MISSOURI FOUNDATION FOR HEALTH

MFH
Missouri Foundation for Health

Cover Missouri Project: Report 9

Increasing Health Insurance Coverage in Missouri Through Subsidies

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About MFH

Established in 2000, the Missouri Foundation for Health is dedicated to its mission of empowering the people of the communities we serve to achieve equal access to quality health services that promote prevention and encourage healthy behaviors. In support of its mission, the Foundation undertakes policy research to educate the public and decision makers on effective health policies that will result in long-term, positive health system change in the state of Missouri. Formulating sound health policies advances the Foundation's efforts to increase access to high quality, cost-effective preventive and curative care, especially for the uninsured, underinsured, and underserved in our service region of 84 Missouri counties and the City of St. Louis.

Cover Missouri Project

Preface

In an effort to inform the discussion regarding practical policy options to expand health care coverage for the uninsured in Missouri, the Missouri Foundation for Health (MFH) has established the Cover Missouri Project. Under this project, MFH has engaged The Urban Institute to produce a series of papers which considers strengths and weaknesses of the current health care system in Missouri and explores options for decreasing the number of uninsured. MFH offers these studies as a means to further understand and ultimately improve access to health care coverage.

Missouri currently faces considerable challenges related to creating an equitable and comprehensive system of health care for all Missourians. In 2005, between 635,000 and 707,000 Missouri residents were without health insurance. In addition, eligibility cuts and cost-sharing changes to Missouri's Medicaid program made in 2005 increased the number of uninsured. Ultimately, these changes may shift Missouri from being one of the 12 states with the lowest uninsurance rates to being among the 12 states with the highest rates of uninsurance.

Research broadly documents the serious health and financial consequences associated with being uninsured. The uninsured live sicker and die younger than those with insurance. They forego preventive care and seek health care at more advanced stages of disease. Society then bears these costs through lower productivity, increased rates of communicable diseases, and higher insurance premiums. Those without health insurance often must choose between visiting a doctor and paying for other essentials.

This paper, "Increasing Health Insurance Coverage in Missouri Through Subsidies" represents the ninth in the series emerging under the Cover Missouri Project. It discusses increasing the number of insured Missourians through the use of income-based insurance subsidies. The author concludes that subsidies targeted to individuals and families have a number of design and policy advantages over employer-based subsidies. The paper provides recommendations for a subsidy structure that would reduce the number of the uninsured by half.

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About the Author

John Holahan, PhD, is Director of The Urban Institute's Health Policy Center. He has managed numerous health research projects in the last 25 years and authored many books and papers on health policy. His recent work has focused on the Medicaid program, as well as state health policy more broadly, and issues of federalism and health. He has published research on the reasons for the growth in the uninsured over the past decade and on the effects of proposals to expand health insurance coverage on the number of uninsured and the cost to federal and state governments. The author thanks John Graves and Marlene Niefeld for their help in preparing this report.

About The Urban Institute

The Urban Institute is a nonprofit nonpartisan policy research and educational organization established to examine the social, economic, and governance problems facing the nation. It provides information and analysis to public and private decision makers to help them address these challenges and strives to raise citizen understanding of the issues and tradeoffs in policy making. The Urban Institute works to promote sound social policy and public debate on national priorities through gathering and analyzing data, conducting policy research, evaluating programs and services, and educating all Americans. More information about The Urban Institute may be found at www.urban.org.

Cover Missouri Project: Report 9

Increasing Health Insurance Coverage in Missouri Through Subsidies

by John Holahan, PhD

A major increase in coverage for the uninsured in Missouri (and elsewhere) can only be achieved with significant governmental financial intervention. This would likely involve some combination of broadening Medicaid eligibility and income-related subsidies to increase the affordability of coverage for low-income Missourians.[1] Health insurance coverage is often unaffordable for those whose incomes are above traditional Medicaid eligibility levels. Therefore, to expand coverage to the uninsured, some form of government subsidies, either through employers or directly to individuals and families, would be required.

This report discusses the issues surrounding employer and individual subsidies. Background data on the uninsured in Missouri and national data on employer offer and take-up rates are provided.[2] Also, this paper describes how employer and individual and family subsidies could be structured and discusses the challenges associated with each approach. The paper concludes with recommended strategies for expanding coverage in Missouri.

