kaiser commission on medicaid and the uninsured

THE HENRY J. KAISER FAMILY FOUNDATION

ISSUE PAPER

July 2001

Covering the Low-Income Uninsured: Assessing the Alternatives

Judith Feder, Larry Levitt, Ellen O'Brien, and Diane Rowland

Most of the more than 42 million Americans lacking health insurance coverage are in poor and low-income families. Most of the low-income uninsured are in working families, but the majority lack access to employment-based health insurance.[1] Although many uninsured children are now eligible for Medicaid or the State Children's Health Insurance Program (S-CHIP), working adults—including many parents of low-income children—are not eligible for public coverage. Most of the uninsured thus fall into a gap in coverage between employment-based health insurance and public programs that cover poor children and some parents, leaving health insurance unaffordable. Filling this gap in health coverage is the goal of recent proposals for expansions of coverage utilizing three strategies: (1) expansions of Medicaid and S-CHIP, (2) tax credits for individually-purchased insurance, and (3) tax credits for employment-based health insurance. This issue brief describes these options and their likely implications for coverage of the low-income population.

Expanding Public Coverage Through Medicaid and S-CHIP

The traditional approach to providing health coverage for the poor is through public programs: the government either provides coverage to eligible beneficiaries or purchases coverage from private insurers on beneficiaries' behalf. The Medicaid program, recently supplemented by S-CHIP, is the primary source of that coverage under current law. As the nation's safety net, Medicaid provides health coverage to 15 million children in poor and low-income families, and ten million working-age adults[2]—typically, the very poor mothers of these children. S-CHIP now covers as many as three million low-income children.

---

[1] According to one estimate, 70 percent of uninsured workers lack access to employer-provided health insurance in 1996 (Cooper and Schone 1997). Less than a quarter of the poor had access to an employment-based plan in 1999 (estimates by Mark Merlis, Institute for Health Policy Solutions, based on the Medical Expenditures Panel Survey).

[2] These are estimates of Medicaid enrollment for the noninstitutionalized population calculated from the March 1999 Current Population Survey (Fronstin 2000). These survey estimates undercount Medicaid enrollments relative to administrative data, which indicate that 36.3 million nonelderly adults, children, and persons with disabilities received services under Medicaid in 1998 (Bruen and Holahan 2001).

One option for coverage expansion is to build on existing programs following the Medicaid/S-CHIP approach. Eligibility for comprehensive benefits at no cost (as in Medicaid) could be extended to all individuals with incomes below 150 percent of the federal poverty level. Benefits with some premiums and cost-sharing (as in S-CHIP) could be extended to individuals with incomes between 150 percent and 200 percent of the federal poverty level. And, 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.

Expanding eligibility for public coverage is an effective way to reduce the number of uninsured Americans for a number of reasons. First, public programs offer low-cost, comprehensive, and secure health coverage to the low-income uninsured. Medicaid is fully affordable to low-income families, because premiums are not charged and cost-sharing is very limited. Under S-CHIP, premiums may not be charged to families with incomes below 150 percent of the federal poverty level ($21,225 for a family of 3 in 2000).[3] Comprehensive benefits are provided. In Medicaid, they include basic benefits comparable to those provided under employment-based health insurance plans (with limited or no cost-sharing), as well as broader benefits to meet the needs of persons with disabilities and other special populations. Further, for people determined eligible, enrollment in a health plan is facilitated by a state agency, rather than leaving beneficiaries on their own. Unlike the private insurance market, in which plans can pick and choose whom to take and what to charge, Medicaid requires plans to enroll all of those who are legally entitled for a full set of benefits. In effect, Medicaid manages a market of private plans.

Moreover, because an administrative structure for Medicaid and S-CHIP is in place in all 50 states, it is possible for an eligibility expansion to be implemented in relatively short order. A decade ago, in fact, the last time a major expansion of Medicaid eligibility was implemented, attention focused on the speed with which Medicaid enrollments grew in response to the changes in federal law and state efforts to implement them. Overall Medicaid enrollments increased from 19.2 million in 1989 to 26.7 million in 1992, with nearly half of the increase among women and children newly eligible for Medicaid.

