Assessing the Combination of Public Programs and Tax Credits

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Overview

Intrinsic to any proposal to expand health insurance coverage is taking a position regarding the coverage that already exists.One set of proposals aims directly at replacing current coverage,creating new mechanisms that would apply to the already insured and to people who have no insurance. These proposals often place as much emphasis on equity—for example, ensuring that all low-income people receive equivalent government subsidies, regardless of how they are insured—as on decreasing the number of people who are uninsured. Another set of proposals aims more narrowly at the uninsured, but affects the already insured indirectly (and sometimes unintentionally) with the incentives and mechanisms newly put in place.

Our approach resembles the second set of proposals in its focus on the uninsured. But, unlike either of the above sets, our objective is the retention, not disruption, of existing coverage—specifically, publicly provided and employer-sponsored health insurance. We adopt this strategy not because we think that these mechanisms have no flaws; we recognize that flaws exist. However, we are concerned that there is more to lose than to gain from disrupting them—particularly for low-income people whose coverage is our primary concern. Simply stated, our goal is to expand coverage for those without it and to "do no harm" to coverage mechanisms now in place.

In the absence of comprehensive health reform aimed at universal coverage, we suggest that the following principles should guide the design of incremental efforts to decrease the number of uninsured Americans:

• New dollars spent on health insurance should be targeted to significantly expand coverage.

• Coverage should be expanded to the uninsured without disrupting coverage already available in the public and private sectors.

• Expansion should begin with,and place priority on, coverage for those uninsured who are least able to pay.

To satisfy these principles, we argue that, for the low-income uninsured, the most effective approach to expanding coverage is to extend the Medicaid and State Children's Health Insurance Program (S-CHIP) eligibility now available to children and some parents to all low-income individuals. Because the lowest-income population is least able to purchase health insurance on its own, this public program should have the highest priority as a claim on federal dollars.

Following the Medicaid/S-CHIP approach would mean extending eligibility for comprehensive benefits at no cost (as in Medicaid) to all individuals with incomes below 150 percent of the federal poverty level,and extending benefits with some premiums and cost sharing (as in S-CHIP) to individuals with incomes between 150 and 200 percent of the federal poverty level. People with incomes above 200 percent of poverty could be allowed to "buy in" to public coverage by paying a sliding-scale premium based on income.

Although public programs are the most appropriate way to extend coverage to the low-income population,they could be combined with tax credits to reach the uninsured who have modest incomes. In such a combination, careful attention is needed to ensure that any tax credits complement rather than substitute for existing public and private sources of coverage.A number of policy makers and

analysts have proposed tax credits that could be used by individuals to buy non-group insurance. Making such a tax credit non-refundable—thereby targeting it primarily to those with incomes in excess of 200 percent of the poverty level—would mitigate conflicts with public coverage. Even so, it is difficult to design a modest, non-refundable individual tax credit that is effective and well targeted, while at the same time avoiding disruption of existing employer-sponsored insurance. For example, allowing application of an individual tax credit to employer coverage would significantly reduce the risk of displacing that coverage, but it would also likely substantially increase the cost of the credits with payments to the already insured.

Because it could be better targeted, a more effective approach to combining a public program expansion and a tax credit might be a health insurance tax credit provided to employers, rather than to individuals. It could be targeted to those small, low-wage businesses least likely to offer insurance today, maximizing the focus of public dollars on improving access to employer-sponsored coverage. Although employer tax credits have the disadvantage of leaving people with modest incomes dependent on their employers' willingness to expand coverage, this downside may be more than balanced by the upsides of better targeting and less disruption.

The following discussion begins by explaining the risks posed by disruption of either employer-sponsored or publicly sponsored coverage, then examines the reasons,in the current policy environment, for reliance on more than one policy instrument to expand coverage. We then make the case for expanding public coverage and explore the issues raised by pairing that expansion with a tax-based approach. We conclude with a discussion of specific design issues raised by the public and private components of a combined strategy.

Why Avoid Disruption?

It is hard to disagree with a critique of the nation's current mix of insurance mechanisms as insufficient, inefficient, and inequitable. However, to advocate replacing these mechanisms with something else presumes the political wherewithal to achieve comprehensive reform and the political and administrative wherewithal to devise an improved system. Experience warrants skepticism on both counts. Over the last century, periodic efforts to achieve comprehensive reform have encountered significant political obstacles. The most recent effort, in 1993–1994, was obviously no exception. There are various obstacles, but high on the list is the concern of those who already have insurance coverage that they will be worse, not better, off under reform. Proponents of the Clinton administration's Health Security Act argued that the plan would secure health insurance for all Americans. But critics successfully countered that the plan would dramatically alter, indeed undermine, coverage of the already insured. The plan that claimed to benefit everyone came to be seen as likely to benefit the uninsured minority, while making the already-insured majority worse off.

