THE KAISER PROJECT ON INCREMENTAL HEALTH REFORM

The Difference Different Approaches Make:

Comparing Proposals to Expand Health Insurance

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Executive Summary

The impact of any proposal to expand health insurance will depend not only on the proposal's specific features but also on people's responses to those features--most importantly, on how many and what kinds of people--low income or higher income, uninsured or already insured--will actually take advantage of new benefits. Because of differences in the nature of subsidies and people's responses to them, different approaches to coverage are likely to have very different impacts on coverage and costs.

The Henry J. Kaiser Family Foundation Project on Incremental Health Reform aimed to examine these differences. The project commissioned a number of policy experts to develop alternative proposals for health insurance expansion; developed a common set of assumptions to examine each proposal's impact; and then, for most of these proposals, estimated the impact on coverage and costs. This paper provides a comparative overview of the project's result.

The proposals fall into two broad groups: proposals related to children only and proposals related to adults and families. The former (which include options under the Children's Health Insurance Program--CHIP--that was enacted in 1997) provide lessons both for CHIP's implementation and for new proposals affecting other populations. In both categories, proposals vary in a number of features--most importantly, with respect to the scope or focus of their eligibility, the generosity of their subsidies (relative to the costs of insurance coverage), and the mechanisms they rely on to provide those subsidies (tax mechanisms vs. direct subsidies and publicly-run programs).

Estimating the impact of any of these proposals on coverage requires assumptions about people's behavior. Drawing on the literature, key assumptions are:

- Under any approach, participation will be heavily affected by the value of the subsidy relative to the cost of health insurance. The probability that an uninsured individual will participate will be greater, the greater the reduction in price (measured as a percent of income), the lower the price level (measured as a percent of income) and the higher the individual's income. Offering full subsidies for coverage has the greatest impact on participation; once people are required to pay, experience indicates that participation falls off dramatically.

- People's willingness to participate in a direct subsidy program will be affected by perceived barriers to enrollment. The probability that uninsured individuals will participate will be lower, if they perceive application as demeaning, enrollment as burdensome, and quality of care as questionable. Although these barriers may be lower in some program approaches than in others, any proposal that requires proof of income through a state-administered process is assumed to pose a significant obstacle to participation (relative to administration through the tax system or through employment).

- Proposals that rely on the tax system pose a different set of barriers, related to the timing and predictability of the subsidy. Providing subsidies at year's end, rather than in advance, or adjusting subsidies provided in advance to reflect actual income at year's

end, is assumed to pose a significant obstacle to participation.

- The probability that already insured people will participate in a new program will depend not only on the program rules but also on the terms on which benefits are offered. The easier it is to obtain benefits (specifically, through the tax system rather than application to a state office) or to apply them to existing employer-based coverage rather than having to shift to a publicly sponsored program, the larger the likelihood of participation among the already insured.

Applying these (and additional) assumptions to the experts' proposals produces the following key findings:

- **Share of the uninsured population covered.** With the exception of one very generous and highly redistributive proposal, our children's coverage proposals achieved roughly similar impacts--with coverage across proposals ranging from about a fifth to about a third of uninsured children. Proposals for adults varied more broadly. Consistent with its modest objectives, one proposal expanded coverage to less than 2 percent of the uninsured; others reached as high as about a quarter of uninsured adults.

- **Participation by the low income population**. Even proposals with similar levels of coverage differed in the degree to which the newly insured came from very low or higher income populations--reflecting variations in the generosity of the subsidy relative to the cost of insurance and other barriers to participation. Participation by children in families with incomes below poverty ranged from a low of 10 percent in a tax credit proposal where credits did not vary with income to highs of 70 percent or more where children's coverage was provided free of charge to low income families. In proposals affecting adults, coverage was similarly lower in tax credit than in direct subsidy programs.

- **Participation by the already insured**. Proposals vary in the degree to which they aim at a broad population, regardless of insurance status, or aim primarily at the uninsured population. Tax credits and direct subsidies made available without regard to prior insurance status will, not surprisingly, disproportionately benefit the already insured. For example, two proposals targeted to children with incomes below 300% of poverty and available regardless of prior insurance status and through employment, were estimated to cover roughly similar numbers of uninsured children as a CHIP program with similar eligibility levels. However, these newly covered accounted for fewer than 10 percent of beneficiaries in the non-CHIP proposals, compared to over half of beneficiaries in a CHIP approach. Among proposals aimed at adults, targeting had a similarly significant impact on the insurance status of participants.

- **Costs per Newly Insured**. Although proposals differ somewhat in their objectives, they can all be compared in terms of their efficiency in expanding coverage—reflected in the costs per newly insured individual. Costs per newly insured will be higher, the more the benefits extend beyond the uninsured to the previously insured. The variation in cost per newly insured was most extreme in children's proposals, in which costs per newly insured beneficiary ranged from a low of less than $2000 in CHIP proposals (which include relatively low proportions of previously insured) to a high of $10,000 in a tax credit proposal with fixed dollar benefits.

THE DIFFERENCE DIFFERENT APPROACHES MAKE: COMPARING PROPOSALS TO EXPAND HEALTH INSURANCE

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Any proposal to expand health insurance will ultimately be judged by its impact on coverage and costs. Unfortunately, however, those impacts are very hard to predict in advance. That is because impacts depend not only on the specific features of any proposal (who is eligible, for what benefits and on what terms) but also on they way people respond to those features (most importantly, how many and what kinds of people-- low income or higher income, uninsured or already insured--actually participate).

Because of differences in the nature of subsidies and people's responses to them, different approaches to coverage are very likely to have very different impacts. To help policymakers consider these differences in advance, in November, 1996, the Henry J. Kaiser Family Foundation initiated a Project on Incremental Health Reform. The goal of that project was to elicit and compare a variety of approaches to the expansion of health insurance. This paper provides a comparative overview of the project's results.

The project began by commissioning the development of alternative proposals from experts with diverse points of view. Experts were asked to identify a population on whom to target coverage, specify a mechanism for providing that coverage, and lay out both the rationale for and the operational details of their approach. A varied set of options resulted--many involving alternative approaches to covering children; others, sub-populations of adults (people between jobs, near elderly, low income adults). As intended, mechanisms also varied--specifically, in terms of reliance on tax preferences, direct subsidies, or a mix of strategies.

We then proceeded to develop a common set of assumptions related to participation, in order to analyze the likely impact of these proposals on coverage and costs. The importance of these assumptions cannot be over-estimated: they are essential to analysis of a policy's impact and they have enormous impact on that analysis. No assumptions are perfect, all are subject to challenge, and the results they produce are suggestive, not definitive. By drawing assumptions as much as possible from the literature and experience, applying them consistently, and explaining how they work, an analysis of this kind offers a systematic way to compare approaches.

The following presentation of the results of this analysis is in two parts-- the first, focusing on options related to children; the second, on options for adults. Since the 1997 CHIP legislation has specified a particular route to coverage for children, a comparative analysis of that route (and of different paths within it) to possible alternatives can be used to derive lessons for CHIP implementation and for next steps in coverage. Whether the target population is children or adults, many of the options remain the same.

Each section's presentation begins with a brief picture of health insurance and lack of health insurance for the affected population--the social problem that coverage proposals aim to address. Next is a description of a set of alternative approaches and a discussion of the assumptions about behavior used to analyze the impact of each proposal. Finally is a comparison of the impact of alternative proposals on coverage, costs and other program outcomes.

Before presenting the results, it is important to raise a caution about the data used for analysis. The data used to identify the potentially eligible population and their previous insurance status is the 1995 Current Population Survey (CPS), aged to reflect 1998 circumstances and adjusted by the Urban Institute's TRIM II microsimulation model to reflect Medicaid program data on actual enrollment.

The use of the 1995 CPS as adjusted by TRIM II provides the detail necessary to conduct a behavioral analysis but has some limitations likely to affect the accuracy of the estimates. First, aging the data does not fully account for changes that have occurred over time. Second, the CPS may overestimate the uninsured population; results from the new National Survey of America's Families, the Survey of Income and Program Participation, and the Community Tracking Survey show more people with insurance coverage than reported in the CPS. [1] Third, although TRIM attempts to adjust the CPS data to better reflect the scope of Medicaid coverage, the adjustment may actually overestimate the population who are both eligible for and participating in Medicaid (and, therefore, underestimate the uninsured population). The adjustment treats someone eligible or enrolled for part of the year as eligible or enrolled for the full year, which is not truly the case. For these reasons, the analysis presented here is more useful as a basis for comparing alternative policies than for providing precise measures of coverage or costs.

EXPANDING COVERAGE FOR CHILDREN

Any proposal to expand coverage is likely to arouse policy and political controversy. Prior to CHIP's enactment, numerous approaches to coverage were possible. And, as noted above, even under CHIP, different approaches remain possible. Following a brief discussion of children's coverage prior to CHIP's enactment and the reasons coverage matters, the following discussion lays out approaches that could have been (or could still be) taken to expand coverage for children and analyzes their likely impact. Alternative ways to implement CHIP, as well as an estimate of CHIP's impact as states have chosen to implement it, are included in the analysis.

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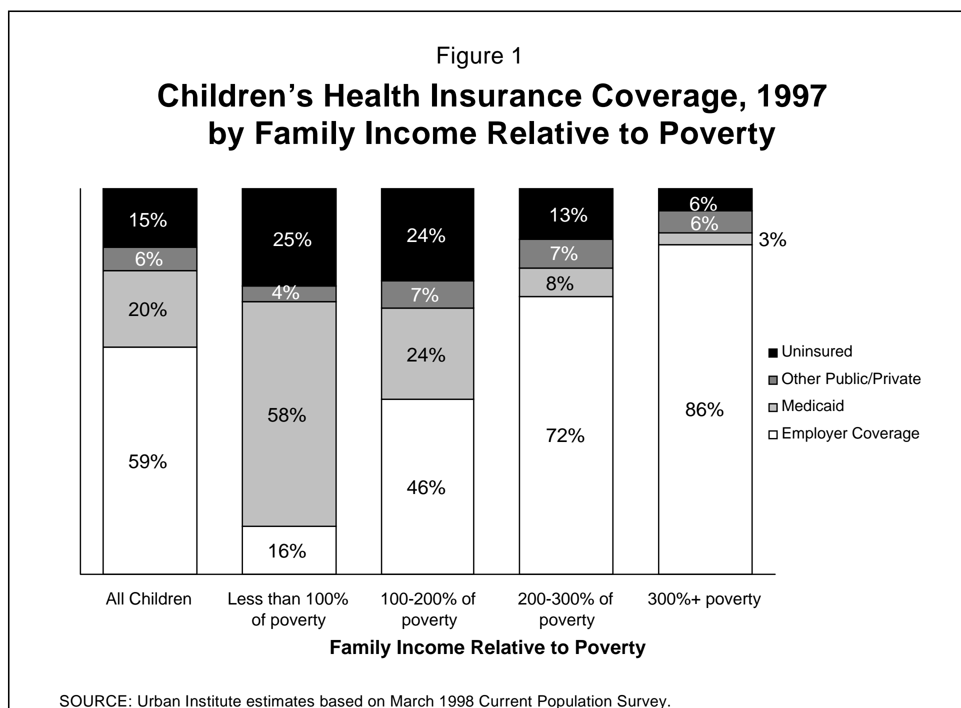
[1] See Holahan, Uccello, and Feder, this volume and and Stephen Zuckerman and Robert Bennefield, "A Comparative Analysis of Health Insurance Coverage Estimates: Data from CPS and SIPP," Paper presented at the Joint Statistical Meeting, Chicago, August, 1996; Kimball Lewis, Marilyn Ellwood and John L. Czajkam, "Counting the Uninsured: A Review of the Literature," Urban Institute Occasional Paper No. 8, July 1998.

Children's Health Insurance Coverage pre-CHIP: An Overview

In 1997, more than 11 million children (15%) were uninsured—more than a quarter of the 43 million Americans without health insurance. The majority of American children (63%) had private health insurance coverage through their parents' employers. Less than a quarter (21%) were covered by Medicaid and 4% were covered by private, non-group health insurance.[2]

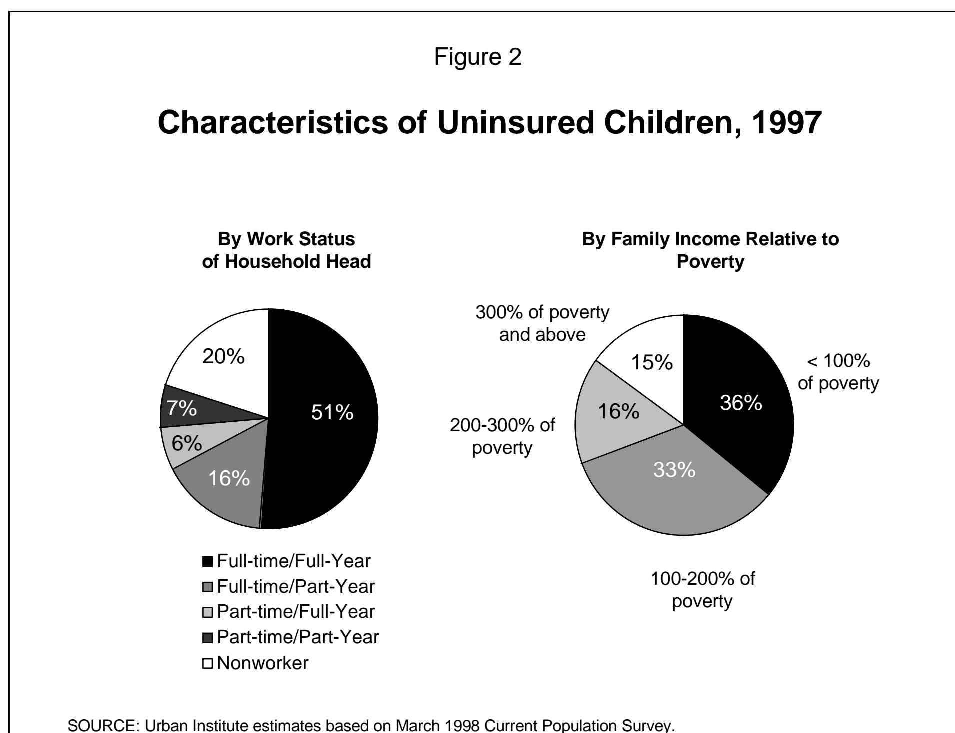
Reasons for lack of insurance. Affordability is the key reason children are without health insurance. Lack of insurance affects children at all levels of income, but children in low-income families (with incomes below 200% of the federal poverty level) are nearly three times as likely to be uninsured as children in modest and high income families (with incomes above 300% of poverty) (Figure 1). Disparities in rates of employer-sponsored health insurance help to account for these differences in rates of uninsurance. Children in families with incomes above 300% of poverty are nearly three times as likely as children in low-income families to have employer-sponsored health insurance. Children in low-income families do not primarily lack coverage because their parents are not working. Rather, they lack coverage because their parents are not offered employer-based health benefits or cannot afford to participate in the plans they are offered.



