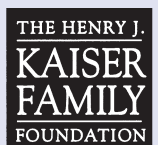


# THE KAISER PROJECT ON INCREMENTAL HEALTH REFORM

## *Options for Expanding Health Insurance Coverage*

### A Report on a Policy Roundtable

**Judith Feder and Sheila Burke, Editors**



October 1999

The Henry J. Kaiser Family Foundation, based in Menlo Park, California, is an independent national health care philanthropy and is not associated with Kaiser Permanente or Kaiser

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## Preface

The purpose of the Henry J. Kaiser Family Foundation conference, “Options for Expanding Health Insurance Coverage: What Difference Do Different Approaches Make?” held in Washington, D.C. on February 17, 1999, was to engage congressional and administration staff, other federal officials, state policymakers, academics and selected members of the press in a discussion of the trade-offs and controversies associated with alternative approaches to expanding health insurance coverage--all of which are either in the process of implementation (new state programs vs. Medicaid under the Children’s Health Insurance Program (CHIP)) or under consideration (tax preferences vs. direct subsidies, use of the CHIP model for adults).

The conference was a key part of the Henry J. Kaiser Family Foundation’s Incremental Health Reform Project. In November 1996, the Foundation initiated a project to examine different strategies for expanding health insurance coverage. The project began by soliciting the development of alternative proposals from experts with diverse points of view: Linda Blumberg, Stuart Butter, Rick Curtis, John Holahan, Pamela Loprest, Mark Merlis, Marilyn Moon, Mark Pauly, Wendell Primus, Tom Rice and Gail Wilensky. 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. The next step was to systematically estimate and compare the impacts of these proposals on coverage and costs, using a common set of assumptions about incentives, disincentives and individual behavior.<sup>1</sup> In addition, a number of analysts were commissioned to explore a variety of issues related to incremental reforms from a variety of perspectives—ethical, political, and empirical.<sup>2</sup>

At the February, 1999 conference, more than 60 individuals representing diverse points of view were invited to present papers and engage in a discussion of the policy, politics and likely impacts of alternative coverage proposals. An overview of the results of the Incremental Reform Project was presented to open the conference and presentations and discussions then focused on issues related to: (1) federal entitlements vs. state discretion; (2) tax preferences vs. direct subsidies; and (3) causes, costs and consequences of crowd out.

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<sup>1</sup> Sheila Zedlewski and Cori Uccello of the Urban Institute undertook the empirical estimates, with assistance from the Actuarial Research Corporation, input from the proposals’ authors and advice from a committee of policymakers and policy experts.

<sup>2</sup> See Appendix A for a list of the expert proposals and issue papers.

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How to expand health insurance coverage is as much an issue today as it was in 1993 when the nation began to engage in an intense debate about health care coverage. At that time, 39 million Americans were without insurance coverage; today, over 43 million Americans are without coverage. In the interim, the President and the Congress have taken some significant steps to address coverage problems – enactment of the Health Insurance Portability and Accountability Act, to promote the availability of insurance, especially to individuals with health problems; and enactment of the State Children’s Health Insurance Program (CHIP), to ensure the affordability of insurance for low income children. However, politicians and analysts alike recognize the importance of further policy initiatives to reduce the scope of “uninsurance”— or, more positively stated, to assure more Americans the affordable access to medical care that health insurance provides.

Further, public opinion polls suggest some renewed public interest in coverage issues that may well stimulate policy debate. First, although no particular policy issue—related to health insurance or any other social concern—currently dominates public views on an agenda for a new Congress and a new President, health issues in general and the problem of the uninsured in particular are receiving noticeable attention. In recent opinion polls, the public has accorded a high priority to health care issues. Even more notable, among those who identified health care as an important issue, providing basic health insurance coverage for all Americans ranked as the number one issue, ahead of the issue historically at the top – making health care more affordable. Second, the public is as divided as they have ever have been on options for coverage expansion (including tax preferences vs. direct subsidies) and on willingness to pay the costs an expansion will entail. Even with renewed interest, these “political realities” suggest that policy initiatives with respect to coverage will likely continue to be incremental—in steps, rather than comprehensive or wholesale reform.

Although more modest in scope, options for incremental health insurance reform are nevertheless hard to design, hard to enact and hard to administer. Given these difficulties, the Henry J. Kaiser Family Foundation is supporting efforts to thoughtfully consider and evaluate the potential for and likely impact of alternative options.

Drew Altman

Diane Rowland

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## **Executive Summary**

Judith Feder and Sheila Burke

With 43 million Americans uninsured, policy initiatives to expand coverage are once again on the policy agenda. The Kaiser Family Foundation's Project on Incremental Health Reform aims to inform public debate through a series of research activities, reports, and policy forums. Phase I of this project, initiated in November 1996, commissioned a series of coverage proposals, a comparative assessment of the impact of those proposals on coverage and costs, and a set of analytic papers on various issues raised by incremental health insurance expansions.

In February, 1999, the products of Phase I of the Kaiser project served as the foundation for a roundtable discussion among policymakers and researchers from across the political and policy spectrum. The conference report summarizes that discussion, which took four approaches to comparing alternative coverage strategies: a comparison of the predicted impact of alternative strategies on coverage of the uninsured; consideration of the policy and political issues of federal entitlements vs. state discretion, as raised by the passage and implementation of the Children's Health Insurance Program (CHIP); assessment of the relative strengths and weaknesses of two specific strategies--tax preferences vs. direct subsidies--in reaching the uninsured; and examination of the causes, costs and consequences of "crowd-out"--the potential substitution of public for private expenditures posed by coverage initiatives.