It is not clear that an alternative policy and political strategy—one that claims from the outset to benefit only the uninsured—will be more successful. After all, it will require explicit recognition of the need to redistribute resources from those who have insurance to those who do not. But given the political problems generated by the fear of disruption, it seems worth trying a more targeted approach. Moreover, when the aim of policy is incremental change—which is the most likely scenario in the near term—the need to minimize disruption becomes even more important, because the gains are not large enough to justify the risk of losses for those who are already insured.

Minimizing displacement requires attention to the policy and political advantages of both existing employer-sponsored and publicly sponsored coverage. Not only do most Americans gain coverage through employment, but polls also indicate that they value that approach, despite changes in the structure of employment and the dissatisfaction that has accompanied changes in employer-sponsored insurance over the last decade.[1] From a policy

[1] Kaiser Family Foundation and Harvard School of Public Health. *Post-Election Survey: The Public and the Health Care Agenda for the Next Administration and Congress.* Menlo Park, CA: Kaiser Family Foundation, 2001.

perspective, the strongest advantages of employer-sponsored insurance are its administrative efficiencies (including practically automatic enrollment of employees) and its significant,if not total,spreading of risks across people of different incomes and health status. Employer coverage is particularly valuable to low- and modest-wage workers, because it provides for easily accessible enrollment and compensates for cash flow problems that would arise if workers had to shop on their own.

Although the tax preference for employer-sponsored insurance is frequently criticized as "inequitable"—and its direct monetary benefits are, in fact, skewed to those who are better off— it also serves as an appropriate incentive to achieve efficient risk pooling. Despite rhetoric to the contrary, there is little or no evidence that newly created administrative structures can replicate the effectiveness of employers in effectively pooling risks.[2] To disrupt employer coverage without confidence in a reasonable alternative ultimately puts the scope and adequacy of coverage in jeopardy.

There is also a significant risk to disruption of public coverage—that is, coverage provided by the Medicaid and S-CHIP programs. Medicaid, in particular, has been criticized as being more discouraging than inviting of participation, whether by beneficiaries or providers. But barriers to participation likely have more to do with Medicaid's means-tested eligibility and the implementation of that means test than with something peculiar to the Medicaid program. States' dramatic expansion of Medicaid coverage at the end of the 1980s, and their more recent implementation of S-CHIP, indicates that a public program's attractiveness, or the ease or difficulty of participating in it, reflects policy choices that are an essential part of any program, new or old.[3]

The fact is that low-income people will always need more public support than the rest of the population if they are to have affordable access to coverage and services. Medicaid's 35-year history of providing health insurance to segments of the low-income population has established both administrative and legal structures that protect beneficiaries' rights to benefits and care. Proposals to replace Medicaid may offer far less support than Medicaid currently provides—whether in benefits, administrative arrangements, or legal foundations (including enforcement of federal entitlements). And creation of new federally financed subsidy mechanisms for the uninsured—even if they ostensibly leave Medicaid untouched—may encourage political pressure to weaken existing protections. (As discussed below, enactment and implementation of S-CHIP raise precisely that possibility.) Just as it is appropriate to question whether new administrative structures can effectively replace employer-sponsored insurance, it is also appropriate to question whether new administrative and subsidy structures can effectively replace Medicaid.

Why Rely on More than One Policy Instrument?[4]

The population without insurance is not a homogenous group. Differences in peoples' circumstances or characteristics do not necessarily require the use of different policy strategies to reach them. But different policy strategies will be more or less effective in reaching different segments of the uninsured population (for example, those with lower versus higher incomes).

Currently, tax policy has gained some political popularity as a strategy to expand coverage—targeted specifically to low- and modest-income people. President Bush campaigned in favor of such a policy, and various proposals for targeted credits have been put forward by both Democrats and

[2] Jack Meyer et al. *Tax Reform to Expand Health Coverage: Administrative Issues and Challenges.* Menlo Park, CA: Kaiser Family Foundation, 2000.

[3] Donna Cohen Ross and Laura Cox. *Making It Simple: Medicaid for Children and CHIP Income Eligibility Guidelines and Enrollment Procedures.* Kaiser Commission on Medicaid and the Uninsured, 2000.

[4] The following discussion draws on: Judith Feder et al. "Covering the Low-Income Uninsured: The Case for Expanding Public Programs." *Health Affairs* (January/February 2001); Diane Rowland, Rachel Garfield, Christina Chang, and Barbara Lyons. *Building on Medicaid to Cover the Low-Income Uninsured.* Washington: Kaiser Commission on Medicaid and the Uninsured, forthcoming.

Republicans in Congress.[5] The appeal of tax preferences to provide subsidies appears to be the potential to operate with minimal government involvement. In theory, people could apply by filing tax returns, rather than applying to a government office, and they could choose a plan on their own, rather than relying on plan options selected by a government agency. However, three factors make this strategy problematic for low-income people.