Past successes demonstrate Medicaid's ability to reach, and even exceed, anticipated enrollment, but several steps can be taken to ensure that future Medicaid and S-CHIP expansions are effective in reaching their target populations. Enrollment procedures in many states—lengthy applications, requirements for face-to-face interviews in welfare offices, extensive documentation to certify income, and frequent eligibility re-determination—have often interfered with participation. However, many states have begun to simplify eligibility determination and enrollment processes. Experience in some states under Medicaid and S-CHIP suggests that expanded outreach activities and simplified application and enrollment processes—including the use of mail-in applications and acceptance of applications at schools and other community sites—can encourage participation. In addition to continued efforts to simplify enrollment, eliminating categorical eligibility requirements—extending coverage to *all* persons with incomes below an eligibility threshold—will also make Medicaid eligibility easier for individuals and families to understand and promote participation.

---

[3]Based on the 2000 poverty guidelines of the U.S. Department of Health and Human Services. The poverty guidelines for a family of three was $14,150 in 2000 (see http://aspe.hhs.gov/poverty/00poverty.htm).

Empirical studies show that Medicaid beneficiaries have better access to care than the uninsured, and fare better than the privately insured in some cases, because of Medicaid's comprehensive benefits and low cost-sharing requirements (Currie and Gruber 1996, Currie and Thomas 1995, Newacheck and others 1998). Although Medicaid demonstrably improves access to care and health outcomes for its beneficiaries—compared to those who are uninsured, and often even low-income children with private health coverage—the program is sometimes criticized for failing to provide access to "mainstream" care. In light of the research evidence which suggests that low-income children covered by Medicaid have better access to care than low-income children with private insurance, these concerns may be overstated. But if low payment levels in some states interfere with access to care and quality of care, raising payment levels is an important complement to eligibility expansions to assure access to care.

Tax Credits for Individual Insurance

Tax credits have been proposed as an alternative to the nation's traditional approach to providing health coverage for the low- and modest-income uninsured. The typical proposals envision that tax credits would build on existing private individual insurance coverage. Since health insurance premiums are out of reach for many of the uninsured, subsidies would be provided (through the tax system) to offset the cost of a privately-purchased plan. Most proposals would provide a $1,000 tax credit to an individual and $2,000 for a family. Subsidies of this size would cover a third to one half of the average cost of a standard policy purchased in the individual market.[4]

This approach relies on the tax code, and on private rather than public coverage. Most significantly, potential eligibles would calculate their eligibility for a credit on their own (perhaps with the assistance of a tax preparer), instead of applying for public coverage. New coverage would be private coverage. Rather than enrolling in a government program like Medicaid, low-income people would be free to choose their own private health insurance plan. The uninsured would not be restricted to the private plans selected by government.[5]

However, the reach of tax credits may be limited. First, about half of the uninsured have incomes sufficiently low that they do not pay any federal income tax . Consequently, tax credits that reduce the amount of taxes owed would do nothing to help many of the uninsured poor. To get around this problem, tax credit proponents now generally agree that tax credits need to be "refundable"—or available regardless of tax liability. With a refundable tax credit, those who owe no taxes (or very low taxes) are eligible to receive the full amount of the subsidy. That is the way the Earned Income Tax Credit (EITC) works, and the EITC is widely perceived as an effective tool for raising the incomes of the working poor.

---

[4]Assuming an average cost of $2,000 for an individual health insurance plan and $6,000 for a family plan. However, the distribution of the costs of plans in the individual market is often disputed, with many tax credit proponents suggesting that plans *will* be available that an individual could purchase for $1,000 and that a family could purchase for $2,000.

[5]Ideally, this expansion of demand for private individual health insurance would increase market competition, creating better and more affordable insurance options for consumers over the long term. Relying on market competition to achieve cost control is viewed as a superior alternative to administered pricing in a public program.

However, tax credits may be more effective as means of supplementing income than of expanding access to health insurance. In particular, since tax credits are usually delivered at the end of the year when taxes are filed, this kind of assistance would come "after the fact." The poor and low-income uninsured would need to receive financial assistance at the time premiums were due. Although an administrative mechanism could be designed to provide for advance payment, it is very difficult to make such systems work. Under the EITC, fewer than one percent of people eligible use advance payment because, analysts assert, they are afraid of owing money to the government at the end of the year. Unless full payments can be made in advance and there is no end-of-year reconciliation (so that there is no danger of having to repay subsidies delivered if a family's actual income exceeds the income they estimate in order to receive an advance payment), the tax system is unlikely to provide much help to the low-income uninsured.