In prepared reports, formal presentations, and actual discussion, the roundtable raised the following set of findings and questions for future policy initiatives.

### **A COMPARISON OF STRATEGIES' IMPACTS**

Any proposal to expand health insurance will ultimately be judged by its impact on coverage and costs. But impacts are hard to predict in advance--not only because they vary in specific features (like who is eligible, for what benefits and on what terms) but also because impacts depend on the 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).

Predictions of any proposal's impact requires assumptions and a comparison across proposals requires a common set of assumptions. No assumptions are perfect, all are subject to challenge, and the results they produce are suggestive, not definitive. The contribution of the Kaiser Project's analysis is not, therefore, in the specific coverage or cost numbers produced for any particular proposal. Rather it is its use of a common and clearly articulated set of assumptions to answer the same questions for a set of specific and varied proposals developed by experts with different points of view. The literature and experience indicate that the following behavior patterns underlie people's likely responses to these different coverage proposals:

- Regardless of approach, participation will be greater, the greater the value of the subsidy. Subsidies will have the greatest impact if they cover the full cost of coverage; participation falls off sharply--most dramatically for people with lower incomes--once people are expected to pay.
- Regardless of approach, eligible individuals may face barriers to participation. With direct subsidies, the greatest potential barriers are an application process perceived as demeaning, an enrollment process experienced as burdensome, and a care delivery system perceived as providing poor quality of care. With tax policies, the primary barriers are timing and predictability of subsidy. Subsidies provided (or adjusted) at year's end, rather than guaranteed in advance, will limit participation by low-income people.
- Regardless of approach, the easier it is to obtain benefits or to apply them to existing employer-sponsored insurance, the greater will be the "crowd-out"--that is, the participation by the already insured.

### **Findings:**

**What share of the uninsured population will be reached?** The likelihood that coverage proposals will reduce the numbers of uninsured varies substantially with the generosity and design of the subsidy. Estimates of the proportion of the uninsured population reached by a specific set of different types of proposals are:

- 1 to 2 percent of uninsured adults and children with a proposal to extend tax deductibility for insurance premiums to individuals lacking employer-sponsored insurance;
- 7 percent of uninsured adults with a proposal to extend Medicaid or CHIP to parents of already-covered children;
- 22 percent of uninsured adults with a proposal to provide direct subsidies under Medicaid or CHIP to all adults (whether childless or parents) with incomes below poverty;
- 26 percent of uninsured adults and children with a proposal to provide a tax credit for the full cost of coverage to families with incomes up to 150% of poverty, declining as income rises up to five times the poverty level.



**How do different proposals affect the low income uninsured?** Proposals that achieve similar impacts on the overall uninsured population may differ considerably in reaching the low income uninsured population. Participation is far greater among the low income uninsured under the proposed expansion of direct subsidies, for example, than under this tax credit proposal. Extremes of participation reflect different barriers to enrollment. Fewer than one percent of eligible uninsured poor adults would likely obtain coverage in response to this proposal to extend tax deductibility for premiums, given the limited value of the subsidy relative to the costs of insurance.. By contrast, virtually all eligible uninsured parents of Medicaid or CHIP covered children would likely respond to this proposed expansion of coverage to parents, given a full cost subsidy and the families already- demonstrated willingness and ability to overcome administrative barriers to enrollment.

**What Share of Participants Will be Uninsured vs. Previously Insured?** Partly because of differences in their objectives, approaches differ in their targeting of the uninsured. Virtually all participants in the proposed tax deductibility expansion are previously insured-- reflecting the proposal's aim to promote equity in tax preferences for the purchase of insurance, whether outside or inside employment.. Similarly, because of the relative ease of participation for the already insured in the proposal to provide tax credits, over 80 percent of its participants are estimated to be previously insured. By contrast, close to 70 percent of participants in direct subsidies targeted to the poor are estimated to be newly insured.

**What Is the Public Cost per Newly Insured Individual?** In all proposals, costs per newly insured adult exceed benefit costs, in part because costs are spread over already insured as well as newly insured participants. But proposals vary substantially in what might be considered "bang for the buck." Extending this tax credit to people with incomes up to five times the poverty level, regardless of prior insurance status, is estimated to cost over \$5000 per newly insured individual--over five times the value of estimated benefits per enrollee. By contrast, direct subsidies targeted to the low income population are estimated to cost \$3300-\$3500 per newly insured, far closer to the benefits per enrollee (\$2300-\$2500). Expanded tax deductibility would cost only a little more per newly insured individual--about \$4000. However, unlike the direct subsidy approach, in which most of the benefits are targeted as full subsidies to previously uninsured participants, under this tax deductibility proposal the expenditures are distributed as small dollar amounts (\$265 on average), primarily to people who are already insured.

### **FEDERAL ENTITLEMENTS VS. STATE DISCRETION: LESSONS FROM CHIP**

Despite what sometimes seemed to be insurmountable political and policy obstacles, Congress enacted a program in 1997 to expand coverage for children. Today, virtually all states are participating. That program represents a compromise between federal entitlements and state discretion. In many respect, it is too early to tell what the impact of this program will actually be on coverage and the extent to which it will provide either a political or operational model for future coverage initiatives. Nevertheless, participants in and observers of CHIP's enactment and early implementation of CHIP see some important lessons and significant questions in experience to date.