The first factor is the tax system's limitations in reaching the low-income uninsured. About half of people without health insurance do not file an income tax return or owe any income taxes.[6] To reach them at all, an income tax credit would have to be refundable—that is, available without regard to tax liability. The Earned Income Tax Credit (EITC) is a refundable tax credit that has been enormously successful in enhancing income for the working poor. However, it is harder to support the purchase of health insurance than to boost income. Tax credits, including the EITC, are typically refunds—money the taxpayer gets back at the end of the year. To buy health insurance, people with limited incomes need the cash in advance. Further, they need to know they can keep the money, even if their income changes. Advance payment and non-reconciliation of income and subsidies at year's end would require significant departures from current tax practices—practices seen as ensuring the accuracy and efficiency of the tax system.

The second factor is problems with the market or insurance products that such a credit could buy. About 70 percent of the uninsured lack access to employer-sponsored insurance, whether through their own jobs or the jobs of family members. Credit recipients without access to employer coverage would be dependent on access to the non-group insurance market to obtain coverage. But that market is riddled with problems. To avoid adverse selection,insurers use practices to avoid enrolling people likely to use services. Except in a few states with comprehensive regulation, insurers can deny people access; exclude coverage for services, conditions, body parts, or body systems; and charge whatever premiums they deem appropriate. As a result, people pay more when they get sick and can lose access to coverage. Overall, benefits in the non-group market are quite limited (often excluding maternity benefits, prescription drugs, and mental health, and typically using significant deductibles or benefit caps). The fact that people insured in the non-group market are no less healthy than people with employer coverage demonstrates the effectiveness of insurer practices in controlling access to coverage by people in relatively poor health.[7]

The third factor is the questionable adequacy of the tax credit. The most prominent proposals involve tax credits that fall far short of the cost of health insurance (for example, a $2,000 credit for a family, when the cost of a typical family insurance policy typically exceeds $6,000). Clearly, the lower a person's income, the less able that individual is to make up any difference between the credit and the cost of an insurance policy.

For some or all of these reasons, even some proponents of tax credits recognize that a public program is better than using the tax system to reach the low-income uninsured. Building on existing public programs has two fundamental advantages. First and foremost is the extension of an adequate subsidy for an adequate product—that is, a subsidy for the full cost of comprehensive insurance to people with limited incomes. Second is the existence of an administrative apparatus in every state to determine eligibility for subsidies in advance and to facilitate enrollment in health insurance plans. Medicaid and S-CHIP programs—which now serve about 40 million people—have contracts in place with providers and managed care plans (indeed, they are public managers of private markets) and have established mechanisms for collecting and matching funds from the federal government. Although recent

[5] Randall Weiss and Mark Garay. *Recent Tax Proposals to Increase Health Insurance Coverage.* Menlo Park, CA: The Kaiser Family Foundation, 2000.

[6] Jonathan Gruber and Larry Levitt. "Tax Subsidies for Health Insurance: Costs and Benefits." *Health Affairs* (January/Feburary 2000).

[7] John Holahan, Unpublished analysis of Medical Expenditure Panel Survey, 2000.

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attention has focused on barriers to participation in public programs,a decade ago attention centered on the speed of Medicaid enrollment expansions in response to changes in federal law—from 19.2 million people in 1989 to 26.7 million in 1992. And, although a year or two ago enrollment in S-CHIP seemed to be expanding slowly, all states have dramatically expanded income eligibility standards for children—above 200 percent of poverty in 36 states—in recent years.[8]

The conclusion that a public program is the appropriate mechanism for reaching the low-income population means that if a tax strategy is to be pursued for those with higher incomes, it should complement, not substitute for, a public program.

Issues at the Intersection of Public Programs and Tax Policies

The likelihood and form of a combination of a tax credit and a public program will depend on the political process. But the effectiveness of such a combination—in expanding coverage with minimal disruption—will rest on answers to some strategic design questions.

Should the Two Instruments Be Parallel or Layered?
Establishing a tax credit alongside existing or new public coverage might seem, on the surface, to offer individuals an attractive choice of how or where they wish to obtain coverage. However, given the complexity of the health insurance market, and the difficulty of obtaining information for meaningful comparison-shopping within it, it is reasonable to doubt whether competing mechanisms constitute meaningful consumer choice.

This doubt is reinforced by the incentives states would face if tax and public programs existed side by side. Medicaid expenditures are always high on the list of state fiscal concerns, and Medicaid costs are once again rising faster than state revenues.[9] A tax credit could enable states to justify a contraction of Medicaid and S-CHIP coverage on the grounds that alternative subsidies were available for use in the private market. And, from the state perspective, these subsidies would have the advantage of being financed at federal, not state, expense. Successful substitution of federal credits for state/federal public programs would mean both a shift from state to federal expenditures and a decline in the benefits and stability of health insurance provided to low-income people.