Medicaid helps to offset the disparities in employer coverage for children in low-income families. Nearly 60% of children in poor families and a more than a quarter of children in near-poor families (with incomes between 100 and 200% of poverty) are covered by Medicaid. But because Medicaid does not fully offset the low rate of employer coverage, the near-poor are worse off than those in poor families; 24 percent of children in near-poor families are uninsured compared to 9 percent of children in poor families.

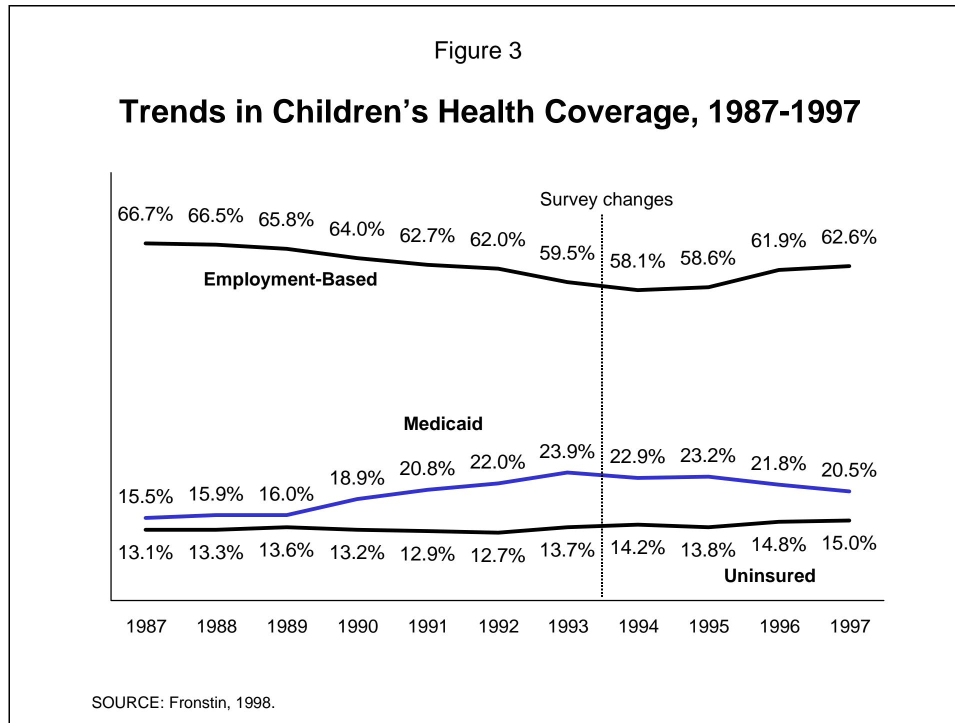
[2] Census Bureau, 1998.

Characteristics of uninsured children. Most uninsured children are in low-income working families. Although children in non-working families lack private health insurance coverage - and tend to be covered by publicly financed coverage, mostly Medicaid-lack of employment does not explain most uninsurance. Eight out of ten uninsured children live in working families; most (51%) are in families where the househead worked full-time, full-year. Most uninsured children (69%) are in low-income families (with family income below 200 percent of poverty), but a substantial number (31%) are in families with income above 200% of poverty.



Trends in coverage. Over the past decade, the dominant trends in the health insurance coverage of children have been the dramatic deterioration in employer-sponsored health insurance coverage and the significant rise in Medicaid coverage (Figure 3). Until recently, increases in Medicaid offset the declines in employer-sponsored coverage, and the proportion of uninsured children remained unchanged. The overall stability in the rate of uninsurance masked a shift in responsibilities for insuring the nation's children from the private sector to the public sector and a significant decline in rates of uninsurance among low-income children who benefited most from the Medicaid expansions.[3]

[3] John Holahan, Colin Winterbottom, and Shruti Rajan. 1995. "A Shifting Picture of Health Insurance Coverage," *Health Affairs* 14 (Winter): 253-264.



In the two most recent years, however, the proportion of children without insurance has begun to creep up. Economic prosperity-rising wages and low levels of unemployment-has led to increases in the rate of employer-sponsored coverage, but the proportion of children without health insurance coverage has increased due to a drop in Medicaid coverage-an unintended consequence of the precipitous decline in the welfare rolls.

Why health insurance matters: access to care. Uninsured children are at risk for receiving inadequate health care; they are less likely to have a usual source of care, have fewer physician visits, are more likely to go without contact with a physician in a given year, and receive inadequate preventive services compared to either privately or publicly insured children. For example, 96% of insured children, but only 75% of uninsured children, have a usual source of care. Uninsured children are six times as likely as insured children to go without needed medical care (1 percent vs. 6 percent) and receive only three-fifths as much ambulatory care. Uninsured children are also more likely to be hospitalized with avoidable conditions and experience worse health outcomes than the insured.[4]

It is especially troubling that these disparities persist among children in poor health: insured children who are in poor health receive substantially more care than their uninsured counterparts. Recent research also suggests that the gap in access between insured and uninsured children may be growing.[5] Although there are too few studies to determine definitively whether the access gap has increased, providers that have traditionally provided care to the uninsured (such as public hospitals and community health centers) assert that their ability to provide care to the uninsured has been affected as the resources available to provide care to the uninsured have dwindled.

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[4] Paul W. Newacheck, Jeffrey J. Stoddard, Dana C. Hughes, and Michelle Pearl. 1998. "Health Insurance and Access to Primary Care for Children," *New England Journal of Medicine* 338(8): 513-519.

[5] Newacheck et al. 1998.

Alternative Approaches to Health Insurance Coverage for Children

Experts participating in this project produced two broad kinds of expansion proposals for children. One group of proposals extends subsidies to the uninsured across a broad range of incomes as part of a broader policy intended to provide new (or replace existing) tax preferences for families who already cover their children. The other group—along with CHIP—targets subsidies to a low income population. (See Table 1 on page 30 for brief descriptions of the proposals and a comparison of their key features).

Coverage Across a Broad Range of Incomes. The first set of options would provide tax credits or combinations of tax credits, subsidies and programs to families with middle (or all) income levels, provided they cover their children. Authors who developed approaches of this type (Mark Pauly and Wendell Primus) did so in the context of legislative consideration of the child tax credit in 1996—which, in theory, could have been made conditional on the provision of coverage. Should Congress wish to provide additional tax credits, as some have proposed, such conditions could be applied.

All of the approaches considered here involve **refundable** tax credits, that is, they would be made available to low income families without regard to their tax liabilities. Beyond that, the approaches differ in the way in which the credit is established, the timing of the credit (subsequent to or in advance of enrollment), and reliance on the current private marketplace or on state-run or state-certified insurance.

The specific proposals are as follows:

- **A fixed dollar refundable tax credit**—set at $500 per child—available to all families with incomes up to 500% of the federal poverty level, on condition they obtain health insurance coverage. The credit would be claimed as part of the tax filing process--that is, after the year in which coverage is purchased. Health insurance would be obtained in the current private marketplace, either through direct purchase or through employment, and applicable to any policy--regardless of benefits--as long as the premium or the actuarial value of the benefits exceeded $500 (Mark Pauly).

- **A fixed dollar refundable tax credit** available on the same terms as outlined above, but applicable only to policies providing a standard set of benefits.

- **An income-related refundable tax credit**—set equal to the cost of a managed care policy for children with incomes below 150% of poverty, phasing out to zero for families with incomes at 500% of poverty. All other features are as in the fixed dollar credit described above (Mark Pauly).

- **A combination refundable tax credit/direct subsidy/ state insurance** designed to replace the child tax exemption for all families, regardless of income. All families would receive a tax credit of up to $800 on proof that they had purchased **certified** health insurance (directly or through an employer) in the previous year or were enrolled for the upcoming year in a Medicaid, or state-run or state-certified health insurance plan. All families would be guaranteed access to the latter, at 100% subsidy or zero cost for the lowest income families. Subsidies would be phased out and credits phased in as income increased, so that credits would be available to (at least) fully offset premiums for families up to a specified income threshold and limited to a share of income above that threshold (Wendell Primus).

Coverage Targeted to Low Income Children. The second set of options is targeted to low income children. The first among them is a hybrid, similar to the combination option above, that ties an income related tax credit to a state-run insurance program and makes coverage available to all income-eligible children. The remaining options are direct subsidy programs, one available in employer-based coverage as well as in state-run programs; another, available from Medicaid or state-run programs and, consistent with the Children's Health Insurance Program, only to children without other insurance coverage. (All four options are **on top of** current Medicaid coverage; that is, they exclude Medicaid-eligible children from eligibility.)

More specifically, the proposals are:

- **An income-related, refundable tax credit,** set equal to the average cost of plans contracting with the state, and available to all income-eligible children without regard to previous insurance coverage. Credits can be used to cover costs in employer-sponsored insurance. Children in families with incomes below 133 percent of the federal poverty level would receive a full credit. The credit would decline (or, the premium obligation would rises) as income rises, to zero (or full premium) at incomes of 300% of the poverty level. The credit would be fully or partially provided in advance of the enrollment year, based on expected income. At year's end, the credit would be reconciled (increased or decreased) based on actual income (Linda Blumberg).

- **A state-run subsidy program** available to all income-eligible children without regard to previous insurance coverage. Subsidies can be used to cover costs in employer-sponsored coverage. Children in families with incomes below 133 percent of the federal poverty level would face no premiums; premiums would be phased in as income increases up to full premium at 300% of poverty. At year's end, subsidies would be reconciled (increased or decreased) based on actual income. Families with employer coverage would receive at least the same protection (or limit on premium liability) as families in plans offered by a state-run program; and, if employer contributions reduced family premium amounts below they subsidy they could receive in the state-run plan, families would receive a share of the "savings" (Mark Merlis and Richard Curtis).

- **The Children's Health Insurance Program**, which creates a state-run subsidy program available to all income-eligible children who do not have access to employer-provided coverage. States have the option to provide coverage through Medicaid or a state-run program, but not through employer-sponsored coverage. Under Medicaid no premiums may be charged, regardless of income; under a state-run program, premiums may be charged to families with income above 150% of poverty. Premiums and cost-sharing may not exceed 5 percent of income. Eligibility, while focused on children not eligible for Medicaid with incomes up to 200 percent of poverty, may go higher--in states that already have high income eligibility standards for Medicaid and in any state that chooses to "disregard" income in calculating eligibility. States have taken different paths in implementing CHIP. For illustrative purposes, our analysis focuses on three distinct routes: a state-based plan with low premiums; a Medicaid option with no premiums; and an estimate of the mix of strategies states have actually implemented.

Assumptions Used to Estimate Participation Among the Uninsured

Any estimate of the impact of a coverage proposal on coverage and costs rests on assumptions about how people in different income and insurance circumstances will react to the availability of a new benefit and to the terms on which the benefit is offered. The following are our most critical assumptions about people's likely participation in various options:

Price and Income. Experience tells us that the likelihood that uninsured families who participate in a benefit program will be heavily influenced by the price or premium they have to pay and by their incomes. Our assumptions regarding these effects rest on evidence on participation rates for the insured population facing different premiums (or premium shares) at different income levels; and on participation rates in public programs. The assumptions—which are consistent with the academic literature on participation—build on earlier approaches,[6] with improvements: incorporation of better data (relying on group insurance data where premiums as a percent of income are low) and distinctions between the effect of income and the effect of price (by developing income-specific matrices) and between the behavior of the newly insured and the uninsured (by constraining the overall participation rate—including the newly insured and the already insured--at any income and premium level to the proportion predicted for both groups). Table 2 shows participation rates as a function of income and price for children and families.

For currently uninsured children, analysis rests on a matrix of participation rates relating a proposal's required premium payment as a proportion of family income to premiums families would face without a new intervention. To help distinguish the income effect from the price effect, a specific set of participation rates is used for each of three different income groups. As shown in the matrix, the probability that an uninsured individual will participate will be greater, the greater the reduction in price (measured as a percent of income), the lower the price level (measured as a percent of income) and the higher the individual's income (Table 3). Clearly, offering coverage at zero prices has the biggest impact on participation; once people are required to pay, participation falls off dramatically.

The probabilities of participation presented in this matrix do not take into account other factors that affect likely participation or "take-up rates." These are described below. (Table 4 presents the full set of assumptions applied to each proposal).

Barriers to Enrollment. Along with price and income, the ease or difficulty with which benefits can be obtained will also affect the likelihood of participation. Direct subsidy programs may pose a number of barriers to enrollment. These include enrollment practices that people may find demeaning (for example, if applications must come through welfare offices) or burdensome (for example, if enrollment requires detailed and extensive proof of resources or income); and reliance on payment methods or delivery arrangements that call into question quality of care (for example, providing access only to "second-class" medicine). Coverage approaches that rely on the tax system do not pose these barriers and state programs that extend access to employer coverage are assumed to pose only modest barriers of this kind.

It is difficult to quantify these barriers; but past public programs provides some evidence of their effects. Historically, Medicaid participation has been substantial, but well below 100% (particularly for people not receiving cash assistance). A different approach to enrollment—to promote easier access and enhance a program's attractiveness—might well produce higher participation rates. In developing proposals for this analysis, our experts were asked to address barriers to enrollment. All means-tested public programs were assumed to pose some such barriers. However, where initiatives to facilitate enrollment or promote program attractiveness were included, they were assumed to pose lower barriers than traditional Medicaid.

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[6] The observed relationship between participation rates and premiums is consistent with findings of Susan M. Marquis and Stephen H. Long, "Worker Demand for Health Insurance in the Non-Group Market," *Journal of Health Economics* 14(1): 47-63 (1995); and Leighton Ku and Teresa Coughlin, "The Use of Sliding Scale Premiums in Subsidized Insurance Programs," Urban Institute Working Paper, March 1997. The approach used here builds upon and extends that of Lewin-VHI in "Expanding Insurance Coverage without a Mandate," Draft Report for the Health Care Leadership Council (Fairfax, VA: Lewin-VHI, 1994).