## **Findings:**

**What made CHIP's enactment possible?** It is hard to say with precision what makes a particular legislative accomplishment happen. But with respect to CHIP, participants and observers see several elements that had the stars aligned in 1997: economic conditions and budget politics made the money available; kids were popular as a target population; both states and the federal government were supportive of expansion; and bipartisan support was present at both the state and federal levels. Whether, when, and for whom the stars similarly come into alignment remain decidedly uncertain.

**What made states respond to CHIP's offer of federal funds?** Not everybody draws the same conclusion. Some participants and observers argue that giving states the opportunity to "build their own" programs with limited fiscal liability was essential to achieving state expansions. Others argue that economic prosperity, enhanced federal matching funds, and public attention to the importance of children's coverage would have made states willing to expand coverage, even if federal dollars were provided only in the Medicaid context. Whether CHIP's compromise between federal entitlements and state discretion was one of many ways to expand coverage or the only way to expand coverage will remain a matter of debate.

**How much will CHIP expand coverage and for whom?** Although states are participating in CHIP, participants and observers agree that we lack the data to assess to what extent and for whom coverage is actually expanding. Further, CHIP's design makes coverage of higher income uninsured children fiscally more attractive to states than coverage of low income children; includes premiums and cost-sharing requirements that, despite some protections, may pose significant barriers to participation; and allows states to make enrollment in new state-based programs easier and more attractive than enrollment in Medicaid.

Participants and observers across the political spectrum agree that data on how many and what kind of children are participating in new state-based programs as well as in Medicaid are essential to determine how well CHIP is working and--more specifically--whether it is expanding or reducing coverage inequities across income groups. Although participants and observers may disagree on means, they agree that active measures to facilitate rather than inhibit enrollment, regardless of applicants' income or program auspices, are critical if coverage objectives are to be achieved.

## **Questions/ Concerns Raised by CHIP:**

As a work-in-progress, CHIP generates a number of questions regarding current and future policy initiatives:

- Are we willing to de-stigmatize enrollment for all families eligible for public programs? Or will we favor the working low-income over the very poor? Are we willing to invest as much resources and energy in facilitating enrollment in Medicaid as we are in new state programs?

- Will the flexibility CHIP gives to the states reduce or exacerbate variation around the nation in benefits and programs?
- What will happen to coverage if economic circumstances change? Will a recession in programs without an entitlement result in waiting lists, cutbacks in services or increased premiums or cost-sharing? Or will it lead to cutbacks in Medicaid and preference for newly developed state programs?
- Does Medicaid's entitlement along with other federally- required protections make it more appropriate than a variety of state-designed programs to provide a nationwide floor on insurance protections?

### **COMPARING TAX PREFERENCES AND DIRECT SUBSIDIES**

Different strategies for incremental coverage have different goals and, as indicated by the analysis presented above, are likely to result in different outcomes. Specifically, pursuit of greater equity in tax treatment of insurance is not the same as pursuit of expanded coverage. In evaluating strategies, its important to be clear about objectives.

That said, if our goal, or, in the words of one participant, our “endgame”, is expanding coverage, it is important to recognize that different population groups are in different circumstances and that some strategies will work better for some populations than others. Higher income people tend to be regularly employed and mostly insured. Among modest income people, there's more variation: most of them work most of the time; some of them have insurance, some of the time; some of them don't. For low income people, work and insurance may be tenuous at best. Depending on which group we're aiming at, the policy solutions we choose may be very different.

#### **Findings:**

**Can tax strategies expand coverage for the low income uninsured?** Tax strategies that promote equity and may, if well-designed, expand coverage among the better off are not an effective mechanism for reaching the low income uninsured. Even strong proponents of tax preferences--notably tax credits--conclude that tax policies are suited to a population with steady employment and income, not a population that tends to be “on the edge.” To paraphrase one advocate of tax preferences: for people who are poor, some government program has to pay the full cost of insurance.

**Do direct subsidy programs work?** Medicaid is enormously resilient and flexible in addressing the problems of low-income people. Consideration of tax mechanisms to expand coverage should not diminish financial support for a fundamental safety net that rests on direct subsidies. In other words, enthusiasm for covering people who are less poor should not cause us to forget what works for the poorest.

**Can we reach different populations at the same time?** Achieving both equity and coverage requires a combination of tax changes and provision of direct subsidies aimed at the low-income uninsured. As long as we don't forget about the poor, we can look at ways that might address the problems of other groups. Our job is to identify the critical pieces that might constitute a broad coverage strategy and make them fit together so that the "system" works. That may mean as much attention to administrative issues--what we can design and put in place that will actually work--as to political feasibility.

**Can we make tax strategies work?** Changes in tax policies will not by themselves change the functioning of private insurance markets. To work effectively to provide coverage, tax strategies must be designed to assure access to affordable coverage, regardless of health status. Agreement exists on these ends, even as there is disagreement on the means to achieve them. However, there appears to be a tradeoff between the administrative simplicity that makes tax policy attractive and the administrative requirements of making tax policy effective in expanding coverage. How much we're willing to trade will affect how effective tax strategies are likely to be.

#### **Questions/Concerns Raised by Tax Strategies:**

- Even if targeted to modest rather than low income people, can administrative mechanisms be found that provide individuals sufficient liquidity in a timely and predictable fashion to assure participation?
- To what extent will the extension of tax policies outside employment lead employers to stop providing or contributing to coverage.
- Are we willing or able to accompany tax strategies with policies that overcome the inefficiencies and inequities of the individual insurance market? Will we promote mechanisms that truly pool risk?