Given the incentives, establishing tax credits alongside public programs can be seen as establishing a choice for states, more than it does for individuals. The result may be to undermine rather than enhance protection for low-income people, especially if (as is likely) the tax credit option is significantly less comprehensive than public coverage. To secure and extend health coverage for low-income people, layering a tax credit on top of a public program—that is, targeting each policy instrument to a different income group within the uninsured population—is a more effective approach.

How High up the Income Scale Should Eligibility for Public Coverage Extend?
Public programs for the low-income population offer comprehensive benefits at little or no cost to beneficiaries, reflecting an emphasis on ensuring affordability of coverage and services for people with limited ability to pay. With the cost of private

[8] Ross and Cox, 2000.

[9] National Association of State Budget Officers and National Governors Association. *The Fiscal Survey of States: December 2000.*

insurance at about $2,500 per adult and $6,000 per family, on average, the income level at which full or nearly full subsidies are arguably necessary to ensure affordability is relatively high. Expenses at this level are clearly beyond the means of people with incomes at the federal poverty level ($8,350 for an individual, $17,050 for a family of four). Indeed, even at incomes of twice that level, a premium would absorb more than 15 percent of family income. Hence, an argument can be made for extending public coverage to incomes up to and even above double the poverty level.

However, as income rises, so does the proportion of people with employer-sponsored insurance. At incomes below 100 percent of the federal poverty level, only 16 percent of the population has employer-sponsored insurance. By contrast, at incomes between 100 percent and 150 percent of poverty, 36 percent of the population has employer-sponsored coverage, and at incomes between 150 percent and 200 percent of poverty, 51 percent has it.[10] In a sense, these modest-income people who have coverage are actually paying for it, whether by forgoing income they would otherwise receive in wages or by paying actual out-of-pocket premiums. Whether people between one and two times poverty are perceived as able or unable to "afford" premiums and cost sharing, therefore, depends on whether the focus is on the 45 percent who actually have coverage, or on the roughly 40 percent not offered coverage (who would be expected to pay for coverage explicitly out-of-pocket instead).[11]

The scope of employer-sponsored insurance among people with incomes above the federal poverty level raises the additional question of how to balance affordability of coverage for low- and modest-income individuals with displacement of private coverage as public coverage is expanded. While the majority of employers offer health insurance to their workers, many also complain about its costs and administrative burdens. Some have talked about providing cash payments in the form of a "defined contribution" rather than sponsoring health insurance coverage. Despite a likely preference among employees for employer-sponsored over publicly sponsored coverage, availability of a public program at higher-income levels would create incentives for employees to choose free or nearly free public coverage over employer coverage that might require a substantial premium contribution. It also might create the opportunity for employers—particularly employers whose employees earn relatively low wages—to drop coverage entirely. Indeed, concern about crowd-out, as it is popularly described, led Congress to limit eligibility for S-CHIP to children in families with incomes of up to 200 percent of poverty who lacked employer coverage. In establishing eligibility levels for a program expansion, experience and analysis indicate the importance of careful attention to the potential disruption of employer coverage.

How Big Should a Tax Credit Be, and to What Kind of Coverage Should It Apply?

The concern about employers dropping coverage is clearly not limited to public program expansions. Departures from the provisions of current tax policy that favor the purchase of health insurance through the workplace instead of coverage purchased individually in the non-group market would perhaps be even more likely to induce employer dropping and employee switching than would public expansions. The likelihood that dropping would occur depends on the scope of a new tax policy. Making premium payments for non-group coverage tax deductible—widely advocated on equity grounds—would partially neutralize the current tax preference for employer coverage, though the benefits of pooling and lower administrative costs would remain. Extension of a tax credit for non-group insurance—more generous in many cases than a deduction—could actually create advantages to purchasing outside the workplace, especially for those employees who are young and healthy and,

[10] Paul Fronstin. *Sources of Health Insurance and Characteristics of the Uninsured: Analysis of the March 1999 Current Population Survey.* Washington: Employee Benefit Research Institute, 2000.

[11] Estimates from the 1996 Medical Expenditures Panel Survey, provided by Mark Merlis, Insitute for Health Policy Solutions.

thus,able to get favorable premiums. The more generous the tax credit, the more willing employees would likely be to seek coverage outside the workplace, and the more likely employers would be to drop sponsorship of health insurance.

The potential for employers to drop coverage can be mitigated if new tax credits are applicable, not just to the purchase of non-group coverage, but also to worker payments toward employer-sponsored coverage. The application of credits toward employer-sponsored coverage is also advocated on grounds of equity—treating individuals with similar incomes similarly, regardless of how they obtain their insurance coverage. However, allowing credits to be applied toward employer coverage will significantly increase the costs of an intervention, because in firms that already offer coverage,credits will go to the bulk (87 percent) of workers who accept coverage,[12] along with the minority who do not. Indeed, such an approach should not be seen as preventing substitution of public for private dollars; rather, it constitutes an explicit substitution of public for private dollars to achieve equity and to secure existing employer-sponsored coverage. A policy choice on this issue will clearly depend on the total dollars available and the willingness to spend on the already insured, as well as the newly insured.

