take into account the long-run effects. For example, after healthy individuals opt out of their employers' plans to obtain individually purchased health insurance, employers' premiums (especially for small firms) will rise, causing more employers to drop coverage or causing some additional employees to opt out. These second round effects may lead to higher crowding out in the long run.[33]

Table 1: Tax Policy Simulation Results (Gruber)

All $ figures in 1999 dollars	Refundable Tax Credit for Non-group Insurance	Tax Deduction for Non-group Insurance
Total participants (millions)	18.4	6.3
Percent of participants previously uninsured	25.7%	9.2%
Net increase in number of insured people (in millions)	4.03	0.25
Percent decrease in the uninsured population	9.5%	0.6%
Number of currently insured who lose coverage (in millions)	0.69	0.34
Percent of participants with incomes below 200% of poverty	53%	32%
Percent of costs spent on participants with incomes below 200% of poverty	56%	29%
Government cost per participant	$723	$138
Government cost per newly insured person	$3,296	$3,544
Total government cost (in billions)	$13.3	$0.9

[30] The deduction would be "above-the-line," which means that it would be available to taxpayers whether or not they itemize deductions.

[31] The Patients' Bill of Rights would allow a deduction for individuals covered under an employer plan as long as the employer contribution does not exceed 50 percent of the premium.

[32] Because there has been limited experience with tax subsidies for health insurance, the estimates of behavioral responses to tax subsidies are based on less solid evidence than that available for simulations of direct subsidies below.

[33] As discussed earlier, this process of adverse selection could in theory cause premiums to spiral up to the point where premiums are unsustainable.

The striking drawback to the tax deduction plan is that the size of the uninsured population falls by less than one percent. (Table 1). Of the 6.3 million participants in this plan, only 580,000 were not previously covered by health insurance. In addition, an estimated 340,000 people who were originally insured under an employer plan become uninsured. Another 300,000 people are dropped from employer plans and move to the individual insurance market. On net, the proposal would increase coverage by about a quarter of a million people. Thus, though the benefit level to each participant is only $138, because 91 percent were previously insured, the cost to the government per newly insured participant is $3,544. Moreover, only 29 percent of the benefits would go to those with incomes below 200 percent of poverty; only 6 percent goes to those in poverty. Thus, though the total cost of this plan is modest, this is not an effective way to extend coverage to the uninsured.

In contrast, the refundable tax credit increases the number of those insured by 4 million, but at a much higher cost. A higher percentage of participants come from the uninsured population—25.7 percent (4.7 million people), compared to 9.2 percent (580,000 people) for the tax deduction. The refundable credit causes some crowding out: over one million people are dropped by firms and purchase individual insurance, and about 3.6 million voluntarily switch from employer-provided insurance to non-group insurance. About 700,000 people who were insured through their employer become uninsured. The net increase in the number of insured people is about 4 million. Because the refundable tax credit is more effective in reaching the uninsured, the government cost per newly insured is slightly smaller under the refundable tax credit than the tax deduction ($3,296 versus $3,544), even though the refundable tax credit provides participants with a much higher level of benefits ($723 versus $138). This higher level of benefits raises the total cost of the tax credit plan relative to the tax deduction plan, but even if it were designed to have the same overall cost—which would require narrow targeting—the refundable tax credit could be expected to be more cost effective at reaching the uninsured than a tax deduction.

Another set of researchers—sponsored by the Kaiser Family Fou7ndation—also simulated the effects of refundable tax credits and tax deductions.[34] The simulation model that they use is different from that of Gruber, and the particular features of the tax proposals that are analyzed are somewhat different from those examined by Gruber.[35]

- The first proposal is a sliding-scale refundable tax credit covering full policy costs for all families with incomes at or below 150 percent of the federal poverty level with private health insurance (either direct purchase or through employment). The credit would decline with income until it was phased out completely at 500 percent of the federal poverty level (about $85,000 for a family of four).
- The second proposal is a policy that would allow individuals without access to employer-sponsored insurance to deduct 80 percent of the premium from taxable income on their tax returns.