#### **ASSESSING COSTS, CAUSES AND CONSEQUENCES OF CROWD-OUT**

No initiative to expand health insurance coverage is perfect. Although incremental coverage expansions avoid the "imperfections" of replacing wholly new systems for existing ones, they pose the daunting challenge of making new programs operate alongside existing ones. To a significant extent, the objective of incremental expansion is to add to, not replace, coverage already provided. However, pressure to avoid or minimize the substitution of new public programs or expenditures for ongoing private insurance or private spending is perhaps one of the most frustrating--and, some would say, unfair--tasks in the design of incremental coverage initiatives.

Although we frequently use different language in discussing tax preferences and direct subsidies, both strategies raise questions of substitution. As outlined above, tax preferences are far more likely to benefit the already insured than the uninsured. As such, they substitute public for private dollars. This substitution is frequently advocated on grounds of equity arguing that benefits should be provided regardless of where or how people purchase insurance (outside as well as inside employment). By contrast, when direct subsidies (like CHIP's) reach the previously insured--and substitute public for private coverage-- they are criticized as "crowding-out" private coverage. This substitution is also a matter of equity arguing that benefits should be provided regardless of employer behavior--that is, whether or not an employer provides coverage.

### **Findings:**

- Achieving equity under either policy requires an expenditure of resources beyond the uninsured. With tax policies, all or most of newly invested resources go to the already insured.. Direct subsidies more effectively target the uninsured. But they too are likely to reach some of the already insured.
- Whether substitution is a problem or a benefit is a policy question. Extending tax preferences substitutes public for private spending, justified on grounds that tax policy should be equitable. Prohibiting direct subsidies (like CHIP's) for individuals who have employer coverage avoids substitution of public for private spending, on grounds that resources should be targeted to the uninsured. The distinction is matter of choice, rather than principle
- The higher up the income scale benefits are provided, the greater the likelihood that substitution or crowd-out becomes—even if the rate at which the already insured drop private coverage is the same. For children, fore example, extending subsidies to families with incomes at 300 percent of the federal poverty level potentially reaches over 21.8 million children; about 80 percent of whom already have insurance. That's more than twice the number of potential eligibles at 250 percent of poverty, fewer than 70 percent are already insured.
- Without a commitment to resources and outreach, policies that ignore the potential for substitution may skew benefits toward the previously insured rather than the uninsured. Extending subsidies to low income people with employer-based coverage and allowing them to keep it makes enrollment both easy and attractive. Unless enrollment is made similarly easy and attractive in public programs, the uninsured will fail to achieve coverage.
- Measures aimed at preventing substitution in direct subsidy programs may backfire or pose new problems. Charging even modest premiums in direct subsidy programs deters participation by the uninsured, without significantly reducing the financial attractiveness of participation to those already spending a lot to purchase insurance. As a result, a larger share of newly invested resources will go to the already-insured than would have occurred in the absence of premiums. Charging higher premiums can redress this balance but does so by discouraging participation by both the uninsured and the insured. Beyond premiums,

requirements to prevent substitution pose new inequities--e.g. making people who have lost employer-sponsored insurance go without protection for a period before allowing them to receive public subsidies.

- As long as we are willing to pay its costs and pay as much attention to the very poor along with those less poor, we should recognize that substitution of public for private coverage has benefits as well as costs. Estimates of savings to previously insured low income families made eligible for direct subsidies are about \$1000 per family, with additional savings for employers who previously provided coverage. Families with low incomes who have coverage are giving up wages and bearing out-of-pocket burdens to obtain it; on equity grounds, they are no less worthy of coverage than people with similar incomes who are without insurance protections.

### **Thoughts for the future**

The roundtable summarized in this report presents evidence of commitment across the political and philosophical spectrum to continued expansion of health insurance coverage. Whether incremental or comprehensive, achieving expansion will never be easy. Systematic analysis of past experience and future options can nevertheless clarify our choices; and convening to consider and discuss that analysis, along with impressions of past experience and future opportunities, can strengthen our collective commitment to moving forward. With support from the Kaiser Family Foundation, we will continue to promote such thoughtful deliberations, hopefully mitigating an inevitably contentious policy process.

## Tradeoffs Raised by Coverage Expansions

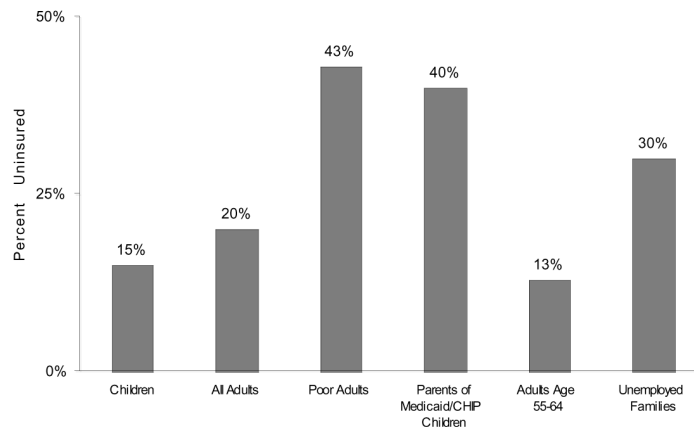
Judith Feder

Initiatives to expand health insurance coverage incrementally require two distinct and fundamental choices. The first is the population group to be covered; the second is the policy mechanism used to provide coverage. As noted above, the Henry J. Kaiser Family Foundation Project on Incremental Health Reform solicited proposals aimed at different populations and using different mechanisms. The following comparison of proposals and their likely impacts – presented by Judith Feder – begins with some description of different target population groups; then turns to a comparison of the impacts of alternative proposals for providing them coverage.<sup>3</sup>

### Choosing a Population Group for Coverage Expansion

Although a variety of considerations can affect the choice of a population group for coverage expansion<sup>4</sup>, two issues are clearly relevant – the extent to which lack of insurance is a problem for the group and the share of the uninsured population a given group represents. Figure 1 shows the extent of uninsurance for different groups within the population; Figure 2 shows the proportion of the uninsured that fall into different groups targeted by specific policy proposals.