Can Subsidies for Public and Private Coverage Be Integrated Smoothly?

A policy that layers a tax credit on top of a public program must pay particular attention to administrative and equity issues that arise at the intersection of the two policy instruments. For example,a policy that abruptly terminates eligibility for relatively comprehensive public coverage that is available at little or no cost at a specific income level creates a cliff: people with incomes below the specified level get a lot, while people with incomes just above that level get nothing. That is, in fact, the way eligibility for both Medicaid and S-CHIP currently works.

Clearly, extension of a tax credit mitigates this cliff, because it creates benefits above the eligibility level for public coverage. The more generous the tax credit, the less steep the cliff becomes. One way to think about establishing the size of the credit, then, is to set it so that the amount of out-of-pocket spending it requires recipients who are just above the limits of eligibility for public coverage to pay for private insurance is similar to the out-of-pocket spending toward public insurance expected of people whose incomes are just below the eligibility limit. The value of the credit, relative to the cost of premiums, could then decrease as income rises. The desire to smooth out cliffs in subsidies, however, must be balanced against the desire to avoid providing a tax credit—particularly one for non-group insurance only—that risks disrupting existing employer coverage.

Smooth integration also requires attention to the availability and characteristics of insurance products. If no changes are made in the private insurance marketplace, some people who are eligible for a credit may be unable to find or afford coverage—given insurance practices that limit access to or set prices for insurance based on people's age, health status, or other factors.[13] One way to address this problem would be to regulate the insurance market by establishing rules affecting both access and price. Another would be to establish a new publicly managed market in which insurance products are made available to all potential purchasers (for example, a purchasing cooperative). A third would be to allow people above the eligibility level for public coverage to "buy in" to the public program—that is, pay a premium from their own resources to obtain publicly sponsored coverage (not really so different from a purchasing cooperative, because most Medicaid and S-CHIP programs now provide coverage to families though private health plans). Making the tax credit applicable toward—and, indeed, equal to—the premium for publicly sponsored coverage would further smooth any transition. Of course, when establishing a buy-in to a

[12] Estimates from the 1996 Medical Expenditures Panel Survey, provided by Mark Merlis, Insitute for Health Policy Solutions.

[13] Deborah J. Chollet and Adele M. Kirk. *Understanding Individual Health Insurance Markets: Structure, Practices, and Products in Ten States.* Menlo Park, CA: Kaiser Family Foundation, 1998.

public program—or a purchasing cooperative, for that matter—one has to pay careful attention to how it relates to the private insurance market to ensure that it does not turn into a dumping ground for high-cost individuals.

The design choices actually made in each of these areas clearly have enormous implications for the cost, effectiveness, and administrative operations of any initiative that combines a public program and tax credits. And, as is often the case in policy making, design choices will require trade-offs. Choices made to smooth integration, for example, may run counter to choices made to minimize substitution or disruption. Following is an array of possible choices.

Establishing a Public Program

The most effective way to reach the low-income people who are now uninsured would be to extend protections that are now available to some of them to all low-income people. Currently, Medicaid concentrates primarily, and S-CHIP almost solely, on low-income children. Although Medicaid covers women while they are pregnant, and states have the option to include parents, in 32 states uninsured working parents are ineligible for Medicaid if they work full-time at the minimum wage.[14] Further, low-income, childless adults, no matter how poor, are ineligible for coverage under federal law unless they qualify as disabled. To reach the entire low-income uninsured population,an initiative would make income, rather than family status,the sole criterion for eligibility.

Such a public program extension must address a number of other policy issues, as outlined below.

Eligibility

The extension of eligibility for comprehensive benefits at virtually no cost to all individuals with incomes below 150 percent of the federal poverty level would ensure affordable coverage with little threat to current employer coverage. Employers now cover only about 16 percent of the population with incomes below the federal poverty level and only 36 percent of the population with incomes between 100 percent and 150 percent of the federal poverty level. Although the proportion with employer coverage rises at higher income levels (about half for people between 150 and 200 percent of poverty), to truly ensure access to affordable coverage, eligibility would have to go beyond this very poor group. One approach would be to build on public policy decisions that have already extended coverage to children in families with incomes up to 200 percent of the federal poverty level and apply a similar policy to their parents and other adults. As in S-CHIP, it might be appropriate to apply some premiums and cost sharing in the income range between 150 and 200 percent of poverty (up to a maximum of 5 percent of income). And (if resources allow) it would be desirable—on equity grounds—to avoid current S-CHIP rules in many states that deny coverage for a period of time to those who have had employer-sponsored coverage (consistent with current Medicaid policy). Finally, to ensure a smooth transition for people with higher incomes,it may be appropriate to allow individuals with incomes above 200 percent of poverty to buy into the public program by paying a sliding-scale premium based on income.