Background Data on the Uninsured in Missouri

The uninsured in Missouri are disproportionately low-income. Using data from the Current Population Survey for 2003 and 2004, Table 1 shows that 32 percent of Missouri's non-elderly population had incomes below 200 percent of the federal poverty level (FPL) (Appendix), while 59 percent of the state's uninsured population, or 355,000 people, had incomes below this level. Of the 355,000 people, 192,000 were below the federal poverty line; and the other 163,000 were between 100 and 199 percent of FPL. At the other end of the income distribution, 36 percent of the state's population was above 400 percent of FPL, but only 13 percent of the uninsured fall into this income group. Thus, the problem of the uninsured is a low-income problem. Another

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Table 1. Characteristics of the Non-Elderly Uninsured, 2003-2004

	Non-Elderly (thousands)	Percent of Non-Elderly	Uninsured Non-Elderly (thousands)	Percent of Non-Elderly Uninsured	Uninsured Rate of Non-Elderly
Total – Non-Elderly	**4,856**	**100.0%**	**599**	**100.0%**	**12.3%**
Age					
Children – Total	**1,478**	**30.4%**	**81**	**13.5%**	**5.5%**
Adults – Total	**3,378**	**69.6%**	**518**	**86.5%**	**15.3%**
19-34	1,222	25.2%	265	44.2%	21.7%
35-54	1,574	32.4%	192	32.0%	12.2%
55-64	583	12.0%	62	10.3%	10.6%
FPL					
<100%	833	17.1%	192	32.0%	23.0%
100-199%	738	15.2%	163	27.3%	22.1%
200-399%	1,558	32.1%	165	27.5%	10.6%
≥400%	1,728	35.6%	80	13.3%	4.6%
Family Work Status					
Full-Time	3,978	81.9%	410	68.4%	10.3%
Only Part-Time	343	7.1%	85	14.2%	24.8%
Non-Workers	536	11.0%	104	17.4%	19.5%

Source: Based on data from the 2004 and 2005 March Supplements to the Current Population Survey.

28 percent of the uninsured were in families with incomes between 200 and 399 percent of FPL. Insurance coverage can also be difficult to afford for this income group, particularly for those without an offer of employer-sponsored insurance (ESI); and some form of subsidies would be necessary to make coverage accessible.

Uninsurance Rates Vary Considerably by Age and Employment Status

Children in Missouri comprised 30 percent of the population but only 14 percent of the uninsured. Statewide children had an uninsurance rate of 5.5 percent. In contrast, the uninsurance rate for young adults was 22 percent; young adults ages 19-34 were 25 percent of the population but 44 percent of the uninsured. Most of the uninsured were in a family with at least one full-time worker.

While the uninsurance rate for those in a family with one or more full-time workers was only 10 percent, these individuals constitute 68 percent of the uninsured. Part-time workers had an uninsured rate of 25 percent but were only 14 percent of the uninsured.

Infrequent rates of ESI coverage contribute to the high uninsurance rates of low-income individuals (Table 2). Only 16 percent of those below the federal poverty line and 40 percent of those between 100 percent and 200 percent of FPL had ESI in 2003-2004. Low-income individuals, particularly those with incomes lower than the federal poverty line, are much more likely to have Medicaid. However, Medicaid does not offset the low rates of ESI. As a result, the uninsurance rates for those below the federal poverty line and between 100 and 199 percent of FPL were 23

Table 2. Health Insurance Coverage of the Non-Elderly, 2003-2004

	Non-Elderly (thousands)	Percent Distribution by Coverage Type				
		Private		Public		Uninsured
		Employer	Direct Purchase	Medicaid	Other	
Total – Non-Elderly	**4,856**	**65.8%**	**5.0%**	**14.9%**	**2.0%**	**12.3%**
Age						
Children – Total	**1,478**	**61.5%**	**3.3%**	**29.0%**	**0.6%**	**5.5%**
Adults – Total	**3,378**	**67.6%**	**5.8%**	**8.7%**	**2.6%**	**15.3%**
19-34	1,222	57.7%	7.4%	12.1%	1.2%	21.7%
35-54	1,574	74.0%	3.9%	7.2%	2.7%	12.2%
55-64	583	71.0%	7.6%	5.6%	5.2%	10.6%
FPL						
<100%	833	16.4%	4.1%	53.2%	3.3%	23.0%
100-199%	738	39.4%	7.1%	27.6%	3.7%	22.1%
200-399%	1,558	78.5%	5.9%	3.8%	1.2%	10.6%
≥400%	1,728	89.3%	3.9%	0.9%	1.3%	4.6%
Family Work Status						
Full-Time	3,978	75.4%	4.5%	8.6%	1.1%	10.3%
Only Part-Time	343	23.7%	8.6%	40.9%	2.0%	24.8%
Non-Workers	536	20.8%	6.8%	44.8%	8.2%	19.5%

Source: Based on data from the 2004 and 2005 March Supplements to the Current Population Survey.

and 22 percent, respectively. Similarly, young adults, as well as part-time workers, have high uninsurance rates because of low rates of ESI.