Figure 1  
Risk of Uninsurance



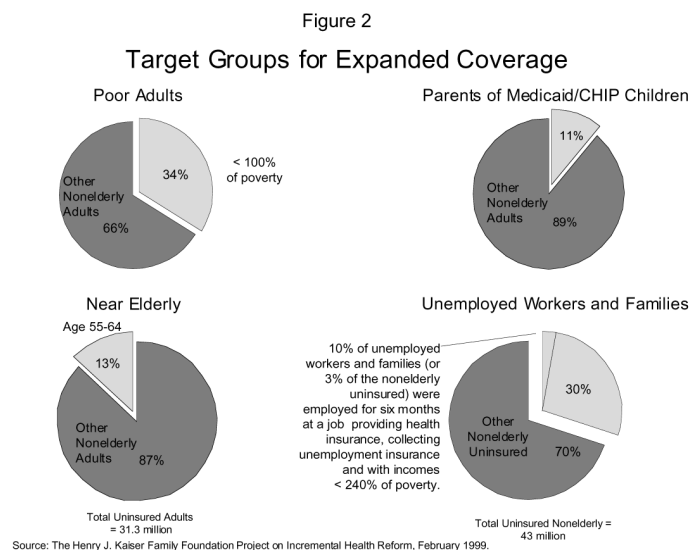
Source: The Henry J. Kaiser Family Foundation Project on Incremental Health Reform, February 1999.

<sup>3</sup> This presentation summarizes the results presented in Judith Feder, Cori Uccello, and Ellen O'Brien, "The Difference Different Approaches Make: Comparing Proposals to Expand Health Insurance." Incremental Health Reform Project, The Henry J. Kaiser Family Foundation, 1999.

<sup>4</sup> For an ethical perspective on choosing a population group, see Ruth Faden and Madison Powers, "Incrementalism: Implications of Policy Choices," Incremental Health Reform Project, The Henry J. Kaiser Family Foundation, 1999.

Looked at by age, two findings are clear: adults are significantly more likely to be uninsured than children (20 percent of adults and 15 percent of children were without insurance in 1997) and younger adults are more likely to be uninsured than older adults (13 percent of 55 to 64 year olds were uninsured in 1997, compared to 21 percent of 19 to 24 year olds and 28 percent of 25 to 34 year olds). Looked at by income, poor adults are particularly likely to be uninsured – with 43 percent uninsured, with somewhat higher rates for childless adults than for parents (43 percent vs. 36 percent). Finally, looked at by employment status, the unemployed are far more likely to be uninsured than those working full-time (30 percent vs. 15 percent).

Choosing different population groups means addressing different proportions of the overall uninsured population. Figure 2 shows the differences. Most proposals reach relatively small proportions of the uninsured. Proposals to cover parents of Medicaid or CHIP covered children or adults ages 55-64 would cover just 11 and 13 percent respectively of the more than 31 million uninsured adults. Covering individuals in families of some temporarily unemployed workers who lose their insurance (limiting eligibility to the previously insured, low-income unemployed receiving unemployment insurance, or about 10 percent of the overall unemployed, uninsured population) would cover just 3 percent of the nonelderly uninsured. By contrast, poor adults represent over a third of uninsured adults.



The incidence of uninsurance and size of the affected population are not the only issues to consider in choosing a target population for incremental coverage. Older adults are sicker and have a harder time finding coverage; people who lose their jobs have trouble holding onto their coverage. Further, targeting smaller groups requires a smaller investment of public resources and may be easier to accomplish than addressing sizable segments of the uninsured population. It is nevertheless important to keep in mind that low-income adults stand out as the population most likely to lack insurance and most substantial as a share of the uninsured.



## Choosing a Mechanism for Coverage Expansion

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 insured, will actually take advantage of new benefits. No one knows with certainty what these responses will be, but estimating the impact of policy initiatives requires that we draw on experience to make some assumptions about what they are likely to be.

Analysis and comparison of a range of proposals required that we develop a common set of assumptions about participation under different circumstances and incentives. 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 and applying them consistently and explaining how they work, this analysis enables us to make comparisons across different proposals. Our 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.

We then applied these assumptions to analyze coverage proposals developed by experts. The proposals fall into two broad groups: proposals related to children only and proposals related to adults and families. The former (which include options states have under CHIP) provide lessons both for CHIP's implementation and for new proposals affecting adults. 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). A side-by-side comparison of proposals for children and adults is presented in **Appendix B**<sup>5</sup>. In brief, the children's proposals are as follows:

Three proposals with broad eligibility were analyzed:

- A **refundable tax credit** for each child, acquired as part of the tax filing process at year's end. A \$500 credit would be available to all families with incomes up to 500% of the federal poverty level, on condition they had obtained a health insurance policy providing a standard set of benefits;
- An **income-related refundable tax credit** for each child, acquired as part of the tax-filing process at year's end. For families with incomes below 150% of the federal poverty level, the credit would be equal to the average cost of health insurance. The credit declines (or the premium obligation increases) as income rises, to zero (or full premium) for families with incomes of 500% of the federal poverty level.
- A **combination refundable tax credit/direct subsidy** (available at year's end or at the start of enrollment) designed to replace the child tax exemption for all families, regardless of income. All families would be guaranteed access to a state insurance plan – fully subsidized 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.