[34] Judith Feder, Cori Uccello, and Ellen O'Brien, *The Difference Different Approaches Make: Comparing Proposals to Expand Health Insurance*, The Kaiser Project on Incremental Health Reform (Menlo Park: The Henry J. Kaiser Family Foundation, 1999).

[35] The Kaiser researchers used their own estimates of behavioral responses to tax subsidies and so their findings would not be directly comparable to the Gruber study even if both studies examined exactly the same tax provisions. Most notably, Gruber assumed a significant number of people would be dropped from their employer-provided group health insurance as a result of the availability of subsidies for non-group insurance.

The simulation incorporates the predicted participation among the eligible population based on historical data from participation in similar plans, the expected costs of the offered plans, and the expected switching of people who were already insured to the more generous full (or near full) subsidy. The table below provides the results of the simulation.

Table 2: Tax Policy Simulation Results (Kaiser)

All $ figures in 1998 dollars	Refundable Tax Credit for Non-group Insurance	Tax Deduction for Non-group Insurance
Total adult participants (millions)	42.5	6.1
Percent of participants previously uninsured	18%	7%
Number of newly insured (in millions of people)	7.7	.4
Percent of non-elderly adult uninsured who become covered	26%	1%
Percent of participants with incomes below 200% of poverty	46%	21%
Percent of costs spent on participants with incomes below 200% of poverty	73%	14%
Government cost per participant	$912	$265
Government cost per newly insured	$5,156	$3,953
Total government cost (in billions)	$38.7	$1.6

A comparison of the refundable tax credit and the tax deduction using the Kaiser model produces the same general conclusions as those reached using the Gruber model. The refundable tax credit reaches a larger fraction of the uninsured (26 percent) than does the tax deduction (1 percent). It is also much better targeted to the poor than the tax deduction, providing almost 73 percent of its funds to persons below 200 percent of poverty. However, the Kaiser refundable tax credit plan provides a very generous subsidy, so it is expensive and has higher take-up rates. Eighty-two percent of the people who use the subsidy were previously insured.

The Treasury Department analyzed the effects of the tax deduction plan proposed in the Patients' Bill of Rights (PBOR), which provides an above-the-line tax deduction for premiums for non-employer acute care health insurance, or employer health benefits if employer contributions are less than 50 percent of the premium. Because eligibility for the subsidy is extended to the insured whose employer pays less than 50 percent of the premium, many more currently insured individuals would be eligible for this subsidy than the deductions considered in the Gruber and Kaiser simulations, which assume that anyone whose employer contributes at least a dollar is ineligible for a deduction. Further, employers who contribute only a bit more than 50 percent of the premium could reduce their contributions to 49 percent and reduce the after-tax cost to their employees. The PBOR proposal would benefit many people currently covered by employment-based health insurance. Accordingly, the Treasury estimates assume that most of the cost of the deduction would go to currently insured workers whose employers would contribute less than 50 percent of premiums.

Another important difference of the Treasury analysis is that it models a fully phased in policy that has been in effect for 10 years. The Treasury Department estimates that, under this plan, 1.2 million additional people would acquire insurance in 2010, but 600,000 people who were insured through their employer would become uninsured, resulting in a 600,000 net increase in the insured population. The policy would reduce tax revenues by $11 billion in 2010, so the cost per newly insured person would be about $18,000.[36]

Overall, tax deductions provide a very small subsidy for the majority of the uninsured, who are lower-income, and thus do very little to increase coverage. Refundable tax credits provide a bigger subsidy that does not increase with income—indeed they could even be designed to provide the largest subsidy to those with the lowest incomes who are least likely to have insurance coverage. Thus, by targeting the people who are left out of the current system, credits can be more effective, more progressive and less disruptive of the employer health insurance market than tax deductions. However, credit proposals, like the ones simulated above, which have broad eligibility may be quite expensive, because the total cost of the tax credit proposals is high when the subsidy attracts many participants who are already insured. For the same reason, they also present the greatest threat to the market for employment-based health insurance. Therefore, they are considerably less efficient than the direct provision proposals described below.