Workers comprise two-thirds of the uninsured (Table 3). Twenty-two percent of all workers (over 600,000) have incomes below 200 percent of FPL and account for 52 percent of the uninsured. In contrast, 45 percent of all workers have incomes above 400 percent of FPL and account for 17 percent of the uninsured.

Workers at small firms, those with fewer than 25 workers, are disproportionately uninsured. While only 28 percent of Missouri's workers were in small firms, these workers accounted for 49 percent of the uninsured. By comparison, 42 percent of Missouri's workers were in firms with more than a 1,000 workers, but these workers accounted for only 25 percent of the uninsured. About three-quarters of uninsured workers worked in industries where employer coverage rates were less than 75 percent. These industries included agriculture, construction, and many service industries. The remaining 25 percent of the uninsured were in industries with rates of employer coverage exceeding 75 percent. These industries included manufacturing, finance, real estate, and government administration.

This portrait of the uninsured implies that

while many individuals are below the federal poverty line and would be better served by a Medicaid expansion, there remains a need for subsidies targeted to those with low incomes who are above the federal poverty line, particularly young adults and small firm low-wage workers. The major difference in the policy impacts of subsidies is contingent upon whether they are directed at employees or individuals and families.

Table 3. Characteristics of Uninsured Workers, 2003-2004

	Workers (thousands)	Percent of Workers	Uninsured Workers (thousands)	Percent of Uninsured Workers	Uninsured Rate of Workers
Total – Workers	**2,790**	**100.0%**	**405**	**100.0%**	**14.5%**
FPL					
<100%	235	8.4%	88	21.7%	37.4%
100-199%	374	13.4%	121	30.0%	32.5%
200-399%	926	33.2%	126	31.3%	13.7%
≥400%	1,256	45.0%	69	17.1%	5.5%
Business Size (# Workers)					
<25	768	27.5%	198	48.9%	25.8%
25-999	857	30.7%	105	25.9%	12.2%
≥1,000	1,165	41.8%	102	25.2%	8.7%
Occupation/Industry					
High-ESI Industries (>75% ESI)	1,110	39.8%	95	23.6%	8.6%
Low-ESI Industries (<75% ESI)	1,680	60.2%	309	76.4%	18.4%

Source: Based on data from the 2004 and 2005 March Supplements to the Current Population Survey.

Employer Offer of Insurance, Eligibility for Enrollment, and Take-Up of Coverage

National data demonstrates that employer offers of coverage and take-up rates vary with income, age, and firm size. Table 4 provides statistics on firm sponsorship (i.e., if a firm offers a health plan), individual eligibility, and coverage take-up. Sixty-one percent of those below the federal poverty line and 74 percent between 100 and 199 percent of FPL work for firms sponsoring a health plan. In contrast, 94 percent of those above 400 percent of FPL work for firms that sponsor a health plan. Low-income individuals are less likely than higher-paid workers to be eligible for an employer's offer.

Table 4. Employer Offer, Eligibility, and Take-Up Rates in the United States, 2004

	Offer	Eligibility	Take-Up	Own ESI Coverage	Any ESI Coverage
All Workers	**86.6%**	**97.4%**	**84.7%**	**69.2%**	**86.4%**
Income (as percentage of FPL)					
<100%	61.3%	72.0%	70.9%	31.3%	53.4%
100-199%	73.9%	88.8%	81.5%	53.4%	66.4%
200-399%	86.6%	94.8%	88.0%	72.2%	86.7%
≥400%	93.7%	96.9%	84.2%	76.5%	96.5%
Business Size (number of workers)					
<10	54.4%	90.3%	76.9%	37.8%	67.1%
10-24	71.7%	93.1%	77.9%	52.0%	74.5%
25-99	84.2%	94.6%	81.3%	64.8%	83.2%
≥100	94.8%	94.7%	86.8%	77.9%	92.0%
Average Hourly Wage					
<$7.00	66.1%	80.6%	71.4%	38.0%	64.2%
$7.00-$9.99	79.0%	91.7%	79.0%	57.0%	76.4%
$10.00-$14.99	88.4%	95.2%	84.9%	71.5%	88.3%
$15.00 or more	94.5%	97.4%	88.5%	81.5%	95.3%

Source: B Garrett, "Employer-Sponsored Health Insurance Coverage: Sponsorship Eligibility, and Participation Patterns in 2001," Kaiser Commission on Medicaid and the Uninsured, 2004.