Three proposals were targeted to low income children. Two of these provided coverage to low income children, regardless of their insurance status – that is, whether previously insured or uninsured. They provide the full cost of coverage for children in families with incomes up to 150% of the federal poverty level. Subsidies decline (premium obligations increase) as income rises to zero (or full premium) at 300% of the federal poverty level. More specifically, the proposals are:

- A **refundable tax credit** to be used for employer-sponsored coverage or in a state insurance program. It can be claimed at the beginning of the year based on expected income; but it is adjusted upward or downward (reconciled) at year's end, based on actual income.

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<sup>5</sup> The full proposals are available through the Incremental Health Reform Project, The Henry J. Kaiser Family Foundation.

- A **state-run subsidy** to be used for employer-sponsored coverage or coverage in a state-run program and available to previously insured as well as uninsured children. The subsidy is available at the beginning of the year, but adjusted upward or downward (reconciled) at year's end based on actual income.

Finally, three versions of the CHIP program – a state-run subsidy program available to children who do not have employer-sponsored health insurance and available through Medicaid or a state-run program, but not through an employer – were analyzed. The first two make subsidies available to families with children up to 300% of poverty – with no premiums under a Medicaid option, with low premiums under a state-run option.<sup>6</sup> The third represents an estimate of the CHIP as states have actually implemented it – that is, with the eligibility levels and premium requirements states have actually imposed.

For adults, we analyzed a narrower set of proposals:

- An **income-related refundable tax credit** for families, on terms similar to the credit for children described above;
- **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% of their premium from taxable income when filing their taxes at year's end.
- **Coverage of all adults with incomes below the federal poverty level** through Medicaid or a state-based program. The full cost of coverage would be subsidized.
- **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 incomes up to 100% of the federal poverty level. Families with incomes above the poverty level would pay a premium – 2% of income for one parent, 4% for two.

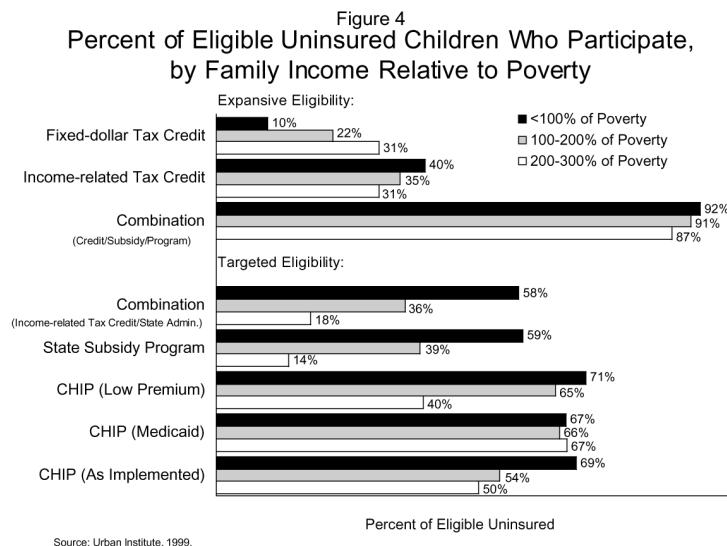
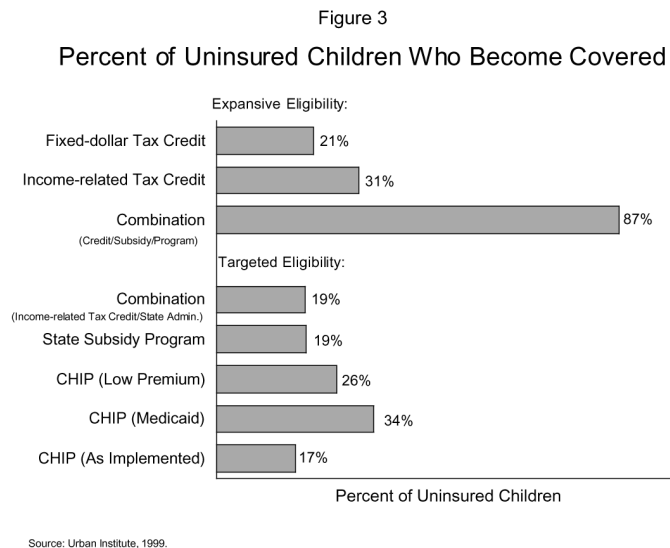
## Impact of Expansions on Coverage and Costs

The estimated impact of these proposals on coverage and costs are presented in Figures 3 through 12. Results are presented first for children, then for adults.