Some existing barriers to coverage also may interfere with the tax credit strategy. The most prominent tax credit proposals anticipate that recipients will use the credits to shop in the non-group insurance market. But that market has a number of problems. Except in a few states with comprehensive regulation, private insurers can reject applicants, limit benefits to exclude not only significant services but also body parts or body systems, or charge rates well above the average. As a result, low- and modest-income people who are older, in poor health, or with pre-existing health conditions will face out-of-pocket costs (for insurance or services) that are well beyond their means. For subsidies to be effective for all of the uninsured, including more than half who are older or in poor health, access to comprehensive and affordable coverage needs to be assured. Unless tax credits are accompanied by individual market reforms, they are likely to be limited in their ability to expand access to coverage beyond the young and healthy.

The amount of the subsidy also matters. Even for the young and healthy, the credit needs to be big enough to ensure participation by the uninsured. The most prominent tax credit proposals involve credits in the neighborhood of $1,000 for individuals and $2,000 for families. But insurance premiums average about $2,000 for individuals and $6,000 for families (even more for people in poor health). Experience suggests that people with low incomes are unlikely to be willing or able to fill that gap. Instead, the primary beneficiaries of such a credit will be people with higher incomes.

Individual market plans may be available for $1,000 for people who are young and healthy, but these plans will typically have high deductibles, limited coverage for prescription drugs, no coverage—or very limited coverage—for mental health care, and no maternity coverage. These policies also often come with limits on office visits and other services, and high copayments on many services. Although insurance plans with these features may be "better than nothing" for someone who is young and healthy and in need of limited health care, their access to care may be limited if they were suddenly in need of expensive medical care. Moreover, a $1,000 deductible would be unaffordable for most low-income people.

Tax credits for individual insurance that provide a limited subsidy in an unregulated market and that do not solve the problems of advance payment and reconciliation are not likely to expand health coverage for many of the low-income uninsured. A limited number of the low income uninsured may take advantage of these credits, but most of the new public dollars will go toward providing subsidies to individuals and families who are already covered. That is, many, perhaps

even most, of those who file for the tax credit will have been previously covered by individual health insurance plans and use the credits to help offset their previous costs. In addition, some of those receiving the credit may have been previously insured by employment-based plans. Individual tax credits present the risk that they may offer an incentive to some employers to stop offering coverage that they currently provide. The ineffective targeting to the low-income uninsured and the potential for disruption to existing employment-based coverage are two of the main weaknesses of individual tax credits for addressing the problem of the uninsured.

Tax Credits for Employment-Based Health Insurance

A third option for incremental reform is to build on existing employment-based coverage. Since employers can purchase health insurance more cost-effectively than can any single individual, it may be better to use tax credits to expand employment-based coverage, rather than individual coverage. Sizable tax exemptions already subsidize employment-based coverage, but because some of the uninsured lack access to employer coverage or are unable to afford the employee share of the premium for coverage they are offered, additional subsidies may help expand that coverage. Making tax credits available for either individually-purchased or employer-provided coverage would help fix at least one potential problem with individual credits: the incentive for employers to stop offering or for some employees to drop their existing plans would be mitigated.

Credits for employment-based insurance confront the same basic difficulty as tax credits for individually-purchased insurance: new subsidies for employment-based health insurance plans are likely to "crowd out" existing private spending. Some of the uninsured may become newly covered if a tax credit helps a low-income worker afford a required employee premium contribution, but most of the new subsidies are likely go to people who are already insured. Even if the law directs assistance to those who were previously uninsured, such a provision would be nearly impossible to enforce. Moreover, proposals to make tax credits available for employment-based coverage typically assume that workers with coverage as well as uninsured workers will be eligible, making such approaches a costly way to reach the uninsured.

A tax credit for employment-based coverage may also be limited in its effect since most uninsured workers lack access to employer-provided insurance. A key question is whether employers will respond to the new subsidies by increasing their offerings. Will some employers not currently offering coverage begin doing so? Will employers broaden eligibility for existing plans to cover uninsured workers?

A fourth option for coverage expansion is to subsidize the employer directly, rather than giving the tax credit to the employee. Since 70 percent of uninsured workers are not offered health insurance by their employers, it may be more effective to provide a direct financial incentive to the employer. An employer tax credit could be targeted to small, low-wage businesses least likely to offer insurance today, maximizing the focus of public dollars on improving access to employer-sponsored coverage. An employer tax credit has the disadvantage of leaving people with modest incomes dependent on their employers' willingness to expand coverage. In addition, low- and modest-income workers in large firms would not benefit from this policy. However, compared to a tax credit for individual insurance, this credit may be better targeted and

more cost effective. At the same time, it helps to reinforce existing coverage, and avoids the disruption to existing employer coverage that tax credits for private individual insurance may create.