Only 72 percent of those below the federal poverty line and 89 percent of those between 100 and 199 percent of FPL are eligible for an ESI offer. Almost all of those above 400 percent FPL are eligible for an employer's offer.

Surprisingly, a majority of people at all income levels take up an employer's offer. For those below the federal poverty line, 71 percent take up an employer's offer. For those between 100 and 199 percent of FPL, over 80 percent take up the employer's offer of coverage. Overall, the data suggests that the likelihood of having ESI sharply declines with income.

Offers, eligibility, and take-up rates vary by firm size. Only 54 percent of those in firms with fewer than 10 workers receive an offer of employer coverage. This increases to 95 percent for firms with 100 or more workers. Take-up rates also vary across firm size. In firms with less than 25 workers, take-up rates fall to the 77 percent range. Take-up rates increase to 87 percent in firms with more than 100 workers. Thus it is clear that employer offer rates and employee take-up rates increase sharply as firm size increases.

Eligibility for ESI, conditional on an offer, also varies with the average hourly wage. Sixty-six percent of those making less than $7 an hour are eligible for an offer, versus 97

percent of those making more than $15 an hour. Take-up rates vary from 71 percent for those making less than $7 an hour to 89 percent for those making $15 an hour or more. Consistent with these variations by wages, 64 percent of workers making less than $7 an hour have health insurance coverage versus 95 percent of those making $15 or more. Employer offer rates and take-up rates also vary with the age of the worker, the length of time that someone has been in a job, hours worked per week, and the type of industry.

Why Employers Offer Coverage

In order to understand how the provision of various types of subsidies might impact insurance coverage, we must understand why some employers offer coverage and others do not.[3] Employer provision of health insurance conveys a number of important benefits to workers, and employers can use these benefits as a mechanism to compete for workers. First, employer contributions to health insurance are exempt from income taxation, making them an attractive form of compensation, particularly for workers in higher marginal tax brackets. Second, administrative loads tend to decrease with the size of the group purchasing coverage, making group coverage cheaper per unit of benefits than individually purchased coverage. Third, particularly with larger groups, opportunities for spreading health care risk are greater for those purchasing within a group than for those purchasing insurance on their own. The ability to spread health care risk across a group makes ESI especially valuable to workers who expect to be above average users of health care services (i.e., older individuals and those with below average health status). Workers who are healthier or who have a spouse with coverage are less likely to place a high value on health insurance as a form of compensation.

A major factor affecting employer offer rates is the extent to which employers can ultimately shift the cost of their health insurance contributions back to workers in the form of reduced wages.[4] The ability to shift these costs back to workers tends to make most employers willing to offer coverage because they do not bear the costs. But the fact that all employers do not offer implies that some employers are either not able to shift the cost of health insurance to workers or that their particular workforce does not value the coverage sufficiently to desire such a wage-benefit tradeoff. For example, low-income workers may prefer additional wages to non-wage compensation.

The existence of the minimum wage also provides a constraint in the ability to shift insurance costs back to low-wage workers. However, with such low-wage workers, preferences for cash income may be the more binding constraint than the minimum wage. In addition, some employers may not be able to shift the full costs of coverage back to their workers due to competitive pressures.[5] For example, a small employer competing with a large employer for the same pool of labor is unlikely to be able to pass the full costs of insurance on to the workers because the cost of a given package of benefits is higher for the small employer than for the large employer. Employers who cannot shift costs to workers may be able to shift them into higher prices. This is particularly true in those markets where competitors face the same economic pressures. However, the fact that employers cannot always shift the cost of health insurance to workers or customers is a reason why small firms with low-wage workers often do not offer coverage. This is also one explanation for why some firms do not make all workers (e.g., part-time or temporary) eligible.