Cash Flow and Uncertainty. Policies that rely on the tax system pose a different set of issues likely to affect participation--issues related to the timing and predictability of the subsidy. Here too it is difficult to quantify effects. However, past experience with tax credits, both for income and health insurance provide some indication of likely responses.[7] Providing a subsidy only after coverage has been purchased (at tax time) requires families to make a direct payment on their own, up front. That raises "cash flow" as a barrier to participation. Providing a subsidy in advance of purchase, but requiring the family to pay it back if their income is higher than expected (that is, requiring after-the-fact *reconciliation*), raises uncertainty as a potential barrier to participation. Our experts were asked to address timing and reconciliation issues in their proposal design and participation rates were adjusted accordingly.

Assumptions Used to Estimate Participation Among the Already Insured

As noted in the descriptions, proposals vary in the extent to which they target benefits to the uninsured or provide benefits to a far broader population. It is important to recognize that some proposals **intend** to provide benefits to the already insured. Even proposals that do not have that objective, however, may encourage people who already have coverage to take advantage of new benefits. How much they do so will depend heavily on the attractiveness of the benefits. The enactment of CHIP generated considerable controversy as to how much of a shift is likely to occur. Review of the several studies on the crowd-out associated with Medicaid expansions suggests that about 20 percent of new enrollees under Medicaid expansions shifted from private to newly available public coverage.[8] Because CHIP extends coverage to higher income children who are more likely to have private health insurance, this proportion might be larger under CHIP. However, CHIP includes rules prohibiting new benefits to already-insured time, a factor that might produce a lower proportion. Recognizing that rules cannot be perfectly enforced and that, even with rules, people may change their behavior in response to newly available public coverage, our analysis assumes that some crowd out will occur. Our assumptions reflect analysis of past experience, adjusted to reflect CHIP's higher income levels.[9] It is important to note that this analysis focuses solely on individuals' decisions to alter their coverage, for which there is evidence in the literature. We do not address employers' decisions to alter their coverage in response to new policies.

The attractiveness of new benefits has two components. The first is whether individuals can take advantage of new benefits *while retaining their existing coverage*, for example, by applying a credit to the costs of their-employer-based coverage. We assume that people able to apply a new benefit to existing coverage are very likely to take advantage of it; people who have to shift from employer-sponsored to publicly provided, much less likely. The latter raises the second factor—how attractive participation is financially, with people more likely to shift coverage, the greater the financial benefit.

Table 5 shows the assumptions applied to each proposal, based on its specific features.

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[7] See Sherry Glied, "An Assessment of Strategies for Expanding Health Insurance Coverage," Project on Incremental Health Reform, The Henry J. Kaiser Family Foundation, 1999.

[8] Lisa Dubay, "Expansions in Public Health Insurance and Crowd-Out: What the Evidence Says," Project on Incremental Health Reform, The Henry J. Kaiser Family Foundation, 1999.

[9] John Holahan, Cori Uccello, and Judith Feder, "Children's Health Insurance: The Difference Policy Choices Make," Project on Incremental Health Reform, The Henry J. Kaiser Family Foundation, 1999.

Assumptions Used to Estimate Costs

A proposal's costs will depend on the costs per covered child (or per policy) and on overall participation. Our estimates address both.

Premiums or Per Policy Costs. Estimates of the costs of insurance were made by Actuarial Research Corporation. Their estimates for most proposals, with premiums from the Health Insurance Association of American 1991 Employer Survey and, for nongroup insurance, the Blue Cross/Blue Shield Survey, are adjusted to reflect premium growth since 1998. Group and non-group premiums are used appropriately, to reflect the market on which the proposal relies. Estimates are also affected by a plan's intent to rely on managed care or fee-for-service delivery; where the former is specified, the cost estimates are reduced. For CHIP, estimates rely on Medicaid experience.

Costs under each approach are heavily affected by participation rates. If participation is low, the higher costs of sicker children—who are assumed to be most likely to participate—will not be offset by the lower costs of healthier children. Hence average costs per child will be higher. Premiums or per child costs used to estimate each proposal therefore reflect the expected participation.

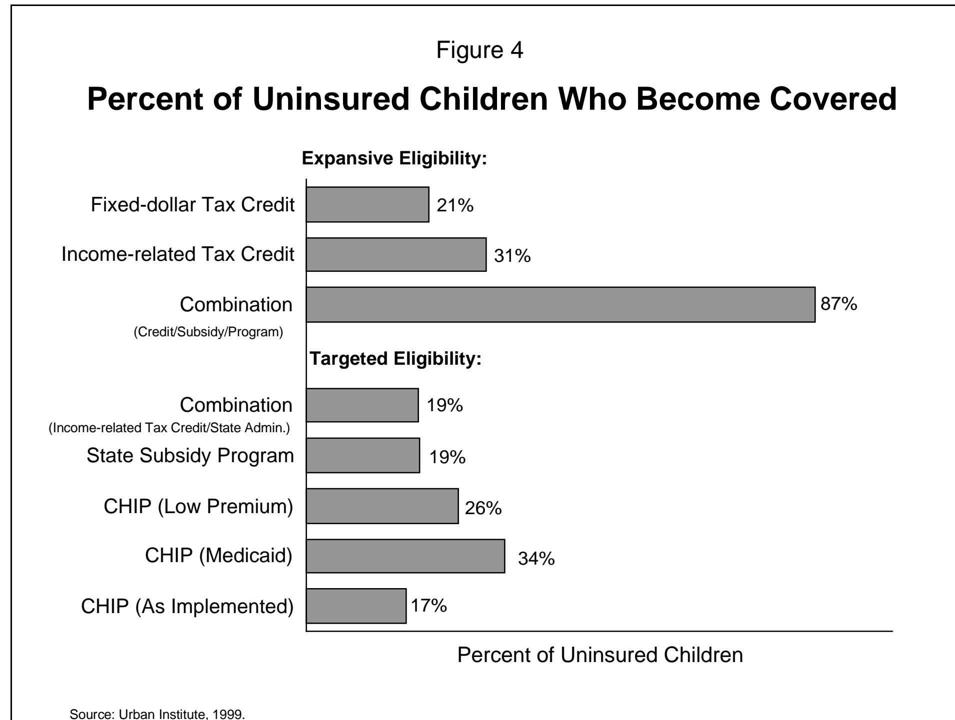
The cost estimates used in each proposal are included in Table 4.

Total Costs. Estimates of total costs also include an assumption that, even when Medicaid is unaffected by the new policy, publicity of a new program will increase participation in Medicaid. The estimates assume that 15 percent of children who are eligible for but not participating in Medicaid under the current system would seek and obtain Medicaid eligibility under a new program (Note, however, these children are not included in new coverage estimates).

Impact of Alternative Approaches

Comparisons of coverage and costs for this set of proposals are presented in Figures 4 through 8. The following highlights and explains key differences across proposals.

Share of Uninsured Children Covered



Although policies may pursue multiple goals, clearly a major objective is to expand coverage among the currently uninsured. The structure of initiatives has a significant impact on how much expansion is likely to occur.

In assessing the differences across proposals, it is important to remember, first of all, that they fall into two groups, based on the scope of eligibility. The first three proposals analyzed make a very broad population eligible for benefits. (Note that no estimates are included for the flat dollar refundable tax credit available for use on whatever benefits could be purchased. For comparison purposes, it was necessary to assume a common benefit package; with varied benefits, "coverage" would mean different things in different approaches and could not be consistently compared.)

Beginning with proposals affecting the broadest populations, the proportion of uninsured children likely to be covered ranges from a low of 21 percent, under a flat dollar, refundable tax credit; to the significantly higher proportion of 31 percent under the refundable tax credit set as a share of income; to the very high proportion of close to 90 percent, under the combination of refundable tax credit/subsidy/ and program approach. The differences in impacts reflect the value of the subsidy relative to the cost of care and the timing of the subsidy:

- A flat-dollar credit covers only 38 percent of the estimated premium ($500/$1311) under this proposal and is provided at the end of the year, not in advance. Despite eligibility for the full credit to families with incomes up to 450% of the poverty level, the presence of substantial out-of-pocket payments and cash-flow barriers is estimated to substantially reduce participation.

- An income-related tax credit tied to premium costs covers the full premium cost for families with incomes up to 150% of poverty and pays a partial premium up to 500% of

poverty. As a result, participation is higher than in the fixed-dollar tax credit. However, the presence of out-of-pocket payments above that income level and cash-flow barriers at all levels of income continue to affect participation.

- The very high levels of participation in the combination approach reflect the provision of a tax credit to virtually everyone (as a replacement for the dependent exemption); and, for the low and modest income population, full subsidies provided in advance (without reconciliation) for state-provided or certified coverage. Equally important, under this proposal, people with modest incomes actually benefit by participating—the credit exceeds the cost of their coverage. Further, the proposal, while relying in part on a tax credit, relies on a public program to overcome the cash-flow and uncertainty barriers to participation posed by the usual tax credit approach.

The next set of proposals targets eligibility to families with incomes below 300% of poverty, with full subsidies up to 150% of poverty, phasing out to zero at 300% of poverty. Impacts range from a low of 19% of the uninsured, under a tax credit approach, to 34% under a Medicaid version of CHIP coverage. The variation in the impact reflects the variation in the value of the subsidy relative to the cost of coverage (as above), as well as other factors likely to affect participation:

- Regardless of approach, the value of the subsidy relative to the cost of care will have a major impact on participation. Once people have to pay, participation declines dramatically. In all these proposals, except the Medicaid CHIP option, full subsidies stop at 150 percent of poverty and all subsidies are phased out at 300 percent of poverty (substantially below the 500 percent of poverty in the income related tax credit above).

- Even if tax credits or subsidies are provided in advance (as under the tax credit and the direct subsidy options, respectively), uncertainties are likely to affect participation and therefore coverage, if benefits are adjusted upward or downward after the fact, based on actual rather than predicted income. A subsidy program that does not reconcile benefits based on actual income (CHIP) is therefore likely to cover more people, even if premiums are charged.

- The relatively substantial impact of the Medicaid CHIP option reflects the high participation associated with providing full subsidies of the cost of care to uninsured individuals with incomes up to 300% of poverty. Estimated coverage under the low premium version of CHIP is somewhat lower. The relatively limited impact of CHIP as states have actually implemented it (reaching 17% of uninsured children) reflects the fact that states have moved up the income scale more modestly and, in many states, have charged premiums above 150% of poverty (or, in some states, at lower levels of income).

Share of Eligible Uninsured Children Who Participate, by Income

Policies differ not only in the share of uninsured children they reach; they may also differ in which uninsured children they reach. Specifically, their design differences imply different impacts across income groups.

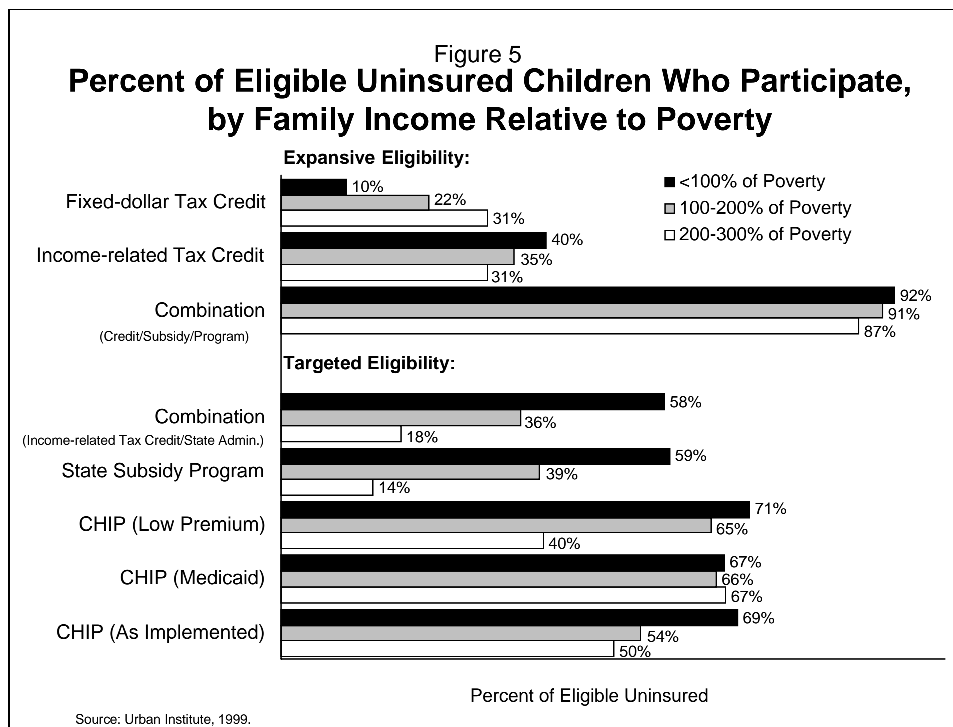


Figure 5 illustrates the participation of eligible children in three segments of the low and modest income population - below poverty, between 100 and 200 percent of poverty and between 200 and 300 percent of poverty. The calculations are based on the population made eligible under each proposal, which differs between the expansive and targeted plans primarily because children eligible for Medicaid are not eligible in the targeted plans. The chart illustrates that, regardless of eligibility, differences in the nature and scope of the subsidy will affect participation in different income groups. Specifically:

- In contrast to all other approaches, a fixed-dollar credit will achieve a higher level of participation among higher than among lower income groups. The reason is that at all levels of income, the credit is insufficient to purchase coverage. People with the lowest incomes will be least able and likely to add their own dollars, in order to purchase coverage.