A final drawback of the refundable tax credit plans evaluated here is that the credits direct people to the individual market which, today, is inaccessible to many individuals because they have pre-existing conditions that render them ineligible for insurance. It also can be unaffordable to many people due to adverse selection. Insurance regulation can help address the accessibility and affordability problems that exist today. Another alternative is to allow refundable tax credits to be used for public group plans such as Medicare, Medicaid, or SCHIP buy-ins.

However, these tax credit plans can be valuable in addressing a different problem—the inequities inherent in the current tax treatment of health insurance. As described above, those currently covered by employer-provided health care receive tax breaks, but those who purchase their own insurance receive very little tax benefit. Therefore, a refundable tax credit that approximately equals the value of the employer deduction would provide equity with the tax advantage currently enjoyed by those who have employer-provided insurance.

B. Direct Government Provision of Health Insurance

The simulation model developed by a Kaiser Family Foundation study is also used to examine the effectiveness of two alternative options that increase the direct provision of health insurance to certain segments of the population.

- The first option is a large-scale plan that would extend government-provided insurance coverage to all uninsured adults with incomes below the poverty level.

[36] A significant part of the difference between the Treasury and Gruber estimates is expected increases in health insurance costs. Treasury assumes that insurance costs will roughly double between 1999 and 2010; thus, Gruber's estimate of $3,544 per newly insured person in 1999 would correspond to about $7,000 at 2010 levels. Most of the rest of the difference is attributable to the difference in policies estimated.

– The second option is a proposal very similar to the Administration's proposal to extend government-provided health insurance to parents of children who are eligible for the Medicaid and SCHIP programs. Under this plan, adults in families with incomes up to 100 percent of the poverty line would receive health insurance that was completely paid for by the government. Families with incomes above the poverty level but below state-determined eligibility limits (typically 200 percent of poverty[37]) would pay a premium of 2 or 4 percent of income, depending on whether one or two parents were covered.

Table 3: Direct Provision Simulation Results (Kaiser)

All $ figures in 1998 dollars	Coverage to all poor adults	Coverage to Parents of Medicaid/SCHIP Children
Total participants (millions)	9.3	3.0
Percent of participants previously uninsured	69%	69%
Number of newly insured people (millions)	6.2	2.1
Percent of non-elderly adult uninsured who become covered	22 %	7%
Percent of participants with incomes below 200% of poverty	100%	93%
Percent of costs spent on participants with incomes below 200% of poverty	100%	94%
Government cost per participant	$2,484	$2,271
Government cost per newly insured	$3,582	$3,306
Total government cost (in billions)	$23.0	$6.7

The results for the two plans are very similar (Table 3), except, of course, for the fact that the broader plan covers many more people and is correspondingly more expensive. The cost per participant is slightly lower in the narrower plan, because some SCHIP parents will contribute a small premium.

The majority of the participants in both plans are newly insured. There is some crowding out evident in this simulation, as 31 percent of participants were previously covered by some other type of insurance. But that is a very low figure relative to the options considered earlier. *Over two-thirds of the participants in the programs are newly insured*. This is because the eligibility for these programs is targeted to lower-income people, who are less likely to be covered by other insurance, and the programs have a generous enough subsidy to get high participation.

[37] State upper income eligibility limits vary from 133 percent of poverty to 350 percent of poverty.

The Office of Management and Budget has estimated the cost of the Administration's FamilyCare proposal, a different proposal with some of the features of the simulation covering parents of children on SCHIP and Medicaid (second column of Table 3), and finds the cost comparable to the simulation's estimated cost per newly insured person. The Administration proposal is broader, projecting 5 million newly insured people, because it includes provisions for the coverage of immigrants, Medicare buy-in for individuals between 55 and 65, and outreach programs to eligible populations.

6. CONCLUSIONS

This report highlights a number of troubling features of the current state of health insurance in the United States.

- Over 44 million Americans—about 1 in 6—are not covered by health insurance. This lack of health insurance has worsened over the past decade, even as the economy has been booming. *Forty-three percent of adults in households below the poverty line did not have health insurance coverage in 1998.* Minorities are less likely to be covered by insurance than the average.