Employer Subsidies

Design Issues

There are several design issues to consider in structuring employer subsidies. These include how to target the subsidies, the structure of the subsidies, the size of the subsidies, and whether the subsidies should apply only in certain organized purchasing arrangements.

Targeting relates to the types of employers that would be eligible for subsidies and/or the types of workers/dependents for whom employers would receive subsidization. The state could limit subsidies to employers of particular size or to employers with an average employee wage below a certain level. The state could also choose to subsidize employers of a designated type according to the number of workers of a particular type (i.e., low-wage workers within small firms). Subsidies could also be designed either to focus exclusively on workers or to provide additional funds for dependent coverage.

Employer subsidies can be structured in a variety of ways. They can be direct subsidies that employers would apply for from the state when offering coverage, or they could be structured as tax credits with the firm applying a specific percentage of premiums as a credit (refundable) against their annual tax liability. In either case, subsidies could be structured as a fixed dollar amount with a minimum employer contribution. For example, the state could offer to pay $400 toward an individual policy; $600 for a worker and spouse; and $1,200 toward a family policy. This would assume that the firm would pay a minimum amount of the premium, with the balance paid by the worker. Rhode Island's RIte Share program is an example – it requires the employer and employee to each pay a share (depending on the worker's income) with the state paying the remainder.[6] This kind of an approach would keep employer payments in the equation but reduce the size of the required employer contribution and/or the amount expected of the employee.

Another arrangement would be to have the government pay a percent of the premium up to a cap, again requiring a minimum employer contribution. For example, the government might pay 30 percent of the premium up to caps of $500 for an individual; $1,000 for worker and spouse; and $3,000 for a family. There would be no additional subsidies for more expensive policies. For example, employers could be expected to pay at least 50 percent of premiums.

Yet another option is to have an employer subsidy that varies inversely with wages; the subsidy could be structured as either a percentage of premium or a flat amount. For example, the government could pay a percentage of the premium for low-wage workers, with the percentage of the premium decreasing as wage increases.

The size of the subsidy defines the generosity of the subsidy program and has an impact on its level of success. Research suggests that relatively generous subsidies would be required to have substantial impact on employer offer decisions.[7] But as the subsidy increases so does the cost to government. Another issue is whether subsidies should be focused solely on individual worker coverage, or whether they should be extended to the worker's family. If extended to the family, should they be as generous with respect to family members as to the worker? Extending subsidies to the

family would allow the state to design mechanisms encouraging workers with Medicaid eligible dependents to enroll in that program, thereby earning federal matching payments and reducing the new costs associated with the employer subsidies.

A related issue is how to address two-worker families. Should the firms of both workers be eligible for subsidies? Should the subsidies available to married couples working in two different firms be more generous than the subsidy to a worker and spouse within one firm? If, for example, subsidies are extended to individuals up to 300 percent of FPL, should children be expected to enroll in Medicaid where the state would be able to receive federal matching payments? If so, subsidies to families would not be necessary and could be limited to workers and spouses. Two-worker families and workers with multiple employers also pose complicated cross-employer coordination issues, which must be carefully considered to ensure equity.

Finally, the state may choose to limit the types of health care policies for which employers may use their subsidies. Subsidizing coverage in plans with very minimal benefits could raise questions about whether taxpayer funds are supporting adequate coverage and effectively increasing access to medical care for the subsidized population. Employer subsidies could be made available only for coverage obtained through a purchasing pool, e.g., a version of the state health employees' plan.[8] Subsidizing coverage only through a pool has the advantage of simplifying administration, assuring a broader mix of risks, and guaranteeing that government funds are going toward acceptable products.

Policy Issues

There are several problems with employer subsidies. First, it is difficult to use them as a mechanism for targeting subsidies to specific types of individuals, particularly the uninsured. As a consequence, they may be inefficient in terms of government cost per uninsured person. For example, an employer's workforce can be made up of low- and high-wage workers, even if the average wage in the firm is relatively low. Consequently, subsidizing an employer with a low average wage may mean subsidizing some high-wage workers as well. Further, employers have information on their workers' wages, but not on their workers' family incomes. Since low-wages workers are not always in low-income families (i.e., a low-wage worker may have a highly paid spouse) targeting subsidies to low-wage workers can be problematic. Subsidies targeted to small firms would miss many low-wage workers in larger firms who do not have an offer of employer coverage. Research by Ferry, et. al., clearly shows that subsidies directed at individuals by income level are much more effectively targeted than subsidies directed at those with low wages or in small firms.[9]