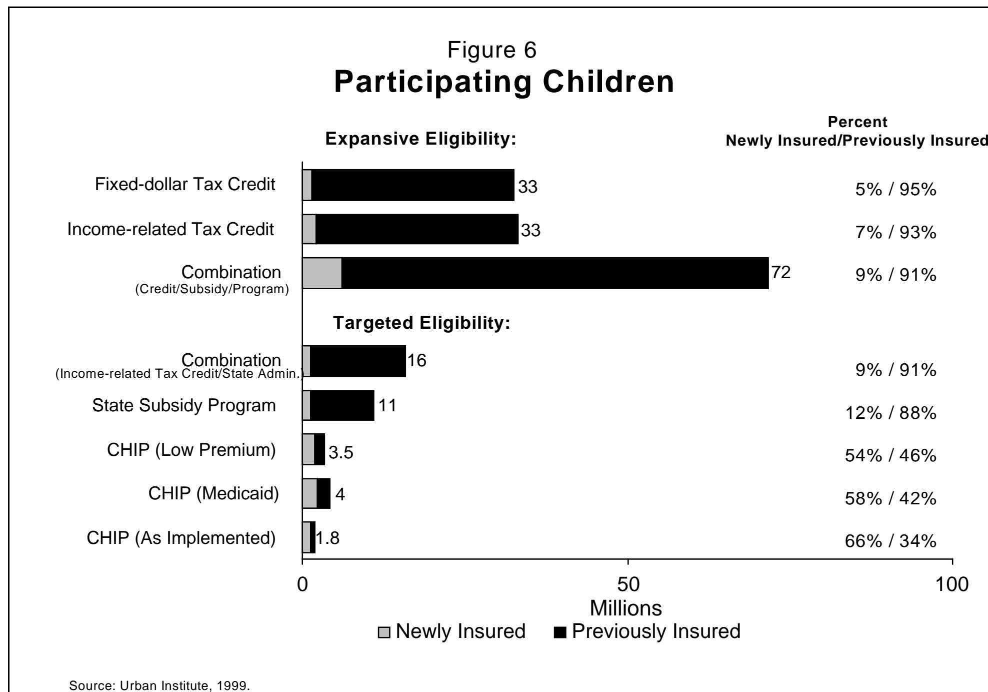
- Proposals that provide people the full costs of coverage regardless of income level (within a specified range) will, not surprisingly, achieve similar levels of participation regardless of income. Among proposals with expansive eligibility, the combination plan assures virtually everyone sufficient resources to purchase coverage. Hence the roughly equal (and, because of the generosity of the credit, very high) proportions of participation in the three income groups. Among proposals with targeted eligibility, only the Medicaid version of CHIP provides coverage with no premiums up to 300 percent of poverty. Hence, the roughly equal (albeit lower than above) participation rates across income groups.

- In all other proposals, participation falls with income, as people are expected to contribute to the cost of coverage. The size of the drop-off depends upon the specifics of the subsidy—how much and how fast it declines. The drop-off is relatively small in the expansive income-related credit proposal, because subsidies are phased out more gradually (between 150 and 500 percent of poverty) than they are in the targeted plans

(between 150 and 300 percent of poverty). Similarly, because they introduce only modest premiums as income rises, participation falls off less dramatically in the low-premium CHIP and in CHIP as implemented.

- Participation among uninsured children with incomes below poverty varies considerably by approach. All proposals except the fixed-dollar credit subsidize the full cost of coverage for this group. However, poor uninsured children are estimated to be least likely to participate in a program that provides benefits at the year's end, rather than in advance (only 40 percent participate in the income-related credit with expansive eligibility). Although a larger proportion of poor children are estimated to participate in tax credit or subsidy programs that provide subsidies in advance (about 58 percent of poor children participate in these two targeted programs), these proposals' provisions to reconcile benefits to income at year's end nevertheless limits participation. Determination of eligibility in advance without reconciliation explains the higher participation rates for poor children in the CHIP options (about 70 percent).

Share of Covered Children Who Were Previously Uninsured



As noted at the outset, proposals differ significantly in the extent to which they intentionally or unintentionally reach the already insured as well as the uninsured. A comparison reveals the following:

- Not surprisingly, the proportion of beneficiaries who were previously uninsured is lowest under the broad-based programs, which explicitly aim to provide credits to the already insured. (Note, however, that the numbers of newly insured are as large or larger here than under other approaches).

- Among proposals targeted to a low income population, approaches also vary in intent and impact in the degree to which they target the uninsured. Although the targeted eligibility proposals reach roughly similar number of uninsured children, they reach very different

numbers of already insured children. Both the targeted income-related tax credit and the direct subsidy proposal extend benefits to low income children, regardless of prior insurance coverage, and allow use of benefits to finance employer-provided coverage. Hence they include a large proportion of previously insured children (91 percent and 88 percent, respectively).

- Even in these two approaches that explicitly include the previously insured, however, actual participation among the already insured varies with the method of coverage. The ease of access to tax credits, relative to a formal application to a means-tested public program, would likely facilitate participation in a tax credit program. This difference in "enrollment barriers" explains the more extensive coverage of the previously insured in the credit approach relative to the direct subsidy. As a result, tax credits have a higher displacement rate than direct subsidies.

- The proportion of beneficiaries who are uninsured is highest in programs that limit coverage to the uninsured—that is, the CHIP options shown here. Even though our estimates assume that some individuals who benefit financially will shift from private to public coverage, the requirement that they actually give up private coverage is likely to limit participation. Programs that extend eligibility higher up the income scale will have larger proportions of previously insured participants than more limited programs, because they will reach a group that is much more likely to have insurance coverage.[10] Hence the larger proportions of previously insured enrollees in the two potential CHIP models (with eligibility up to 300 percent of poverty), relative to CHIP as actually implemented—where income eligibility is much lower.

- The presence or absence of premiums will likely affect the mix of insured and uninsured beneficiaries even in a public program targeted to the uninsured. The number and proportion of newly insured beneficiaries, though substantial, is slightly lower in the low-premium model of CHIP than in the Medicaid model (54% vs. 58%). That is because charging even a modest premium is likely to deter participation among the uninsured more than it deters the already insured. A modest premium will only slightly reduce the financial benefit an already-insured family would receive from the new subsidy. By contrast, experience indicates that having to pay even a modest premium significantly reduces participation for families who do not have insurance to begin with. (Analysis not shown here indicates that charging higher premiums reduces participation of the previously insured as well as the uninsured).[11]

Total Program Costs

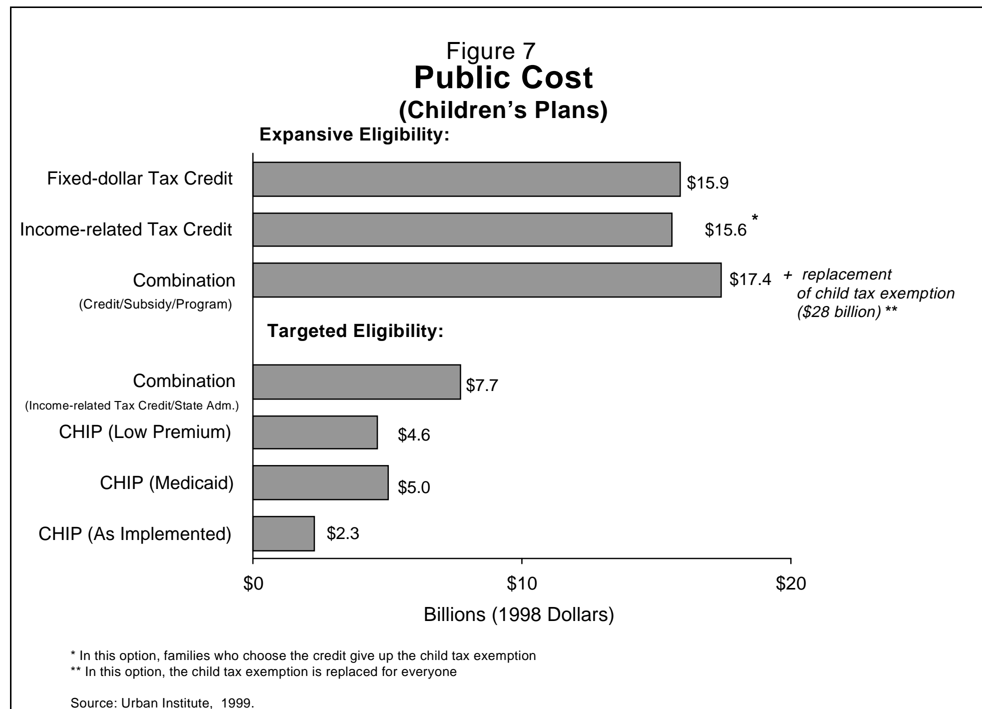
Program costs for all the options are compared in Figure 7. Differences in relative costs flow fairly directly from differences in numbers of children covered. Some explanatory points are nevertheless worth making:

- The combination approach with expansive eligibility is the only proposal in the group to rely on an explicit financing mechanism—replacement of the child tax exemption. Although new costs are therefore comparable to costs of other proposals, total costs—including the redistributed exemption—are much larger, just as coverage is much broader.

[10] See Holahan, Uccello and Feder, 1999.

[11] See Holahan, Uccello, and Feder, 1999.

- Variation in costs does not fully parallel variation in coverage for two reasons: (1) the dollar subsidy value will differ across proposals (across income groups in most proposals; and between fixed-dollar and other proposals); and (2) premiums will differ across proposals because of differences in participation (lower participation means higher premiums) and other factors, including reliance on a private market or a public program and explicit reliance on managed care.



Public Costs per Newly Insured Child and Benefits per Enrollee

Although proposals have a variety of goals, expanding coverage is an important element of any approach. Proposals can therefore be compared in terms of their efficiency in expanding coverage—reflected in the costs per newly insured child. Costs per newly insured child will vary, depending on the degree to which a proposal concentrates its benefits on the uninsured or extends benefits to the previously insured population. Not surprisingly, differences in costs per newly insured child and in benefits per enrollee are substantial, reflecting the variations in coverage described above.

- Reflecting their focus on virtually the full population and explicit inclusion of the already insured, expansive eligibility proposals spend the most per newly insured individual; the combination approach is low because it has a built-in financing mechanism (the redistribution of the dependent tax exemption).

- Programs with targeted eligibility that explicitly restrict coverage to the uninsured (e.g. the CHIP programs) might also be characterized as the best financially targeted, since--even though they may include some beneficiaries who are already insured—their costs per newly insured are relatively low.

- Benefits per enrollee are largest in programs that concentrate benefits on the fully subsidized—that is, the CHIP programs.

Figure 8

Public Cost Per Newly Insured Child and Per Enrollee

(Children's Plans)

	Public Cost per Enrollee	Public Cost per Newly Insured Enrollee
Expansive Eligibility:		
Fixed-dollar Tax Credit	$488	$10,704
Income-related Tax Credit	$469	$7,161
Combination (Credit/Subsidy/Program)	$243	$2,833
Targeted Eligibility:		
Combination (Income-related Tax Credit/State Admin.)	$485	$5,675
State Subsidy Program	$493	$3,983
CHIP (Low Premium)	$1,342	$2,509
CHIP (Medicaid)	$1,208	$2,095
CHIP (As Implemented)	$1,235	$1,882

$0 $6,000 $12,000

1998 Dollars

Source: Urban Institute, January 21, 1999

EXPANDING COVERAGE FOR ADULTS AND FAMILIES

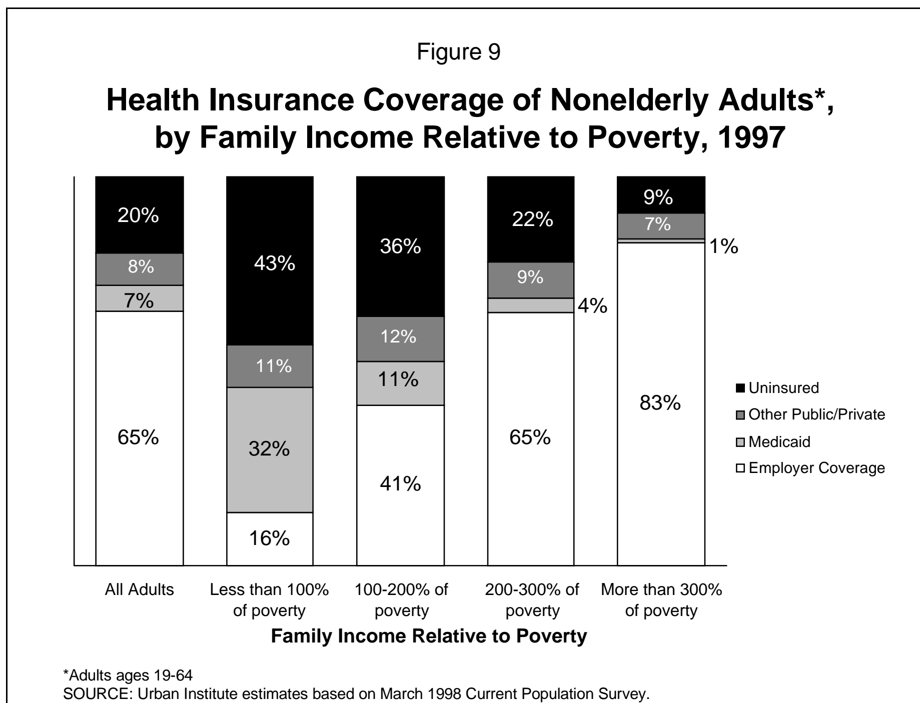
Although CHIP is not designed to reach all uninsured children and its implementation continues to demand policy attention, efforts to expand coverage since CHIP's enactment are likely to focus primarily on adults (or, more broadly, on families). As with children, a variety of strategies are possible. The analysis that follows will examine different mechanisms to expand coverage and their impacts. However, proposals to expand coverage to adults have an element not presented by proposals for children--that is, differences in the segments of the adult population on which they focus. These differences in population targets are addressed here as well.

Following a description of insurance coverage among adults and the reasons insurance matters, this discussion will lay out a broad set of options, developed by commissioned experts, that could be applied to coverage for adults. The focus will then narrow to the set of options that differ by mechanism—tax policy vs. direct subsidy—for which we were able to estimate the impact on coverage and costs.