Federal/State Roles

Extension of public coverage requires consideration of the way federal and state governments share financing and authority. Medicaid (and S-CHIP) is a federal/state matching program, under which the federal government offers to match state expenditures to entice states to provide more coverage than they would on their own. The matching formula provides more federal money (raises the matching rate) for states with poorer populations. States accepting federal funds are required to abide by federal rules for eligibility, benefits, administration, and other aspects of program operations.

Over the years, provision of federal matching funds has helped to expand coverage. But matching funds (without minimum federal eligibility standards) have not achieved uniform coverage across

[14] Jocelyn Guyer and Cindy Mann. *Employed But Not Insured: A State-by-State Analysis of the Number of Low-Income Working Parents Who Lack Health Insurance.* Washington: Center on Budget and Policy Priorities, 1999.

Given the priority we place on covering the low-income uninsured, the most effective approach to expanding coverage is to extend the Medicaid and S-CHIP eligibility now available to children and some parents to all low-income individuals.

states, nor have they mitigated states' discomfort with applying rules that reflect federal priorities. In 1990, Congress decided to achieve greater uniformity of coverage by phasing in a floor on eligibility levels for children—requiring states to cover children in families with incomes below 100 percent of poverty as a condition for receiving any Medicaid funds. Above the floor, eligibility levels continue to vary. In 2000, 36 states had extended eligibility under Medicaid or S-CHIP to children with incomes above 200 percent of the federal poverty level, while in eight states, eligibility standards were below 150 percent of poverty. Variation is wider for parents, where no federal floor exists. Eighteen states extend eligibility for parents to incomes above 100 percent of the poverty level, but 14 states limit eligibility to parents with incomes below 50 percent of the federal poverty level.

Variation in eligibility across states reflects not only the reluctance of some states to spend, but also their reluctance to extend programs that are expected to comply with federal rules—as a condition for receipt of federal money. Rules affect benefits, provider payment,a host of administrative arrangements, and—as discussed below—beneficiaries' "entitlement" to benefits. In recent years, states have successfully sought waivers from and elimination of rules that limit their ability to manage the federal dollars they receive according to state, rather than federal, priorities. To overcome state reluctance, S-CHIP legislation explicitly increased federal matching rates and expanded state flexibility (on benefits and, as discussed below, establishment of an individual entitlement).

Creation of a new public program aimed at covering adults would confront similar issues of limits on certain states' willingness to spend and to operate under federal requirements. Simply making federal funds available at Medicaid matching rates to states willing to cover childless adults—who are ineligible under current federal law, regardless of income—might lead to coverage expansions by some states. But other states—particularly those that do not even take advantage of the existing option to cover parents of Medicaid children—are likely to respond only to an increase in federal matching rates or, perhaps,full federal funding. And a uniform response undoubtedly would require establishment of a federal floor (as former President Clinton proposed to apply to coverage for parents,if states failed to act). Without such action, any new coverage initiative would likely produce considerable variation in coverage across states.

Entitlement vs. Block Grant

Perhaps the most fundamental conflict over rules attached to federal matching funds has been whether the new coverage constitutes an individual entitlement (as with Medicaid) or a benefit provided at the discretion of the state (as with S-CHIP). Medicaid funds are available only as a federal entitlement—that is, everyone who satisfies eligibility requirements is guaranteed coverage. Under Medicaid, federal financing follows the individual. Although states can establish eligibility levels, determine how easy or difficult it is for people to participate, and affect how generous or restricted benefits and access to care are, they cannot deny coverage to an eligible individual. By contrast,S-CHIP is a block grant that provides capped federal funds to states and allows them to choose whether to create an individual entitlement. States can choose to use the new federal funds to expand Medicaid, thereby creating Medicaid-like obligations to individuals (and assuring access to federal funds at the regular Medicaid matching rates if the cap is exceeded). But, if they prefer—as many have—states can create separate programs in which they can cap enrollment and receive a capped federal allotment to help pay for services.

This aspect of S-CHIP's design was a critical element of the political compromise believed to be necessary both to enact the S-CHIP legislation and to ensure state participation. However, deterioration of economic circumstances, rising health care costs, and strained state budgets could lead states to limit enrollment by establishing waiting lists. To states concerned about existing, let alone new, coverage commitments, the option under S-CHIP that permits states to receive federal funds without an open-ended coverage guarantee is far more attractive than Medicaid's open-ended entitlement. The existence of S-CHIP makes it likely that states would seek a similar option under any extension of public programs.

It is ironic that the absence of a federal entitlement in a public program expansion would contrast sharply with the creation of a federal entitlement to any new tax credit. Under federal law, anyone who qualifies for a tax credit is entitled to receive it; obligations cannot be capped. A tax credit, like Medicaid, is a federal entitlement (albeit to a dollar amount, rather than to a defined set of benefits). If Congress is willing to establish tax credits as entitlements—as is the case for all other tax subsidies—consistency would suggest a similar approach to the expansion of public coverage.