Another major issue with employer subsidies is that they are not likely to change employer offers very much. Reschovsky and Hadley have estimated an elasticity of employer offer with respect to price of about 0.5 (i.e., a 10 percent reduction in premiums would result in a 5 percent increase in the share of firms offering coverage).[10] Other researchers have estimated different elasticities, but they are generally in this stated range.[11] Elasticities in the range of 0.5 would increase employer offer rates marginally. For example, the employer offer rate in small firms of less than 25 workers is about 60 percent. A 30 percent reduction in premiums would increase employer offer rates by 15 percent or to 69 percent from 60 percent, still below the offer rate of large firms. The effect would be even smaller if not all workers benefit from the employer

subsidy. For example, if subsidies were only available to low-wage workers, the program might only benefit a small share of a given employer's workforce, thus not changing preferences of a sufficient number of workers to change the employer's decision to offer health care coverage. The increase in employer administrative burden could also be a significant deterrent to changing the offer decision.

Employer subsidies also have the potential to displace private coverage. The probability of having ESI increases with income. Unless subsidies are targeted to low-wage workers, it would be hard to avoid giving subsidies to many of those who currently have coverage. Thus, if employer subsidies do little to result in more firms offering coverage, the principle impact would be to help employers who are now offering and contributing to their workers' coverage. Only some of these new subsidies will go to those without coverage. It is extremely difficult to exclude those with prior coverage from subsidization. Attempting to do so might also provide incentives for those with existing coverage to drop it, in order to become eligible.

Furthermore, employer subsidies themselves will not affect the take up of offers by those who do not currently take advantage of their employer's offer. The major reason for the recent decline in employer coverage is the reduction in take-up rates that has occurred as insurance has become more costly and less affordable.[12] In addition to giving employers incentives to offer coverage, other subsidies to help offset employee costs would be required to stem the declines in take-up among low-income workers. Additionally, in order to achieve significant expansions of coverage, the state would also have to provide subsidies directly to individuals whose employers still do not offer coverage, as well as to those who are not connected to the workforce. Such subsidies could be used to purchase coverage in the private non-group market or to buy individuals into the state employees' plan or the State Children's Health Insurance Program (SCHIP).

Finally, any policy attempting to build on the current system needs to recognize that small employers are not efficient purchasers of coverage. Not only are the administrative costs high, but small employers are also not able to bargain effectively with insurance companies over premiums. Providing incentives for small employers to purchase coverage on their own is unlikely to be an efficient solution to the problem of low rates of coverage. Careful consideration should be given to developing options for small groups to purchase coverage either through existing purchasing entities (such as the state employees' plan) or through new ones (such as a group purchasing pool).

Individual and Family Subsidies

The alternative to employer subsidies is to directly provide subsidies to individuals and families on an income-related basis. Ferry, et. al., has shown that providing subsidies to individuals and families is a more target efficient mechanism for subsidizing the uninsured and results in less displacement of existing private coverage than providing subsidies to small firms or low-wage workers.[13] This means that the government's

cost per uninsured person would be lower using individual and family subsidies as opposed to employer subsidies.

Individual and family subsidies can be provided directly to individuals (e.g., vouchers) or can be structured as refundable tax credits. In either case it is important that subsidies be available immediately upon confirmation of eligibility so that individuals can purchase insurance in the current year. This is straightforward in the case of direct subsidies. Individuals would go to a state administrative office, present documentation on income, and have their appropriate level of subsidy determined. The subsidy could be provided in the form of a voucher which could then be used to purchase coverage through an insurer or insurance purchasing entity. Purchasers could then communicate directly with the agency determining eligibility to obtain the relevant information for each individual prior to enrollment, eliminating the need for individuals to move documentation between agencies.

Tax credits could be designed to work much the same way. An individual would go to a state administrative office to determine the estimated tax credit and receive funds (or vouchers) in advance of purchasing coverage. Over- or under-payments of credits advanced during the previous year could be reconciled as part of the tax filing process as well. On the advantage side, reconciliation may lead to a higher level of public accountability and target accuracy in the distribution of subsidy funds. On the negative side, uncertainty about final subsidy amounts may dissuade participation of some and be less effective at providing short-term support for those having transitional financial crises, such as those brought on by the temporary loss of a job or change in family status.