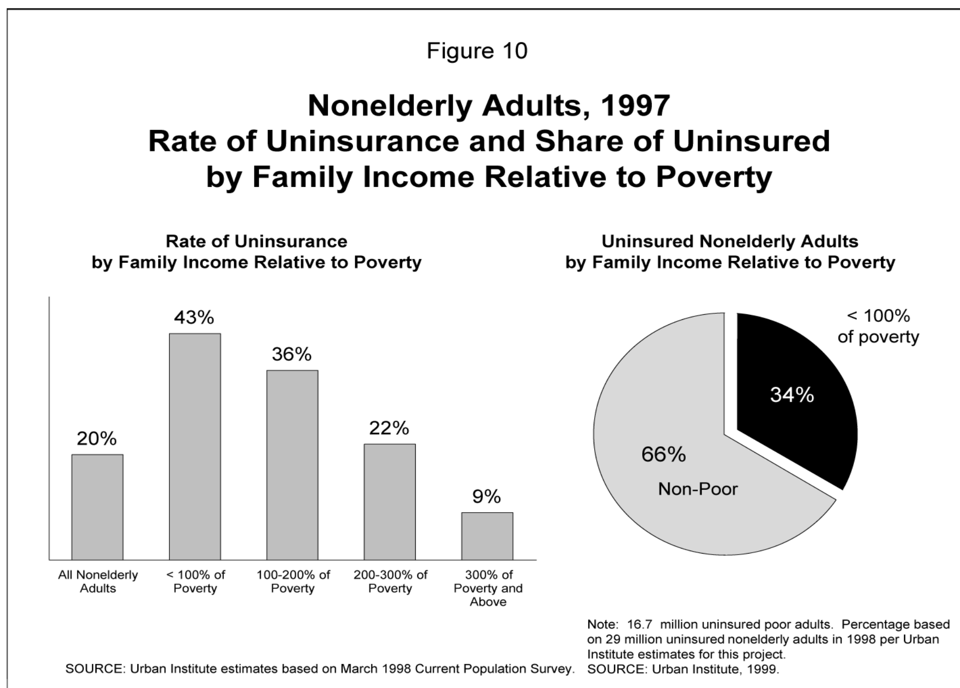
Insurance Coverage for Adults: An Overview

Of the 43 million nonelderly Americans without health insurance in 1997, nearly three-quarters (31 million) were adults ages 19 to 64. Adults are more likely to be uninsured than children (20% vs. 15%).

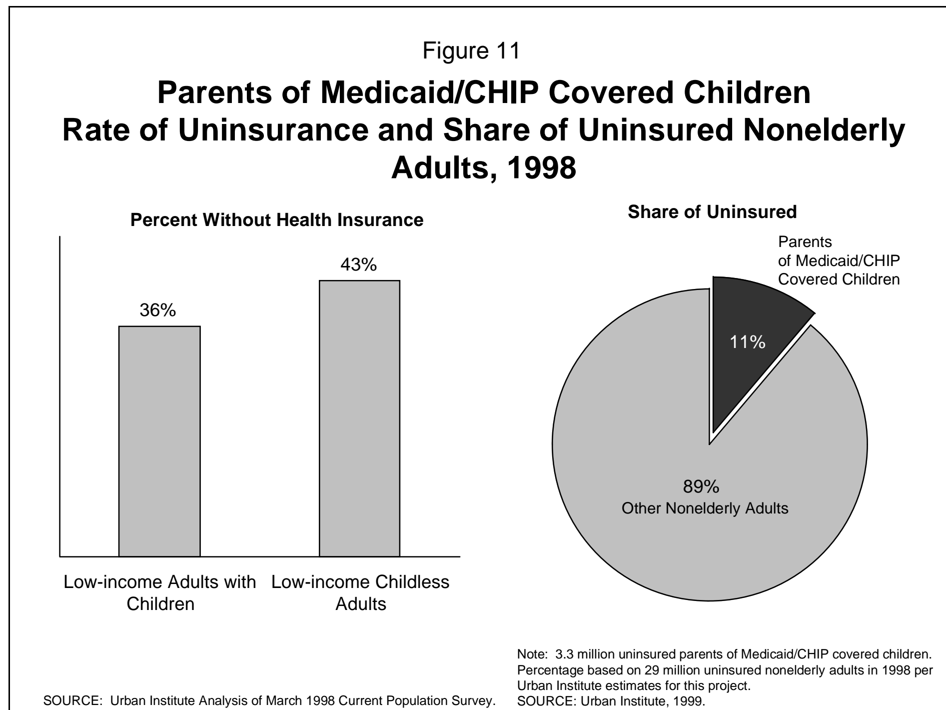
Who are the uninsured? Only 16% of poor adults (with incomes below 100% of poverty) and 41% of near-poor adults (with incomes between 100 and 200 percent of poverty) had employer-sponsored health insurance coverage, compared to 65% of adults with incomes between 200 and 300% of poverty and 83% of adults with incomes above 300% of poverty (Figure 9).



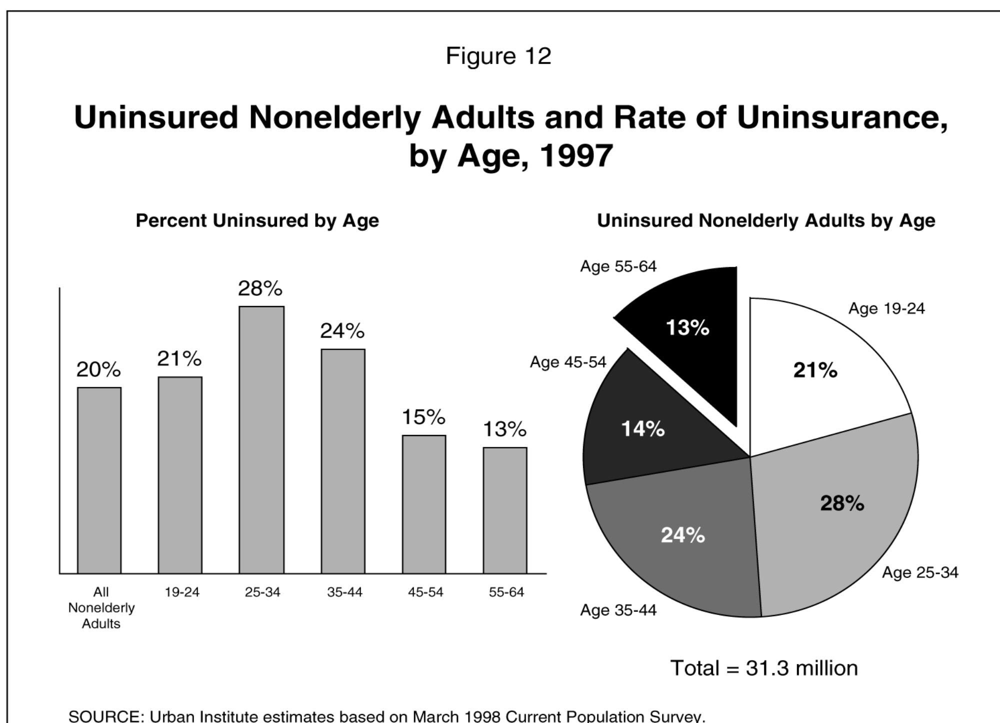
Low-income adults benefit from Medicaid, but they are far less likely than children in low-income families to have Medicaid coverage and are much more likely to be uninsured. Thirty-two percent of poor adults and 11% of near-poor adults have Medicaid, compared to 58% of poor and 24% of near-poor children. Consequently, 43% of poor adults and 36% of near-poor adults are uninsured, compared to a quarter of children in poor and near-poor families (Figure 10).



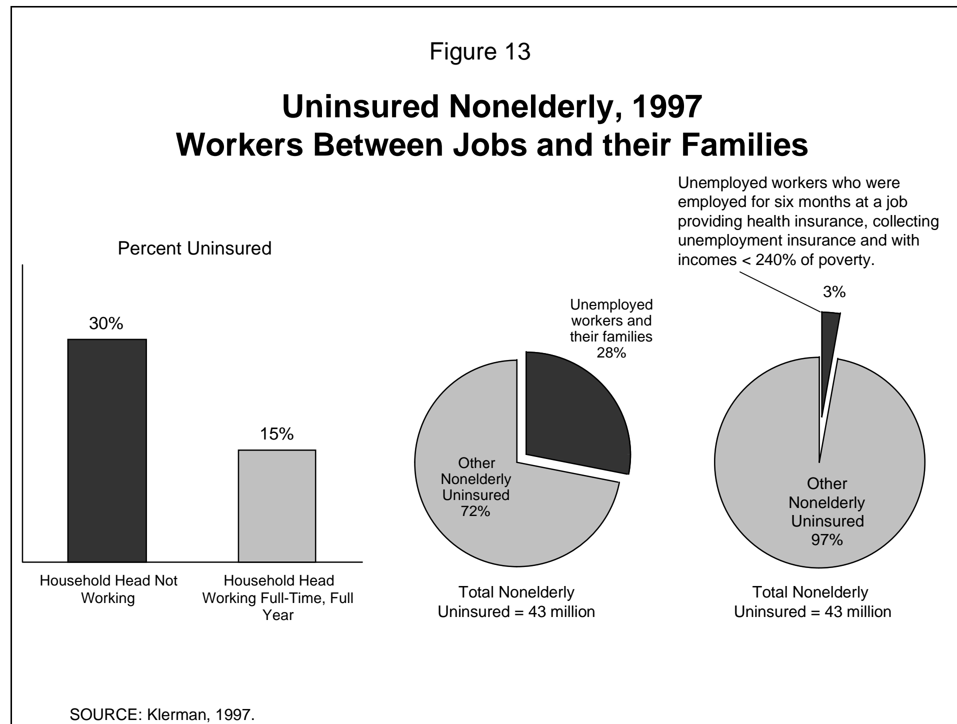
Uninsurance is high for both childless adults and low-income adults with children, at 43% and 36%, respectively (Figure 11).



Young adults are also particularly likely to lack insurance. More than 20% of adults age 19 to 24 are uninsured, 28% of those age 25 to 34 and 24% of adults age 35 to 44. Insurance coverage is higher among older adults. About 15% percent of adults ages 45 to 64 and 13 percent of adults ages 55 to 64 are without health insurance (Figure 12).



The unemployed are particularly likely to be uninsured. Among individuals in families where the family head was not working, nearly 30% were uninsured in 1997, compared to 15% of those in families where the family head worked full-time, full-year.[12] Although most of the unemployed are not uninsured, unemployed workers and their families comprise 28% of the nonelderly uninsured.[13] Unemployed individuals who, in the previous six months, lost a job that provided health insurance represent only a small portion (3 percent) of the broad unemployed uninsured population. In other words, most of the unemployed lacked coverage even while they were working (Figure 13).



Characteristics of uninsured adults. The distribution of uninsured nonelderly adults is shown in Figures 10-13**.** More than a third (34%) of uninsured nonelderly adults are poor (with incomes below 100% of poverty), 11% are parents of Medicaid or CHIP covered children, 13% are between the ages of 55 and 64, and 3% are unemployed, low-income workers and their families who were covered by health insurance on their previous job.

Trends in coverage. Over the past decade, the proportion of nonelderly adults without health coverage increased by 4 percentage points, rising from 15.6% in 1987 to 19.7% in 1997.[14] Most of this increase occurred in the first half of the decade and was caused by a significant decline in employer-sponsored coverage. Although children lost employer coverage at a faster rate than adults during this period, increases in Medicaid for children offset the decline in employer-sponsored insurance and the rate of uninsurance among children in fact declined.

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[12] Paul Fronstin, *Sources of Health Insurance and Characteristics of the Uninsured*, (Washington, D.C.: Employee Benefits Research Institute, 1998), p. 7.

[13] Jacob Alex Klerman. 1997. "Cost and Coverage of a Program to Provide Health Insurance to the Temporarily Unemployed," (Santa Monica, CA: Rand), p. 10.

[14] Paul Fronstin, *Sources of Health Insurance and Characteristics of the Uninsured*, (Washington, D.C.: Employee Benefits Research Institute, 1998), p. 5.

Rates of employer-sponsored coverage have remained more or less stable in the past few years, and a drop in Medicaid coverage is mostly to blame for increases in the proportion of adults without health coverage. The proportion of adults with Medicaid coverage dropped by one percentage point between 1994 and 1997, falling from 7.9% to 6.9%, and the proportion of adults without insurance increased by more than a percentage point, rising from 18.5% to 19.7%. Most of the recent increase in the uninsured is thus due to a rise in rates of uninsurance among adults, especially those with low-incomes.

Why health insurance matters: access to care. Adults without health insurance have more difficulty accessing the health care system and use less care as a result, often suffering adverse consequences due to delayed or postponed care.[15] One of the consequences of the lack of insurance is that the uninsured often have higher mortality rates than the insured. A study of hospitalized patients found that the uninsured were up to three times more likely to die in the hospital than privately insured patients and were less likely to receive procedures subject to discretion, including total hip replacement and coronary bypass surgery.[16] In a study of the relationship between insurance status and survival rates from 1971 to 1987, the risk of death for insured people was 25 percent higher than that of the privately insured population.[17]

The differences in health outcomes by insurance status are particularly striking in the case of women with breast cancer. Early diagnosis and treatment of breast cancer is important to successful management of disease. Women without health insurance are more likely to be diagnosed at a more advanced stage of the disease than privately insured women, and during the four to seven years following their initial diagnosis, they are 49 percent more likely to die.[18]

In an attempt to get behind these numbers and to understand the behavior that produces them, a more recent study of adults examined problems that the insured and uninsured have in getting and paying for health care. A majority of uninsured adults (53 percent) reported some difficulty in getting and/or paying for health care. The uninsured were four times more likely to report an episode of needing but not getting needed medical care, and three times more likely to report a problem paying for health care than insured adults. The sickest adults surveyed were most likely to report problems. Three out of four adults in poor health reported problems getting care and 67 percent said they had problems paying for care.[19]

Proposals to Expand Coverage

The commissioned expert proposals for adults and families can be classified into three distinct groups. (See Table 6 for brief descriptions of proposals and a comparison of their key features). First are tax-subsidy approaches of various kinds—ranging from a fundamental change in tax treatment of health insurance that would effect the entire population to more

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[15] Rowland, D., J. Feder, and P. Keenan. 1998. "Uninsured in America: The Causes and Consequences," in S. H. Altman, U. Reinhardt, and A.E. Sheilds, eds. *The Future U.S. Health Care System: Who Will Care for the Poor and Uninsured?* Chicago: Health Administration Press.

[16] Hadley, J. E.P. Steinberg, and J. Feder. 1991. "Comparison of Uninsured and Privately Insured Hospital Patients: Condition on Admission, Resource Use, and Outcomes," *Journal of the American Medical Association* 265(3): 374-79.

[17] Franks, P. C.M. Clancy, and M.R. Gold. 1993. "Health Insurance and Mortality: Evidence from a National Cohort," *Journal of the American Medical Association* 270(6): 737-41.

[18] Ayanian, J. Z.. B.A Kohler, T. Abe, and A.M. Epstein. 1993. "The Relationship between Health Insurance Coverage and Clinical Outcomes among Women with Breast Cancer," *New England Journal of Medicine* 329 (5):326-31.