- For families without health insurance, health problems often go untreated—leading to poorer health outcomes, including a higher likelihood of being hospitalized with conditions that could have been treated out of the hospital or avoided altogether. *Uninsured Americans are more than three times as likely to delay seeking care.* For many uninsured families, major health problems can lead to financial devastation. Health insurance, while seemingly expensive, may be the most cost-effective way to ensure a healthy society. The benefits of prenatal care, often delayed because of a lack of health insurance, for example, are enormous.

- The cost burden of the uninsured falls on the public at large, because ultimately the entire society absorbs the costs of medical treatment for individuals who are unable to pay for medical care.

- The federal tax code provides a very large subsidy for the purchase of employer-based health insurance by not including employer premium contributions in taxable income. But, because the effective subsidy depends on an employee's marginal tax rate, the value of the health benefit to households rises sharply with household income. Low-income households receive little or no tax incentive to participate in health insurance plans—a key reason that so many low-income households do not have coverage.

A number of policy responses to the problem of the uninsured are discussed in this report, using a discussion of the economic issues involved and quantitative estimates from simulation models. The analysis suggests that some approaches are likely to be more effective than others.

- **Tax deductibility is not an effective policy to extend coverage.** Studies indicate that extending tax deductibility to non-group policies would expand medical insurance coverage only modestly, and would do very little to expand insurance coverage to low-income

families. It would provide a tax break to predominately middle- and upper-income households already purchasing such coverage.

- **Refundable tax credits may reach some low-income families, but, to the extent that tax credits encourage the use of non-group insurance, this creates different problems.** Initiatives of this sort can be scaled to provide a reduction in the number of uninsured—at substantial cost to the government. Refundable tax credits are far more effective in targeting low-income families than are new tax deductions, because a refundable tax credit can be used by families at lower-income levels to reduce the cost of insurance. However, serious problems exist in the non-group insurance market. Lack of availability, adverse selection and administrative costs make the non-group insurance market inefficient and expensive. The difficulties can be addressed with appropriate insurance regulation, which would have to be part of any substantial effort to expand coverage through tax subsidies for non-group coverage. Alternatively, tax credits can be used for individuals to buy insurance through small business purchasing groups or public programs that do not have these problems.

- **Direct provision of health insurance, like the SCHIP initiative, would be particularly effective in targeting low-income families.** Research indicates that this type of initiative, while not affecting as many uninsured people as some of the tax credit proposals, is very effective at reaching the lower-income uninsured for a relatively small total cost. Thus, direct provision has an advantage over tax credits in more effectively making health insurance affordable and accessible for many Americans. *Simulations suggest that over two-thirds of expanded direct provision participants would be newly insured.*

- **Serious problems arise in the non-group insurance market**. Lack of availability, adverse selection and administrative costs make the non-group insurance market inefficient and expensive. This means that policies that encourage households to move into this market are problematic. To an extent these difficulties can be overcome with appropriate insurance regulation, which would have to be part of any substantial effort to expand coverage through tax subsidies for non-group coverage.

Reversing the trend of declining insurance coverage among Americans will require a major commitment by the public sector. One common theme in these studies is that there is no silver bullet that will easily or inexpensively resolve the problem of the uninsured in America. Indeed, taken as a whole, these studies suggest that a careful blend of different policies may be required to reach the uninsured effectively. For Americans at moderate income levels, direct provision policies, such as the Administration's proposal to expand SCHIP to cover adult members of families with eligible children, are particularly cost-effective. Although well intentioned, tax changes (even when based on more-efficient refundable credits rather than tax deductions) are not very effective at reaching a high percentage of the uninsured, because the uninsured are predominantly low-income and the poor simply cannot afford insurance even at a reduced cost. However, tax-credit programs, with insurance regulation or for purchase of public insurance, can be useful to families as their incomes rise and they become ineligible for subsidies through direct provision programs. Such a combination of programs might offer an effective way to provide health insurance to those who have been left out of the current health-care system.