Design Issues

There are several important design issues to structuring income and family subsidies. The first is the generosity of the subsidies. The key issue is determining the amount people at different income levels should be expected to pay toward health coverage. The expectation is that people should pay relative to their income.

There are at least two ways that income-related subsidies could be designed. One is to fix the subsidy as a percentage of the premium, with a cap on the amount of the premium set at a level that would permit individuals to purchase a policy of sufficient comprehensiveness and quality, and then allowing that percentage to decline as income increases. For example, individuals may receive 100 percent subsidy at the federal poverty line, which would reduce incrementally so that there is no remaining subsidy for those at 300 percent of FPL and above. The percentage of the premium covered by the subsidy and the phaseout schedule would determine whether premium payments required of individuals and families were affordable for the full distribution of incomes. Both can be adjusted for greater generosity as funding allows.

An alternative way to structure the subsidy schedule is to cap individual and family insurance payments at a percentage of income. That is, the government subsidies would cover health insurance costs exceeding a specified percentage of a family's income. Individuals or families would not be expected to pay more than these percentages for health insurance premiums, and the excess would be paid as a government subsidy. Again, the premiums could be limited by a cap, ideally one providing modest income individuals and families with a sufficient benefits package. If subsidies were

provided for coverage purchased within an organized purchasing arrangement, the caps could be based on a benchmark premium. Those enrolling in plans with premiums exceeding the benchmark premium would not receive additional subsidization; those opting for a less expensive plan might be allowed to reap a share of the government's savings. Ideally, the benchmark premiums would be adjusted for the health status of the enrollee, thus allowing for higher absolute subsidies for those facing higher premiums due to health care risk.[14] The percent of income used to limit premium payments would have to be determined by the state legislature.

A major issue is whether the subsidies should simply be income-related or should also subsidize high-cost individuals. For example, if premium payments are capped as a percentage of income, it is likely that those facing high premiums because of health risk would benefit the most. Individuals with health issues would be more likely to seek subsidized coverage, but this could, in itself, drive up premiums. The state could choose to not let premiums be affected by the mix of people using state subsidized insurance, in effect by setting a benchmark premium tied to average statewide premiums rather than an average of premiums from plans eligible for subsidies.[15] The state would then be choosing to pay the excess health costs above the percent of income caps. In this case, the state would be subsidizing those with high-cost health conditions as well as low-income individuals.

One closely related issue is whether income-related subsidies work best within some kind of purchasing pool arrangement. Allowing for the use of income-related subsidies in the open non-group market could lead to increased subsidy costs because of inefficiencies in that market. If individuals were allowed to buy into the state employees' plan (or a plan operated by the state employees' plan with a separate risk pool), the state could choose not to subsidize health insurance plans offered outside of this arrangement.[16] Providing subsidies within a pool arrangement also helps with administrative difficulties of structuring subsidies. Individuals would go to the pool not only to select a plan, but also to have pool administrators determine the amount of the subsidy or tax credit for which they are eligible. Providing subsidies only within the pool also helps assure that the pool has a broader mix of health risks.[17]

Policy Issues

An issue with individual- and family-related subsidies is that take-up rates may not be particularly high in voluntary arrangements outside of employer settings. Research shows that many individuals will not take up ESI even with reasonably generous subsidies.[18] There may be stigma attached to receiving government support. For this reason, tax credits may be more attractive than subsidies, although the uncertainty of end-of-year financial obligations may deter their use.

Income-related subsidies could also result in potentially significant displacement (or crowding-out) of current coverage as income increases.[19] Efforts to prevent crowd-out can create equity problems; that is, subsidies would not be available to individuals who are now making sizeable payments to get coverage but would be available to those who are not now paying for coverage. Subsidizing those with current coverage is fairer but more costly.

The state may face a greater administrative burden of signing up individuals because there are so many more individuals than firms. To the extent that firms can remain

active as purchasers of insurance, this burden would decline. The best approach may be to have enrollment continue through firms, even when they are not making contributions toward premiums.

A closely related issue is how to integrate individual and family subsidies with Medicaid. It is more fiscally efficient for the state to maximize its Medicaid program while layering a system of individual and family income-related subsidies on top. Families and unrelated individuals would be eligible for subsidies at higher income levels. Medicaid currently provides coverage for children up to 300 percent of FPL. This could be continued while adding Medicaid eligibility for the lowest income adults and providing new income-related subsidies for adults in private plans.