[19] Donelan, K. R.J. Blendon, C.A. Hill, and C. Hoffman. 1996. "Whatever Happened to the Health Insurance Crisis in the United States?" *Journal of the American Medical Association* 276(16): 1346-50.

limited, albeit significant, changes in tax policy. Second are a set of program options aimed at particular segments of the adult population, defined by factors other than (or in addition to) income. Third are a set of proposals targeted to low-income adults.

Tax-subsidy approaches. Three distinct tax subsidy approaches were developed for this project:

- **Replacement of the tax exclusion for employer-sponsored health insurance with refundable tax credits** for unreimbursed medical expenses including insurance premiums, direct spending and contributions to medical savings accounts. The credit would be available to all, regardless of income or insurance status. The amount of the tax credit would vary with health spending as a share of income along the following lines—22 percent for expenses below 10 percent of income; 44 percent for expenses between 10% and 20% of income; 66 percent of expenses above 20 percent of income. Specific credit shares would be determined based on funds available from the tax exclusion (and savings from individuals' shift from Medicaid to the new tax-subsidy arrangement). In other words, the proposal is designed to be budget-neutral. Credits would be administered through the tax system (including employer-withholding) and could be applied to insurance policies that meet minimum standards for catastrophic coverage. Insurers would be prohibited from varying premiums based on health status and could apply only limited exclusions for pre-existing conditions (Stuart Butler).

- **An income-related tax credit** available to all families with incomes up to 500% of the federal poverty level, on the condition they obtain health insurance coverage providing at least a "bare bones" benefit. The credit would cover the full policy costs for families with incomes below 150% of poverty. Its value would decline as income raises, reaching zero at 500% of poverty. The credit would be claimed as part of the tax filing process—that is, after the year in which coverage is purchased. Health insurance would be obtained in the current private marketplace, either through direct purchase or through employment. However, any family receiving the benefit would not be eligible for the tax exclusion of employer-provided benefits (Mark Pauly).

- **Deductibility of premiums for individually purchased insurance** to parallel tax preferences for employer-sponsored coverage. Individuals without access to employer-sponsored insurance could deduct 80 percent of their premium from taxable income when filing their taxes (Gail Wilensky).

Subgroups of adults and families. Three proposals to target specific groups of adults:

- **Coverage for workers (and their families) between jobs** through COBRA subsidies for families with incomes below 300 percent of poverty. Eligibility could be limited to workers receiving unemployment insurance and could be limited to six months. Subsidies would be administered through welfare or unemployment offices and would vary with income: 90 percent of the COBRA premium for families with incomes below 200% percent of poverty, phasing out at 300 percent of poverty (Tom Rice).

- **Coverage for people ages 62 to 64** by allowing them to buy into Medicare, specifically, into private health plans participating in Medicare. Premiums would be based on a community rate for all persons potentially eligible (regardless of participation) and would be subsidized based on income. Subsidies would be based on the costs of Medicare-covered services and would equal the full cost of coverage for people with incomes

below poverty and phasing out to zero at incomes of twice the poverty level. Subsidies would also be available to persons with their own employer-sponsored insurance at the lower of their actual employee contribution or the allowed subsidy for their income level.

The Social Security Administration would determine eligibility (applied for through employers, for persons with employer-sponsored coverage) (Pam Loprest and Marilyn Moon).

Low income adults. Two options are considered for low income adults:

- **Coverage of parents of Medicaid/CHIP covered children** through Medicaid or a state-based program. The subsidy would fully cover the cost of coverage for families with income up to 100% of poverty. Families with incomes above the poverty level would pay a premium—2% of income for one parent, 4% for two.

- **Coverage of all adults with family income below poverty** through Medicaid or a state-based program. The full cost of coverage would be subsidized.

Assumptions Used to Estimate Impacts

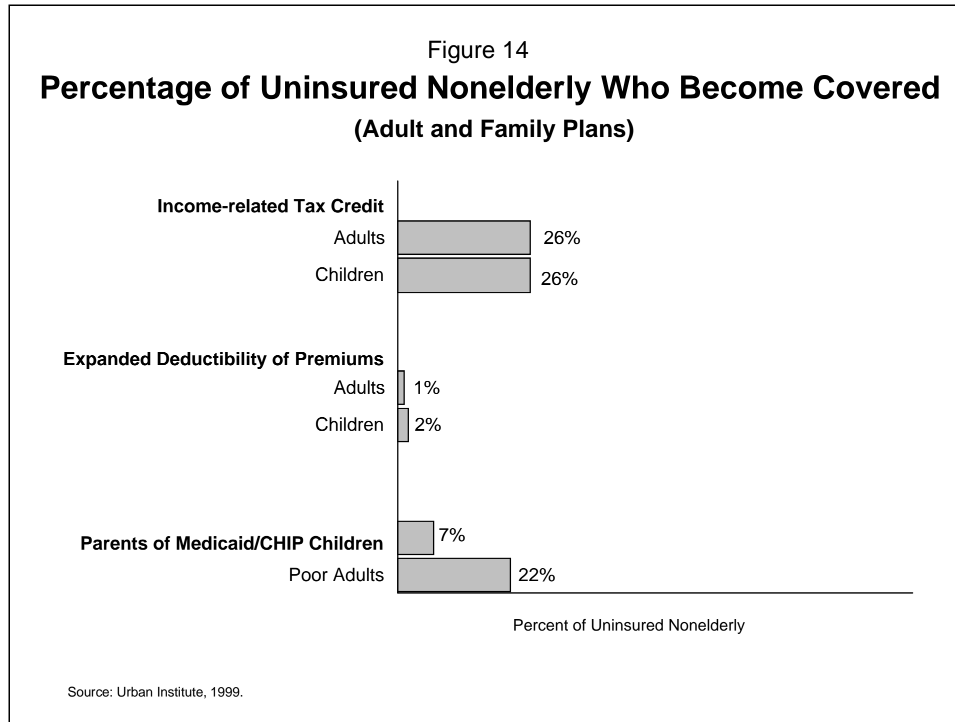
Estimates of the impact of proposals on costs and coverage were limited to the income-related tax credit proposal, the tax deductibility proposal, and the proposal for Medicaid or state-based coverage for low income adults or parents of Medicaid/CHIP-covered children. Note, however, that the tax credit proposal is estimated based on the costs of a managed care benefit, rather than a "bare bones" proposal.

In estimating the impact on coverage, the baseline was adjusted to include new coverage from CHIP. Hence, impacts here are in addition to the estimated impact of the 1997 children's program. Our approach to estimating this impact of proposals for adults and families is the same as described above with respect to proposals for children. Assumptions specific to each plan are presented in Table 7.

Impact of Alternative Approaches

Comparisons of coverage and costs for this set of proposals are presented in Figures 14 through 18. The following highlights and explains key differences across proposals.

Share of Uninsured Nonelderly Adults (and Children) Covered



The proportion of the uninsured population reached by these proposals reflects the generosity of their eligibility and of their subsidies. Specifically,

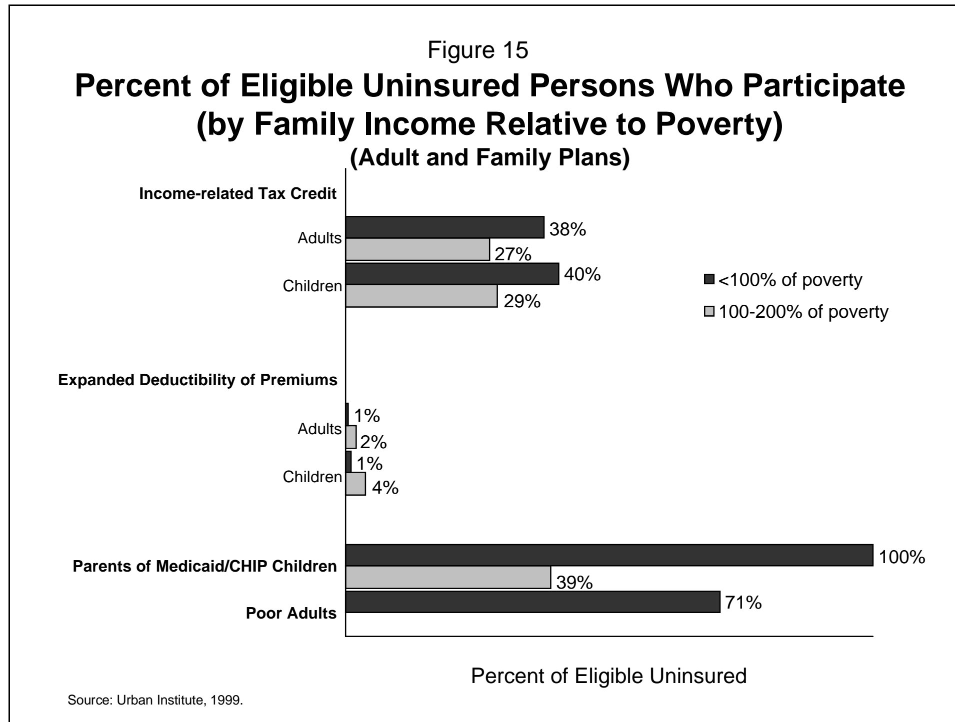
- A refundable income-related tax credit available to families across a broad range of incomes--and paying the full cost of insurance for families with incomes up to 150 percent of the poverty level--would cover a substantial segment of the uninsured population--over a quarter of adults and children respectively.

- By contrast, the very limited impact of extending tax preferences outside the workplace reflects the modesty of this subsidy relative to the costs of insurance.

- Despite much more limited eligibility--only up to the poverty level--a direct subsidy program that provides publicly sponsored coverage would reach almost as large a share of uninsured nonelderly adults as the income-related tax credit.

- A program aimed at parents of children covered under Medicaid and CHIP would reach a smaller proportion of the uninsured, because its eligible population is limited.

Share of Eligible Uninsured Who Participate, by Income



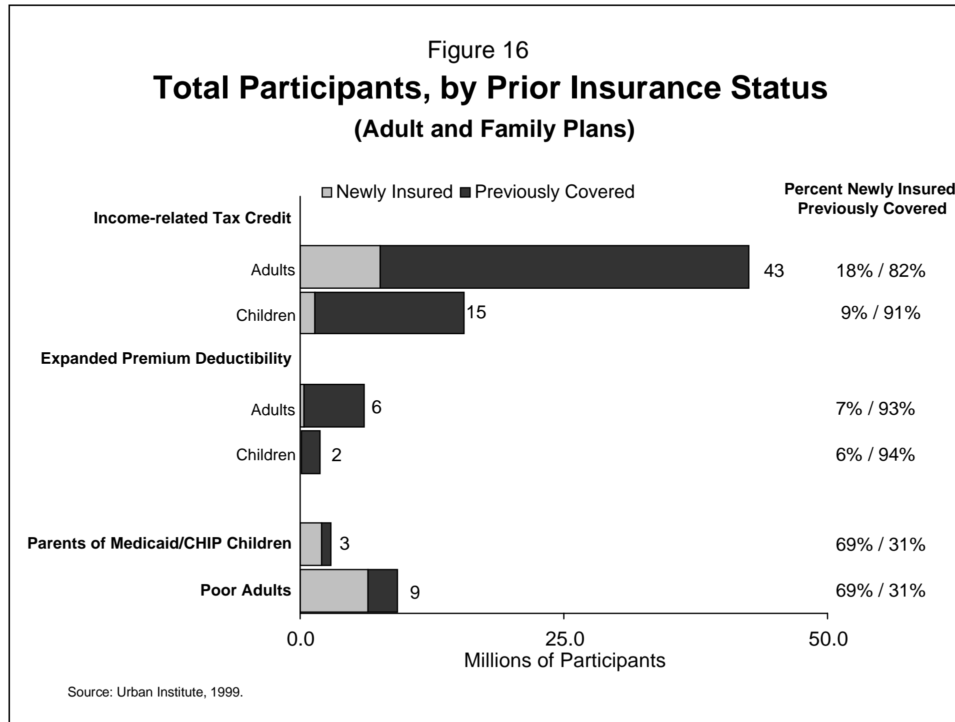
Participation by income reflects the generosity of the subsidies and the strength or weakness of other barriers to entry.

- Full participation of poor parents of already covered children in a program directed at this population reflects the fact that these parents already participate in a public program and coverage is free. (Lower levels of participation for families with incomes above poverty (39%) reflect the imposition of a premium). In a program directed at all poor adults, participation is high because coverage is free; however, barriers to enrollment produce less than full participation.

- Modest participation by the poor in the income-related tax credit reflects the absence of subsidies provided in advance. The lower participation higher up the income range reflects the phase-out of subsidies.

- Participation in the tax deductibility extension is minimal (and somewhat lower for the very poor) because of the very limited value of the subsidy relative to the cost of insurance.

Share of Participants Who Are Newly Insured



Consistent with their intent, these proposals have very different implications for the degree to which benefits are targeted to the uninsured or the already insured.

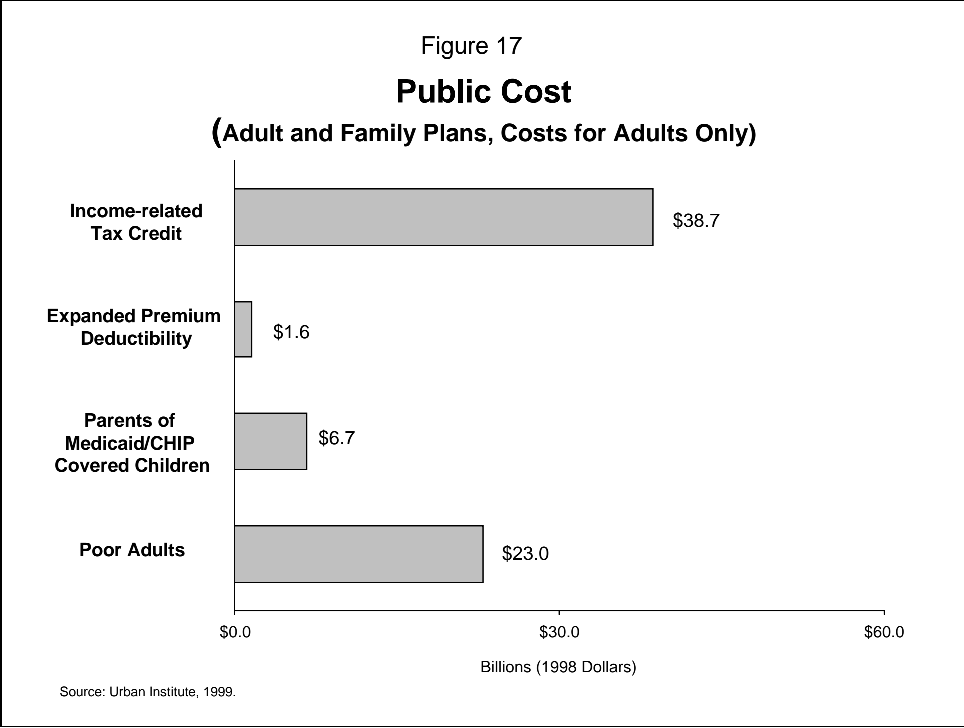
- Although the income-related tax credit reaches substantial numbers of uninsured, the bulk of its beneficiaries are previously covered--reflecting its aim of providing assistance based on income without regard to employment (and related coverage) status.