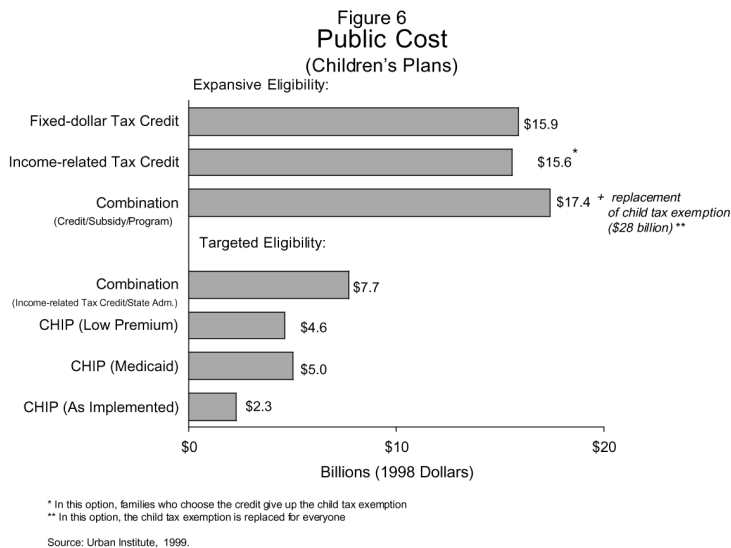
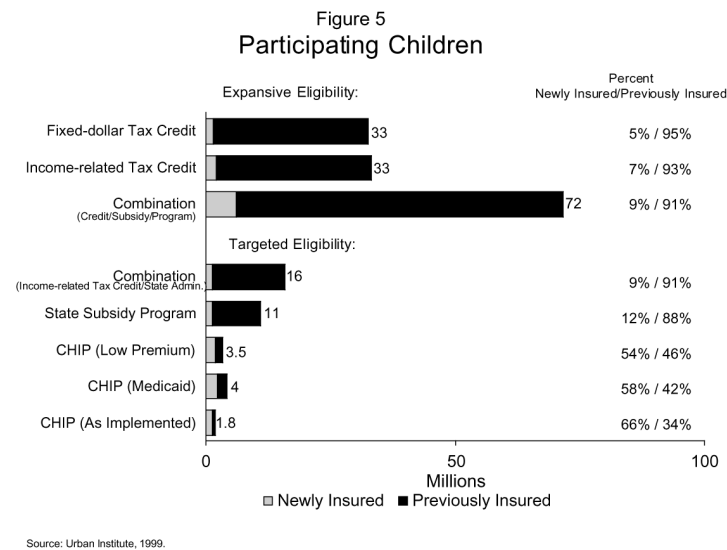
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<sup>6</sup> Although CHIP explicitly targets children not eligible for Medicaid in families with incomes up to 200% of poverty, states can extend eligibility to higher income groups – either because of previously high eligibility standards or because they choose to “disregard” more income in calculating eligibility.

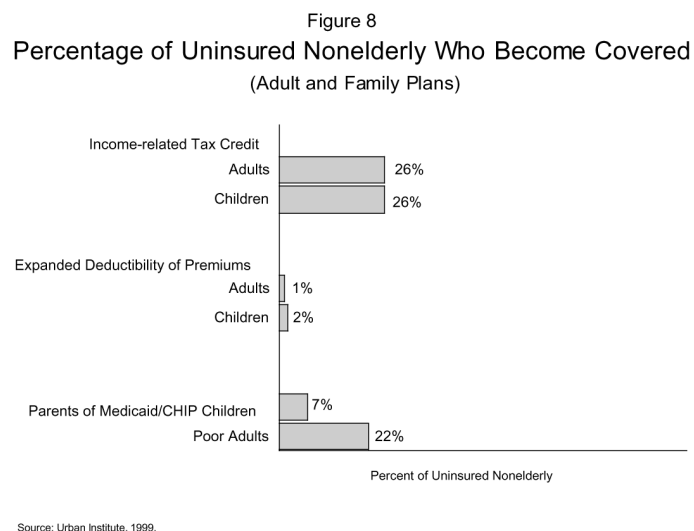
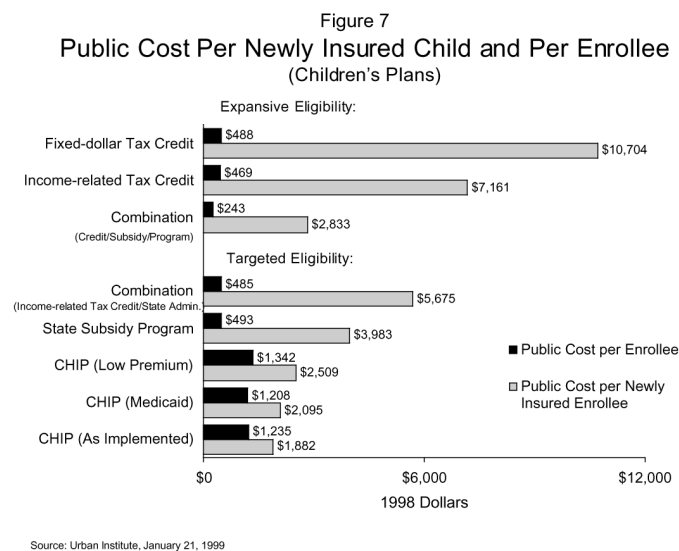
- **Share of the uninsured population covered.** With the exception of one very generous and highly redistributive proposal, our children's coverage proposals achieved roughly similar impacts – with coverage across proposals ranging from about a fifth to about a third of uninsured children [Figure 3]. Proposals for adults varied more broadly. Consistent with its modest objectives, one proposal expanded coverage to less than 2% of the uninsured; others reached as high as about a quarter of uninsured adults [Figure 4].