Conclusion

Individual and family subsidies have some important advantages over employer subsidies. They are better at targeting lower income people. These are likely to lead to less displacement of existing coverage and are more equitable. Employer subsidies are much more difficult to target efficiently. They also have to be very generous to significantly affect offer rates of small firms. In addition, with employer subsidies, there is a need to subsidize not only employers to encourage offers, but also a need to subsidize employees to encourage take-up and to subsidize those who do not have employer offers.

Given these issues, it is probably best to rely primarily on individual and family income-related subsidies. Highly targeted employer subsidies to small firms with low average wages may also be a part of a successful policy. The advantage of the latter is that the employer contribution can offset some of the cost that would otherwise fall to government.

Recommendations

Thus a recommended subsidy structure would be as follows:

- First, Medicaid would be expanded to all those below 100 percent of the federal poverty line. This may require redirecting funds from the state's DSH program under a Section 1115 waiver and perhaps some state funding to cover childless adults below the poverty line.[20] Coverage for children up to 300 percent of FPL would continue. The state would also engage in intensive efforts to maximize participation.
- Second, employer subsidies would be used and targeted at firms with fewer than 25 workers with an average wage of less than $10 per hour. Employers would be expected to pay a minimum of 50 percent of the premium for coverage of workers and spouses, up to a cap. Employer subsidies would be available only through a purchasing pool (perhaps the state employees' plan, though segregated into a separate risk pool, at least initially) that would be responsible for coordinating employer subsidies with individuals and family subsidies.

- Third, the state would establish income-related subsidies through refundable tax credits that would be available for workers and spouses with incomes up to 300 percent of FPL. The subsidies would be available only to individuals purchasing through the pool. Subsidies would be based on a benchmark premium that would be unaffected by the health status of those obtaining coverage through the pool.[21,22] Individuals would not have to spend more than a certain percentage of income on their premium, for example, 5 percent of income for families at 100 percent of FPL, increasing up to 10 percent of income for families at 300 percent of FPL. Workers with employer coverage through the purchasing pool would be offered similar protections. Policies offered in the pool that cost less than the benchmark premium would reduce an individual's premium payments. Policies costing more than the benchmark premiums would require additional payments by individuals, with the premium amount in excess of the benchmark not subsidized. This arrangement would result in subsidies provided to people not only based on income, but to the extent there was adverse selection into the pool, it would provide support to individuals with high health care costs.

This combination of policies in a voluntary system would probably reduce the number of uninsured by about half.[23] Further progress would require mandating that individuals and families obtain coverage.

Appendix. 2004 Federal Poverty Levels (FPL)*

Family Size	Annual Income		
	100% FPL	200% FPL	300% FPL
1	$9,310	$18,620	$27,930
2	$12,490	$24,980	$37,470
3	$15,670	$31,340	$47,010
4	$18,850	$37,700	$56,550
5	$22,030	$44,060	$66,090
6	$25,210	$50,420	$75,630

*These apply to the 48 contiguous states and the District of Columbia.

ENDNOTES

[1] Low-income workers are those earning below 200 percent of FPL; in 2004, 200 percent of FPL was $38,614 for a family of four.

[2] The term "take-up rate" refers to the percent of workers with access to a plan who participate in the plan. Take-up rates vary considerably among different categories of workers. For example, the take-up rate on medical care plans for part-time workers is only 54 percent, compared with a take-up rate of 77 percent for full-time workers. At the same time, take-up rates between different types of health care plans for a given worker or establishment characteristic vary little (except among part-time workers). Among full-time workers, for example, the take-up rates are 77 percent for medical care plans; 80 percent for dental care plans; 76 percent for vision care plans; and 76 percent for prescription drug coverage. U.S. Bureau of Labor Statistics, www.bls.gov/opub/cwc/cm20060120ch01.htm

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[20] The DSH program is designed to provide hospitals with financial assistance to help cover uncompensated care costs associated with caring for Medicaid and uninsured patients. Each year the federal government gives states a DSH allotment, which is the maximum amount of DSH payments that can be matched with federal Medicaid funds.

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The Cover Missouri Project includes a series of reports and fact sheets produced in early 2006. All materials are available online at www.mffh.org. Printed fact sheets and reports are available while supplies last. For more information about the Cover Missouri Project, contact the MFH Health Policy staff at info@mffh.org or toll-free at 1-800-655-5560.

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