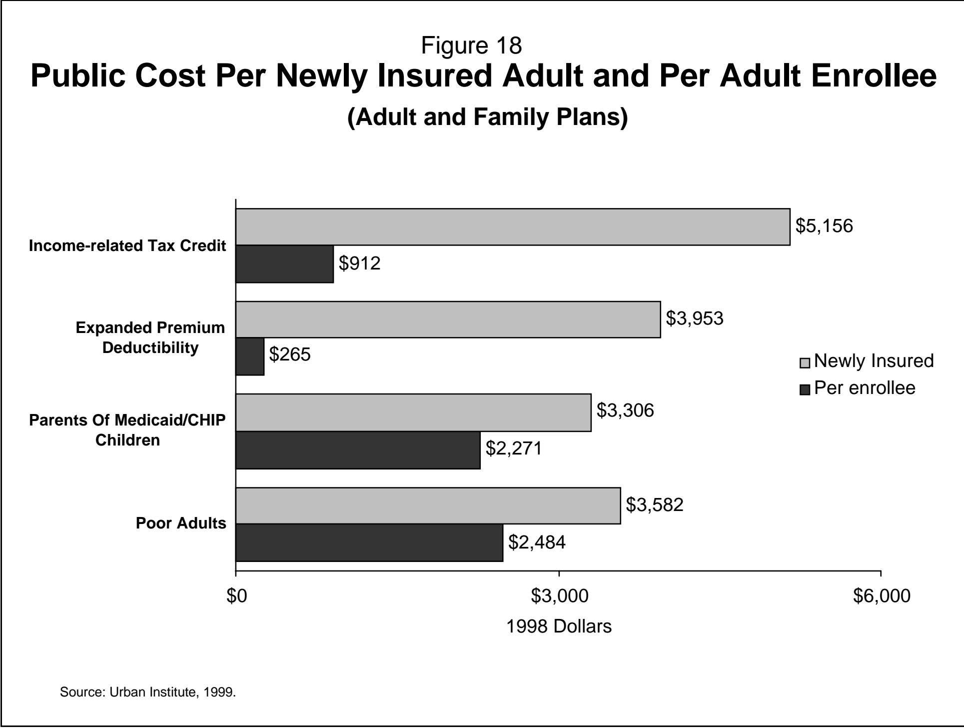
- Virtually all of the small number of participants in the tax deductibility extension are previously insured--reflecting the proposal's aim to promote equity in tax treatment, regardless of employment status.

- Proposals aimed at low income parents of covered children would likely reach some of the already insured along with the uninsured. However, because employer-sponsored private insurance coverage among the low income population is limited and people are assumed reluctant to leave it, most of the beneficiaries are newly insured.

Program Costs

Total program costs reflect the number of participants (the focus is on adults, for comparative purposes). Not surprisingly, the range is substantial—from under $2 billion where participation is very low, to nearly $40 billion where participation is extensive. More interesting are the differences in costs per newly insured adult and benefits per enrollee.





- In all proposals, costs per newly insured adult exceed benefit costs, in part because costs are spread over insured as well as uninsured participants.

- Not surprisingly, costs per newly insured adult are the largest for the income-related-tax credit, which reaches significant numbers of people without regard to prior insurance status. Its benefits per enrollee are more modest than for low income direct subsidy arrangements because it phases benefits out slowly, from 150 percent to 500 percent of the poverty level.

- Despite low total expenditures and low benefits per enrollee, costs per newly insured are substantial in the tax deductibility proposal, because it reaches so few uninsured.

- Despite significant differences in their total costs, costs per newly insured are comparable for the tax deductibility and the direct subsidy proposals. However, in the direct subsidy arrangements for low income parents of covered children and poor adults, the costs are roughly equivalent to the benefits per enrollee--because most of the benefits go to the participants who are fully subsidized. By contrast, in the extension of deductibility, the sizable expenditures per newly insured are distributed as small dollar amounts, primarily to already insured individuals.

Table 1
Summary of Health Insurance Plans
Children's Plans

Plan	Population	Other Categorical Eligibility	Financial Eligibility	Subsidy /Benefit	Insurer	Administration and Flow of Funds
Tax Credit Proposals						
Fixed Dollar Tax Credit	Children	Medicaid enrollees are ineligible	500% PL (AGI)	• Fixed Dollar Tax Credit • Refundable $500 per child • No limit on the number of children • Full credit available for families with incomes below 450% of poverty, phasing out linearly to 0 at 500% of poverty	Individual Chooses in Unrestricted Market	• IRS • Employer responsible for reporting coverage and policy value to IRS • Timing: Annual, Retrospective • Full federal funding; funds flow to families
Income Related Tax Credit (Pauly)	Children	Medicaid enrollees are ineligible	<500% PL (AGI)	• Income related tax credit to substitute for tax-shielded employer-paid premiums • Refundable • Amount tied to cost of managed care policy • Full credit available for families with incomes below 150% of poverty, phasing out linearly to 0 at 500% of poverty	Individual Chooses in Unrestricted Market	• IRS • Employer responsible for reporting coverage and policy value to IRS • Timing: Annual, Retrospective • Full federal funding; funds flow to families
Combination (Credit/Subsidy /Program) (Primus)	Children	None	All incomes	• Elimination of current child exemption • For people who insure their children, a tax credit up to $800 per child[20] plus an income related premium subsidy • Subsidy limits family contributions to 10% of earnings above threshold.	Individual Chooses State Plan or Group Market	• IRS • State welfare/ Medicaid offices • Employers responsible for reporting coverage to IRS • Full federal funding; funds flow to families

[1]. An $800 credit was modeled, rather than the $900 credit indicated in the Primus proposal.

Plan	Population	Other Catagorical Eligibility	Financial Eligibility	Subsidy/Benifit	Insurer	Administration and Flow of Funds
Combination (Income Related Tax Credit/ State Administration) (Blumberg)	Children	Federally mandated Medicaid eligibles are ineligible[1,2]	<300% PL (AGI)	• Income related tax credit • Refundable • Amount tied to "kids only" premium • Full credit available for families with incomes below 133% of poverty, phasing out linearly to 0 at 300% of poverty • Credit applied to child portion of premium only • Credit is applied first to worker premium share, with any excess applied to employer share 100% of credit can be received up front	Individual Chooses State Plan or Private Group Market	• State welfare/ Medicaid offices and other certified offices • Option for partial advance with IRS reconciliation • Employer responsible for reporting coverage and policy value to IRS • Full federal funding; funds flow to states or to employers/insurers in transferable tax credits
Subsidy Proposals						
State Subsidy Program (Merlis and Curtis)	Children without access to ESI	Federally mandated Medicaid eligibles are ineligible	<300% PL (family income)	• Income related premium subsidy • Amount tied to "kids only" premium • Full subsidy for families with incomes below 133% of poverty, phasing out linearly to 0 at 300% of poverty	State approved child health plan (single private carrier or purchasing cooperative)	• State Welfare / Medicaid Offices • Advance payments with IRS reconciliation • Full federal funding; funds flow to states

Plan	Population	Other Categorical Eligibility	Financial Eligibility	Subsidy/Benefit	Insurer	Administration and Flow of Funds
	Children with access to ESI	Federally mandated Medicaid eligibles are ineligible	<300% PL (family income)	Income related premium subsidy To promote retention of employer plan, extra subsidy available for families with access to ESI	Employer plan only	State Welfare / Medicaid Offices (or IRS) Full federal funding; funds flow to employers
CHIP Low Premium (Holahan, Uccelo, Feder)	Children	Federally mandated Medicaid eligibles are ineligible	<300% PL (family income)	State plan Free coverage for families with incomes below 150% of poverty. Thereafter, premiums are phased in to $250 at 200% of poverty and then to $375 at 300% of poverty (regardless of the number of kids).	State plan	State welfare offices and other certified offices Federally and state funded; federal funds flow to states
CHIP (Medicaid) (Holahan, Uccello, Feder)	Children	None	<300% PL (family income)	Medicaid coverage Full subsidy for families with incomes below 300% of poverty	State Medicaid	State welfare/ Medicaid offices Federally and state funded; federal funds flow to states
CHIP (Plan Implemented) (Holahan, Uccello, Feder)	Children	Non	Varies by State*	Varies by State (Medicaid/State Plans)	State plans or Medicaid	State welfare/ Medicaid offices Federally and state funded; federal funds flow to states

* CHIP (Plan Implemented) is composed of 5 plans:

30% Medicaid-based: free coverage up to 150% of poverty
5% Medicaid-based: free coverage up to 200% of poverty
10% Medicaid-based: free coverage up to 250% of poverty
45% state based: free coverage up to 133% of poverty;
premiums phase in started at $0 at 133% of poverty, to $125 at 150% of poverty, to $250 at 200% of poverty, to $300 at 250% of poverty (this results in a kinked premium curve); eligibility to 200% of poverty
10% state based: free coverage up to 133% of poverty; premiums phase in started at $0 at 133% of poverty, to $125 at 150% of poverty, to $250 at 200% of poverty (this results in a kinked premium curve); eligibility to 250% of poverty

Table 2
Baseline Participation Rates
(Individuals and Families)

INDIVIDUALS

Premium As a Percent Of Income	Cash Income		
	<150% of Poverty	150-250% of Poverty	250+% of Poverty
Free	74%	79%	86%
$1	49	56	63
<2%	36	43	52
2-6%	25	33	39
6-10%	20	28	31
10-14%	16	19	24
14-20%	11	16	20
20+	8	11	14

FAMILIES

Premium As a Percent Of Income	Cash Income		
	<150% of Poverty	150-250% of Poverty	250+% of Poverty
Free	82%	88%	95%
$1	70	80	90
<2%	60	72	86
2-6%	50	65	78
6-10%	40	55	62
10-14%	32	38	47
14-20%	22	31	39
20+	15	22	28

Table 3
Take-Up Rates
(Individuals and Families)

INDIVIDUALS

Incomes < 150% of Poverty

Premium As a Percent Of Income (Before Reform)	Premium as a Percent of Income (After Reform)							
	Free	$1	<2	2-6	6-10	10-14	14-20	20+
Free	na	na	na	na	na	na	na	na
$1	.49	na	na	na	na	na	na	na
<2%	.59	.20	na	na	na	na	na	na
2-6%	.65	.32	.15	na	na	na	na	na
6-10%	.67	.36	.20	.06	na	na	na	na
10-14%	.69	.39	.24	.11	.05	na	na	na
14-20%	.71	.43	.28	.16	.10	.06	na	na
20+	.72	.45	.31	.19	.14	.09	.04	na

Incomes 150-250% of Poverty

Premium As a Percent Of Income (Before Reform)	Premium as a Percent of Income (After Reform)							
	Free	$1	<2	2-6	6-10	10-14	14-20	20+
Free	na	na	na	na	na	na	na	na
$1	0.53	na	na	na	na	na	na	na
<2%	0.64	0.23	na	na	na	na	na	na
2-6%	0.69	0.34	0.15	na	na	na	na	na
6-10%	0.71	0.39	0.21	0.07	na	na	na	na
10-14%	0.74	0.46	0.30	0.17	0.11	na	na	na
14-20%	0.75	0.48	0.32	0.20	0.14	0.04	na	na
20+	0.77	0.51	0.36	0.25	0.19	0.09	0.06	na

Incomes 250+% of Poverty

Premium As a Percent Of Income (Before Reform)	Premium as a Percent of Income (After Reform)							
	Free	$1	<2	2-6	6-10	10-14	14-20	20+
Free	na	na	na	na	na	na	na	na
$1	0.62	na	na	na	na	na	na	na
<2%	0.71	0.23	na	na	na	na	na	na
2-6%	0.77	0.39	0.21	na	na	na	na	na
6-10%	0.80	0.46	0.30	0.12	na	na	na	na
10-14%	0.82	0.51	0.37	0.20	0.09	na	na	na
14-20%	0.83	0.54	0.40	0.24	0.14	0.05	na	na
20+	0.84	0.57	0.44	0.29	0.20	0.12	0.07	na

Table 3, continued

FAMILIES

Incomes < 150% of Poverty

Premium as a Percent of Income (Before Reform)	Premium as a Percent of Income (After Reform)							
	Free	$1	<2	2-6	6-10	10-14	14-20	20+
Free	na	na	na	na	na	na	na	na
$1	0.40	na	na	na	na	na	na	na
<2%	0.55	0.25	na	na	na	na	na	na
2-6%	0.64	0.40	0.20	na	na	na	na	na
6-10%	0.70	0.50	0.33	0.17	na	na	na	na
10-14%	0.74	0.56	0.41	0.26	0.12	na	na	na
14-20%	0.77	0.62	0.49	0.36	0.23	0.13	na	na
20+	0.79	0.65	0.53	0.41	0.29	0.20	0.08	na

Incomes 150-250% of Poverty

Premium As a Percent Of Income (Before Reform)	Premium as a Percent of Income (After Reform)							
	Free	$1	<2	2-6	6-10	10-14	14-20	20+
Free	na	na	na	na	na	na	na	na
$1	0.40	na	na	na	na	na	na	na
<2%	0.57	0.29	na	na	na	na	na	na
2-6%	0.66	0.43	0.20	na	na	na	na	na
6-10%	0.73	0.56	0.38	0.22	na	na	na	na
10-14%	0.81	0.68	0.55	0.44	0.27	na	na	na
14-20%	0.83	0.71	0.59	0.49	0.35	0.10	na	na
20+	0.85	0.74	0.64	0.55	0.42	0.21	0.12	na