Conclusion

Incremental reforms to achieve coverage expansion may rely on one of these options or on a combination of these approaches. Few would argue, however, that limited subsidies should go first and foremost to those least able to purchase it on their own, and that subsidies should be designed in a way that is most likely to secure meaningful coverage for the most people. Proposals to expand public coverage are likely to succeed in reaching the more than 27 million low-income uninsured, while providing relatively limited opportunities for crowd out (since most working poor adults lack access to employer-sponsored insurance). Tax credit policies may reach some of the low-income uninsured, but they are also likely to go to many people who are already covered, making tax credit approaches significantly more costly than expansions of public programs, and potentially disruptive of existing employment-based coverage. For the low-income uninsured, expansions of public programs are likely to be more effective in terms of both cost and numbers of uninsured reached than either individual or employment-related tax credits.

References

Bruen, Brian, and John Holahan. *Medicaid Spending Growth Remained Modest in 1998, but Likely Headed Upward.* Washington, D.C.: The Kaiser Commission on Medicaid and the Uninsured, 2001.

Chernew, M., K. Frick, and C. G. McLaughlin. "The Demand for Health Insurance Coverage by Low-Income Workers: Can Reduced Premiums Achieve Full Coverage?" *Health Services Research* 32, no. 4 (1997): 453-70.

Chollet, Deborah A., and Adele M. Kirk. *Understanding Individual Health Insurance Markets: Structure, Practices, and Products in Ten States.* Menlo Park, CA: The Henry J. Kaiser Family Foundation, 1998, Report No. 1376.

Cooper, Philip F., and Barbara Steinberg Schone. "More Offers, Fewer Takers for Employment-Based Health Insurance: 1987 and 1996." *Health Affairs* 16, no. 6 (1997): 142-149.

Coughlin, Teresa A., Leighton Ku, and John Holahan. *Medicaid Since 1980.* Washington, D.C.: Urban Institute Press, 1994.

Cox, Laura, and Donna Cohen-Ross. *Medicaid for Children and CHIP: Income Eligibility Guidelines and Enrollment Procedures, Findings from a 50-State Survey.* Washington, D.C.: The Kaiser Commission on Medicaid and the Uninsured, 2000.

Currie, Janet, and Jonathan Gruber. "Saving Babies: The Efficacy and Cost of Recent Changes in the Medicaid Eligibility of Pregnant Women." *Journal of Political Economy* 104, no. 6 (1996): 1263-1296.

Currie, Janet, and Duncan Thomas. "Medical Care for Children: Public Insurance, Private Insurance and Racial Differences in Utilization." *Journal of Human Resources* 30, no. 1 (1995): 135-162.

Feder, Judith, Cori Uccello, and Ellen O'Brien. *The Difference Different Approaches Make: Comparing Proposals to Expand Health Insurance.* Washington, D.C.: The Kaiser Commission on Medicaid and the Uninsured, 1999, Report No. 1532.

Fronstin, Paul. *Sources of Health Insurance and Characteristics of the Uninsured: Analysis of the March 1999 Current Population Survey.* Washington, D.C.: Employee Benefit Research Institute, 2000. EBRI Issue Brief, No. 217.

Glied, Sherry. *An Assessment of Strategies for Expanding Health Insurance Coverage.* Washington, D.C.: The Kaiser Commission on Medicaid and the Uninsured, 1999, Report No. 1533.

Gruber, Jonathan, and Larry Levitt. "Tax Subsidies for Health Insurance: Costs and Benefits." *Health Affairs* 19, no. 1 (2000): 72-85.

Meyer, Jack A., Sharon Silow-Carroll, and Elliot K. Wicks. *Tax Reform to Expand Health Coverage: Administrative Issues and Challenges.* Menlo Park, CA: The Henry J. Kaiser Family Foundation, 2000, Report No. 1562.

Newacheck, P. W., M. Pearl, D. C. Hughes, and N. Halfon. "The Role of Medicaid in Ensuring Children's Access to Care." *Journal of the American Medical Association,* 280, no. 20 (1998): 1789-93.

1450 G Street NW, Suite 250, Washington, DC 20005
Phone: 202-347-5270, *Fax:* 202-347-5274,
Website: www.kff.org

Additional free copies of this publication (#2258) are available on our website or by calling our publications request line at 800-656-4533.