Establishing a Tax Credit along with a Public Program Expansion

An individual tax credit aimed at people with incomes too high to qualify for public coverage—above, say, 200 percent of poverty—could reach its target population without requiring any significant variations from standard tax practices. At this income level, tax liabilities are generally high enough to make refundability unnecessary, and individuals could simply apply for the credit retrospectively when they file their taxes. Cash flow problems are less severe than for lower-income populations, or they can be mitigated easily by making funds available through standard tax withholding mechanisms (which people in this income range are accustomed to using, for example, to account for mortgage interest).

If the goal were to assure individuals with incomes above 200 percent of the poverty level that they would have to pay no more than 5 percent of their income for coverage—the maximum level under S-CHIP—tax credits in the range of $1,500 for an individual and $3,000 for a family (phased out gradually as income rises) would be required. However, credits of this amount could prove disruptive to employer coverage, and smaller amounts would provide a smoother transition from public coverage than exists today.

Policy issues posed by establishing an individual tax credit include the following:

Ensuring Access to a Market or Product

Given that the bulk of uninsured individuals with modest as well as low incomes lack access to employer coverage,most of the beneficiaries of a tax credit will be dependent on the non-group or individual insurance market. Expanding that market may mitigate, but will not eliminate, the risk selection and instabilities it creates. These problems could be addressed by regulating access to and premiums in the non-group market. However, efforts to enact such regulations have run into enormous barriers—both political and technical—at the state and federal levels. A frequently proposed alternative to regulation is to make tax credits applicable to premiums paid to a publicly managed insurance market, in which access, benefits, and premiums are regulated. Medicaid could legitimately be considered such a market, given many state programs' reliance on private insurance plans. Allowing credits to be used in Medicaid would assure individuals eligible for a credit that a product was indeed available to buy. However, allowing a buy-in to Medicaid in the absence of broader regulation—or creating a new insurance arrangement to accomplish the same thing—would likely increase the costs of a public program. The program is most likely to attract higher-risk and more costly individuals who are likely to find public protection a better buy, given the underwriting practices of insurers. An extra subsidy toward the premium for public coverage would be necessary to ensure affordability for this population; indeed, it could be thought of as a mechanism for spreading risk with a broad source of financing

(that is, general tax revenues). Unless resources are available to support that subsidy, however, adverse selection is likely to make the buy-in unworkable.

Balancing Access and Disruption

Deciding who gets how much of a tax credit would determine the degree to which a credit would disrupt existing coverage. With respect to public coverage, a decision to make the tax credit non-refundable—in other words, to layer a tax credit on top of a public program by design—avoids the problem of encouraging states to substitute tax credits for public programs. Hence, disruption of public coverage would not be a major problem. With respect to employer coverage, the question is whether a tax credit at the levels described is high enough to promote participation, but not so high that it promotes substantial employer dropping and worker switching. The answer is uncertain.

One way to prevent the credit from leading employers to drop or workers to switch coverage is to allow it to be applicable to a worker's share of employer-sponsored coverage, as well as to non-group coverage. As noted above, such an approach would actually substitute public for private dollars as a means to secure employer coverage but also to promote equity. Security and equity, however, come at considerable public cost. Although a new credit would induce some employees to take up coverage for the first time, the bulk of credit recipients under these rules would likely be individuals who already have coverage, rather than the uninsured.

Providing the credit to employers rather than to individuals might offer a more targeted means to prevent the credit from inducing employers to drop coverage—especially if eligibility for credits can be limited to a subset of employers (like small, low-wage employers) that are currently unlikely to provide coverage. A refundable tax credit could be provided to employers in the subset that do provide coverage, offsetting corporate income taxes.[15] For example, each eligible employer could receive a flat dollar amount—possibly varying for single or family coverage—for each eligible employee who is covered by health insurance. Previous efforts to induce employer offering of coverage through subsidies at the state level or through local pilot projects have not been successful, but this may be because these subsidies were either too small or perceived as temporary by employers.[16] In fact, recent economic analysis indicates that small employers are at least as responsive as individuals to changes in the price of insurance.[17]

Based on that analysis, subsidy levels and coverage expectations might be similar under the two approaches. To induce offerings, an employer credit would have to be at least as generous in relation to premium costs as an individual subsidy, and it would likely need to be refundable. Though an employer credit would not help individuals without a connection to an employer or uninsured workers whose employers do not offer coverage, many of these uninsured would be eligible for or could buy into public coverage. Furthermore, the employer credit could also be extended to those self-employed who may be uninsured despite higher incomes.

Though the primary goal of an employer tax credit would be to encourage more employers to offer health coverage, equity and ease of administration would require that it be made available to eligible employers who already provide insurance. These employers would likely use at least some of the proceeds of the credit to lower employee premium contributions and, therefore, increase take-up among currently uninsured workers. But because the vast majority of workers who have access to employer coverage already take it up, these resources would likely go primarily to those already insured (for example, in the form of higher wages).