Incomes 250+% of Poverty

Premium as a Percent of Income (Before Reform	Premium as a Percent of Income (After Reform)							
	Free	$1	<2	2-6	6-10	10-14	14-20	20+
Free	na	na	na	na	na	na	na	na
$1	0.50	na	na	na	na	na	na	na
<2%	0.64	0.29	na	na	na	na	na	na
2-6%	0.77	0.55	0.36	na	na	na	na	na
6-10%	0.87	0.74	0.63	0.42	na	na	na	na
10-14%	0.91	0.81	0.74	0.58	0.28	na	na	na
14-20%	0.92	0.84	0.77	0.64	0.38	0.13	na	na
20+	0.93	0.86	0.81	0.69	0.47	0.26	0.15	na

Table 4
Participation Rate Adjustments and Premium (For Those Uninsured in Baseline)
Children's Plans

Plan	Coverage	Enrollment Barrier Factor	Uncertainty Factor[1]	Cash Flow Factor[1]	Open Enrollment Factor	Premium[2]
Income-related Tax Credit	ESI and nongroup	None **0%**	Low (high cutoffs) **0%**	Low (flat dollar credit is %30 of premium) **5%**	None	$1311
Fixed-dollar Tax Credit (Pauly)	ESI and nongroup	None **0%**	Low (high cutoffs, but slow phase-out) **5-15%**	High (no advance) **5-40%**	None	$1163
Combination (Credit/ Subsidy/ Program) (Primus)	State Plan ESI and nongroup	Medium **15%** Low **5%**	None—credit can be based on last year's income. **0%**	None—credit can be based on last year's income. **0%**	Yes (state plan and nongroup) No (ESI)	$695
Combination (Inc-related Credit/State Admin) 100% (Blumberg)	State Plan ESI	Medium **15%** Low **5%**	Medium (reconciliation) **5-20%**	None (entire credit is advanced) **0%**	Yes (state plan) No (ESI)	$1079
Combination (Inc-related Credit/State Admin.) 60% (Blumberg)	State Plan ESI	Medium **15%** Low **5%**	Low (reconciliation) **5-15%**	Medium (60% of credit is advanced) **5-15%**	Yes (state plan) No (ESI)	$1051
State Subsidy (Merlis and Curtis)	State Plan ESI	Medium **15%** Low **5%**	Medium (reconciliation) **5-20%**	None (up front subsidy) **0%**	Yes (state plan) No (ESI)	$1404
Buy-In (Merlis and Curtis)	State Plan ESI	Medium **15%** Low **5%**	Medium (reconciliation) **5-20%**	None (up front subsidy) **0%**	Yes (state plan) No (ESI)	$1444
CHIP—State-based, High Premium (Holahan, Uccello, Feder)	State Plan	Medium **15%**	None (reconciliation) **0%**	None **0%**	Yes	$1051 (base) $1422 (Alt 1) $1549 (Alt 2)
CHIP—State-based, Low Premium (Holahan, Uccello, Feder)	State Plan	Medium **15%**	None (reconciliation) **0%**	None **0%**	Yes	$1051 (base) $1317 (Alt 1) $1330 (Alt 2)
CHIP—Medicaid Holahan, Uccello, Feder)	Medicaid	High **20%**	None (reconciliation) **0%**	None **0%**	Yes	$1068 (base) $1167 (Alt 1) $1133 (Alt 2)
CHIP—Plan Implemented (Holahan, Uccello, Feder)	Medicaid State Plan	High **20%** Medium **15%**	None (reconciliation) **0%**	None **0%**	Yes	$1068 (A 30%) $1166 (B 5%) $1145 (C 10%) $1220 (A 45%) $1372 (B 10%)

[1] Where a range is given, the adjustment used varies by the amount of the subsidy as a percentage of the premium. The maximum adjustment is used for families with a subsidy of 80% of the premium or more; the minimum adjustment is used for families with a subsidy of 30% of the premium or less. Adjustments for families with subsidies between 30 and 80% of the premium are based on a linear interpolation between the two extremes.

[2] Premiums for the Income-related tax credit and fixed-dollar tax credit (Pauly) represent the premiums for a children-only plan. Premiums for Primus, Blumberg, and Merlis and Curtis represent premiums for a state kids-only plan. The Blumberg state plan is a managed care plan. Premiums for Holahan et. al. represent the premiums for Medicaid. Premiums shown reflect the costs for covering one child. The cost of insuring two or more children is 2.7 times the premium for one child.

The premiums include adjustments to account for differences in the expected spending patterns among children who participate in the plan compared with already insured children. In general, these adjustments vary by the percentage of eligible children who participate in the program and whether they were previously insured. In general, plans with lower participation among previously uninsured children will have higher premiums, all else equal, because it is assumed that the children who participate are in poorer health. In addition, premiums for managed care plans are reduced to reflect the reduced spending under these plans.

Although the participation under the Blumberg and Merlis/Curtis plans are similar, their premiums differ significantly. This is because the Merlis/Curtis plan requires that the state plan include coverage for services such as dental, vision, and hearing, thus increasing the premium cost. Also, the Blumberg state plan is based on managed care while the Merlis/Curtis plan is not.

Table 5
Participation Assumptions (For Those Insured In Baseline)
Children's Plans

Plan	Families Covered by Employer-Sponsored Insurance	Families Covered by Nongroup Insurance
Income-related Tax Credit	All get credit. None drop kids from ESI to take-up kids-only nongroup insurance.	All get credit 75% of those who would save $100+ drop kids from nongroup and take-up kids only nongroup (this is relatively high because it involves moving to a private plan rather than a state plan).
Fixed-dollar Tax Credit **(Pauly)**	If credit is more than tax, then get credit. None drop kids from ESI to take-up kids-only nongroup insurance.	All get credit. 75% of those who would save $100+ drop kids from nongroup and take-up kids only nongroup (this is relatively high because it involves moving to a private plan rather than a state plan).
Combination (Credit/Subsidy/ Program) **(Primus)**	All get credit.	All get credit. 40% of those who would save $300+ drop kids from nongroup and take up state kids-only plan.
Combination (Credit/State Admin.) **(Blumberg)**	All get credit. None drop kids from ESI to take-up state kids-only plan.	Credit unavailable for nongroup coverage. 80% of those who would save $300+ drop kids from nongroup and take up state kids only plan
State Subsidy **(Merlis and Curtis)**	75% of those eligible for a reduction in ESI premium costs of $100+ get the credit (less than 100% due to demeaning nature, hassle, etc.) None drop kids from ESI and take up state kids-only plan	Credit unavailable for nongroup coverage. 80% of those who would save $300+ drop kids from nongroup and take up state kids-only plan.
CHIP— State-based **(Holahan, Uccello, Feder)**	17.5% of those who would save $300+ drop kids from ESI plan and take up Medicaid	80% of those who would save $300+ drop kids from nongroup and take up Medicaid
CHIP— Medicaid **(Holahan, Uccello, Feder)**	12.5% of those who would save $300+ drop kids from ESI plan and take up Medicaid	80% of those who would save $300+ drop kids from nongroup and take up state kids-only plan.
CHIP— Plan Implemented **(Holahan, Uccello, Feder)**	Medicaid-based: 12.5% of those who would save $300+ drop kids from ESI plan and take up Medicaid State-based: 17.5% of those who would save $300+ drop kids from ESI plan and take up Medicaid	80% of those who would save $300+ drop kids from nongroup and take up state kids-only plan.

Table 6
Summary of Health Insurance Plans
Indivdual and Family Plans

Plan	Population	Other Catagorical Eligibility	Financial Eligibility	Subsidy/Benefit	Insurer	Administration and Flow of Funds
Tax Credits						
Tax Credit for Premiums and Medical Expenses **(Butler)**	Individuals and Families	None	All Inc omes	· Elimination of tax exclusion for employer-provided health benefits and deductions for health insurance (for self-employed) and health expenses · Refundable tax credit for premiums, unreimbursed medical expenses and MSA contributions · Tax credit equal to : · 22% of expenses, if expenses are below 10% of gross income; · 44% of expenses, if expenses are between 10-20% of gross income; · 66% of expenses, if expenses exceed 20% of gross income	Private Market · Must have at least coverage with $1000 deductible ($2000 family); $5000 cost sharing minimum · Premiums can vary only by age, sex, geography and family/single coverage · Preemption of state insurance mandates	· IRS · At request of majority of employees, an employer must disband current insurance plan or allow it to be transferred to an organization chosen by the employees

Plan	Population	Other Categorical Eligibility	Financial Eligibility	Subsidy/Benefit	Insurer	Administration and Flow of Funds
Income Related Tax Credit **(Pauly)**	Individuals and Families	Medicaid enrollees are ineligible	<500% PL (AGI)	Income related tax credit to substitute for tax-shielded employer-paid premiums Refundable Amount tied to cost of managed care policy Full credit available for families with incomesbelow 150% of poverty, phasing out linearly to 0 at 500% of poverty	Individual Chooses in Unrestricted Market	IRS Employer responsible for reporting coverage and policy value to IRS Timing: Annual, Retrospective Full federal funding; funds flow to families
Expansion of Health Insurance Premium Deductibility **(Wilensky)**	Individuals and Families w/o access to ESI	None	All incomes	Deductibility of 80% of health insurance premium	Nongroup Market	IRS Timing: Annual, Retrospective Full federal funding: funds flow to families
			Subgroups			
Subsidize COBRA **(Rice)**	Workers between Jobs and their Families	$ COBRA rules $ 6 months of continuous ESI $ Medicaid enrollees are ineligible $ Must be receiving UI compensation $ Coverage limited to 6 mo.	<300% PL (family income)	Income related subsidy Maximum subsidy amount is a percent of COBRA premium 90% subsidy for those with incomes below 200% of poverty, phasing out linearly to 0 at 300% of poverty	Group Market	Employers responsible for verification of employment Welfare or unemployment offices assess income eligibility Full federal funding; funds flow to employers
Subsidized Medicare Buy-In	Persons age 62-64	Medicaid enrollees are ineligible	<200% PL (family income)	Full subsidy for persons with incomes less than 100% of poverty, phased down linearly to 0 at 200% of poverty (the subsidy is limited to the employee	Individual Chooses Private Medicare	Social Security Administration Full federal funding; funds flow to private

Plan	Population	Other Categorical Eligibility	Financial Eligibility	Subsidy /Benefit	Insurer	Administration and Flow of Funds
Subsidized Medicare Buy-In (Loprest and Moon)	Persons age 62-64	Medicaid enrollees are ineligible	<200% PL (family income)	• Full subsidy for persons with incomes less than 100% of poverty, phased down linearly to 0 at 200% of poverty (the subsidy is limited to the employee contribution for persons choosing to use the subsidy toward an employer-sponsored plan) • Persons with incomes over 200% of poverty could buy-in at full cost	Individual Chooses Private Medicare Plans or Group Market	• Social Security Administration • Full federal funding; funds flow to private Medicare plans
Low-Income Adults						
Expansions for Low-Income Adults (Holahan)	Parents of Medicaid/ CHIP Covered Children	Kids enrolled in Medicaid	All	• Free coverage up to 100% of poverty for parents of children enrolled in Medicaid/CHIP • Thereafter, premiums are 2% (4%) of income for families covering 1 (2) parents • No income eligibility limit	State Plan	• State welfare/ Medicaid offices • Federally and state funded; federal funds flow to states
	Poor Adults	None	<100% FPL	• Free coverage up to 100% of poverty for adults without children	State Plan	• State welfare/ Medicaid offices • Federally and state funded; federal funds flow to states

Table 7
Participation Rate Adjustments and Premium (For Those Uninsured in Baseline)
Family and Individual Plans

Plan	Coverage	Enrollment Barrier Factor	Uncertainty Factor[1]	Cash Flow Factor[1]	Open Enrollment Factor	Premium
Income-related Tax Credit **(Pauly)**	ESI and nongroup	None **0%**	Low **5-15%**	High (no advance) **5-40%**	None	Premiums faced in the baseline
Expanded Premium Deductibility **(Wilensky)**	Nongroup	None **0%**	None **0%**	Medium **5-15%**	None	Nongroup Premiums faced in the baseline
State-based Expansion for Parents of Medicaid/ CHIP Covered Children **(Holahan)**	State Plan	None **0%**	None **0%**	None **0%**	Yes	Initial composite premium : $2,472; Final composite premium: $2,514
State-based Expansion for Poor Adults **(Holahan)**	State Plan	Medium **15%**	None **0%**	None **0%**	Yes	Adults with kids in Medicaid: (same as above) Adults with no kids, or without kids in Medicaid: Initial composite premium : $2,472; Final composite premium: $2,293

[1] Where a range is given, the adjustment used varies by the amount of the subsidy as a percentage of the premium. The maximum adjustment is used for families with a subsidy of 80% of the premium or more; the minimum adjustment is used for families with a subsidy of 30% of the premium or less. Adjustments for families with subsidies between 30 and 80% of the premium are based on a linear interpolation between the two extremes.

* Composite premiums are average for the 18-64 age range. Premiums for three age ranges were used in simulations: Premiums for age 18-34 = .986*composite; Premiums for age 35-54 = 1.042*composite; Premiums for age 55-64 = 1.775*composite.

Table 8
Participation Assumptions (For Those Insured In Baseline)
Family and Individual Plans

Plan	Families Covered by Employer-Sponsored Insurance	Families Covered by Nongroup Insurance
Income-related Tax Credit **(Pauly)**	If credit is more than tax, then get credit.	All get credit.
Expanded Premium Deductibility **(Wilensky)**	Ineligible	All get credit. Some families with uninsured members may upgrade coverage.
State-based Expansion for Poor Adults **(Holahan)**	17.5% of those who would save $300+ drop ESI plan and take up state plan	80% of those who would save $300+ drop nongroup and take up state plan
State-based expansion for Parents of Medicaid/CHIP Covered Children **(Holahan)**	No parents with family coverage would drop their coverage to participate in the state-based plan if this would mean a loss of coverage for dependents. If there would be no such losers of coverage, parents drop according to the following: 17.5% of those who would save $300+ drop ESI plan and take up state plan	No parents with family coverage would drop their coverage to participate in the state-based plan if this would mean a loss of coverage for dependents. If there would be no such losers of coverage, parents drop according to the following: 80% of those who would save $300+ drop nongroup and take up state plan (as long as there are no family members who would lose coverage).

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