Targeting an employer tax credit to those

[15] Jack A. Meyer and Elliot K. Wicks. *A Federal Tax Credit to Encourage Employers to Offer Health Coverage.* New York: The Commonwealth Fund, 2000.

[16] Sharon Silow-Carroll. "Employer Tax Credits to Expand Health Coverage: Lessons Learned." Unpublished paper, The Commonwealth Fund, 2000; K. E. Thorpe et al. "Reducing the Number of Uninsured by Subsidizing Employment-Based Health Insurance: Results From a Pilot Study." *Journal of the American Medical Association 267* (7) (1992): 945-48.

[17] Jonathan Gruber and Michael K. Lettau. "How Elastic is the Firm's Demand for Health Insurance?" NBER Working Paper W8021. Cambridge, MA: National Bureau of Economic Research, 2000.

employers least likely to offer insurance today would maximize the focus of public dollars on improving access to employer-sponsored coverage. The credit could be limited, for example, to small, low-wage employers,the majority of which do not offer coverage. Among firms with between three and 199 workers that have 35 percent or more of their workers earning less than $20,000 per year, just 35 percent offer health insurance (compared to 67 percent of all firms with fewer than 200 employees).[18] Smaller, low-wage firms are even less likely to offer coverage. Unfortunately, limiting subsidies to firms in this category is not a perfect solution to the problem of substitution. Large firms can spin off low-wage workers to create new small, low-wage "firms," thereby qualifying for subsidies they would not get otherwise. In addition, a subsidy targeted at small, low-wage firms may be perceived as inequitable, since it is not available to larger low-wage employers. Nevertheless, directing subsidies to small, low-wage employers offers a reasonable approach for targeting a tax credit to the uninsured, rather than the already insured.

Because most economic evidence suggests that individuals rather than employers actually bear the cost of insurance (even if the employer ostensibly pays), a subsidy provided to employers may be virtually identical in its effect to a subsidy provided to individuals for the purchase of employer coverage. But, in practice, focusing on employers may facilitate the targeting of credits based on employer characteristics (like small size and low wages) that are associated with an absence of coverage offerings. As a result, the primary beneficiaries would be uninsured workers, rather than workers who already have insurance. Focusing on the employer would also ease the cash flow problems posed by individual subsidies, because by its nature, employer insurance would guarantee coverage prospectively.

A tax credit for employer coverage rather than for individual insurance has clear advantages in terms of targeting and avoiding disruption of employer coverage. But these advantages can be perceived as disadvantages by advocates of individual choice, because the availability of subsidies to individuals would depend on the action of their employers. Undoubtedly, many individuals would not become beneficiaries of the new policy. Only if there is a buy-in to public coverage—as discussed above—would these individuals have access to guaranteed support in a combined public program/tax credit initiative of this kind.

Summary: A Viable Merger?

Given the priority we place on covering the low-income uninsured, the most effective approach to expanding coverage is to extend the Medicaid and S-CHIP eligibility now available to children and some parents to all low-income individuals. Although health insurance tax credits of various kinds could be combined with this public program expansion, careful attention should be paid to ensure that any tax credits complement rather than substitute for existing public and private sources of coverage. It is difficult to design a modest individual tax credit that is simultaneously effective and well targeted, while at the same time avoiding disruption of existing publicly sponsored and employer-sponsored insurance.A better approach may be tax credits provided to employers, rather than to individuals, to encourage greater offering of insurance.

What is probably most important to the current policy process is attention to the questions we have raised about the way various policy instruments and their application affect who will benefit from and who will be hurt by adoption of any new policy initiative. Given how difficult it has been to obtain the public resources that are essential to expand coverage, it is crucial that any resources that do become available to expand coverage be used to achieve that goal, especially for those least able to protect themselves.

Acknowledgements
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[18] Kaiser Family Foundation and Health Research and Educational Trust. *Employer Health Benefits 2000.* Menlo Park, CA: The Henry J. Kaiser Family Foundation, 2000.

Feder, Levitt, O'Brien, and Rowland Approach

Key Elements

Judith Feder, Larry Levitt, Ellen O'Brien, and **Diane Rowland** outline an expansion of Medicaid and the State Children's Health Insurance Program (S-CHIP) and explore its interaction with tax credits for individuals or employers. Specifically, they conclude that:

COVERAGE FOR LOW-INCOME PEOPLE is best achieved by extending eligibility for public programs without cost sharing or premiums to all individuals with incomes below 150 percent of the federal poverty level, and, as in S-CHIP, extending eligibility for public programs with modest premiums and cost sharing (up to a maximum of 5 percent of income) to people with incomes between 150 percent and 200 percent of poverty. People with incomes above 200 percent of poverty could also be allowed to "buy in" to public coverage by paying a sliding-scale premium based on income.

A TAX CREDIT THAT IS TARGETED to small, low-wage employers for providing coverage to their employees is a more effective and less disruptive complement to a public program than a tax credit directed at individuals to purchase non-group coverage.

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