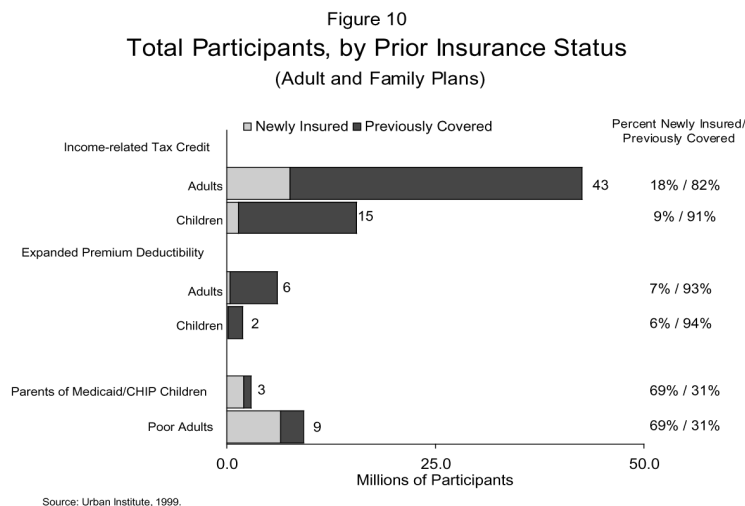
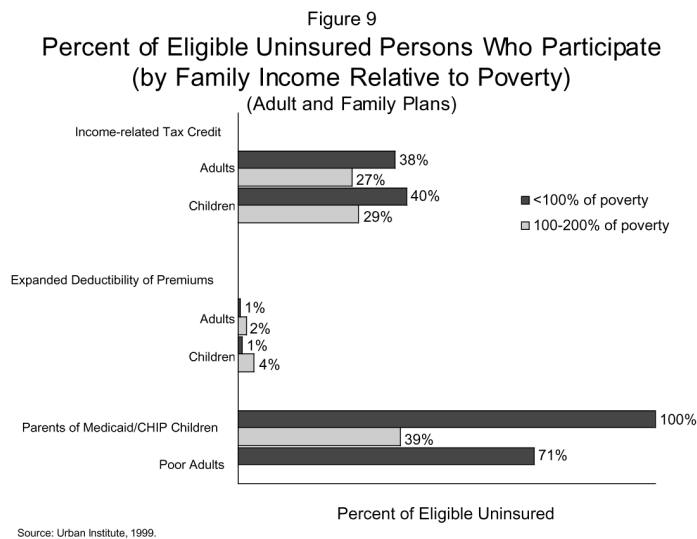
- Participation by the low income population.** Even proposals with similar levels of coverage differed in the degree to which the newly insured came from very low or higher income populations—reflecting variations in the generosity of the subsidy relative to the cost of insurance and other barriers to participation. Participation by children in families with incomes below poverty ranged from a low of 10% in a tax credit proposal where credits did not vary with income to highs of 70% or more where children’s coverage was provided free of charge to low income families [Figure 5]. In proposals affecting adults, coverage was similarly lower in tax credit than in direct subsidy programs [Figure 6].



- 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% of beneficiaries in the non-CHIP proposals, compared to over half of beneficiaries in a CHIP approach [Figure 7]. Among proposals aimed at adults, targeting had a similarly significant impact on the insurance status of participants [Figure 8].



- Total Program Costs.** Differences in total costs flow fairly directly from the number of people covered. The total public cost for proposals with expansive coverage is much greater than that for those with more limited eligibility [Figures 9-10]. Variation in costs do not fully parallel variation in coverage for two reasons: (1) the dollar value of the subsidy differs across proposals, and (2) premiums will differ across proposals because of differences in participation (e.g., lower participation means higher premiums) and other factors, including whether the expansion is based on private insurance markets or public programs and whether there is explicit reliance on managed care plans.



- 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 [Figure 11]. There is similar variation in the proposals for adults [Figure 12].

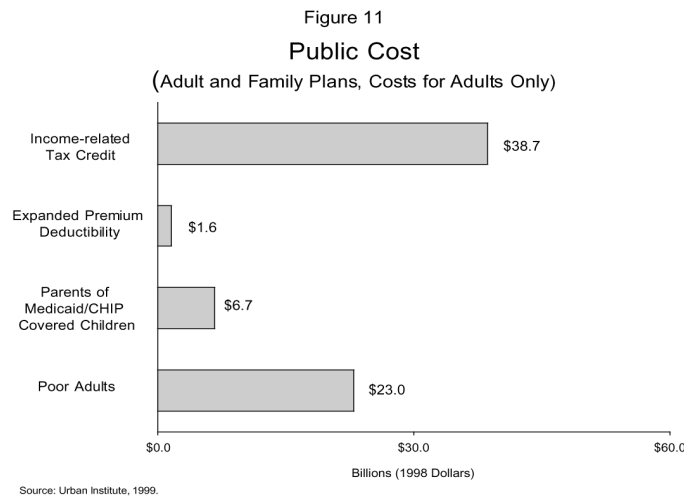
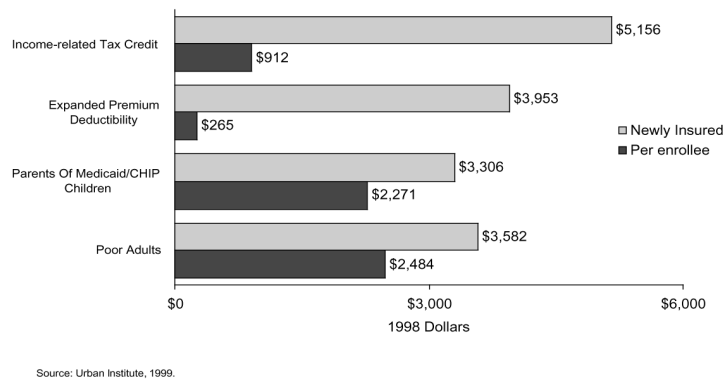


Figure 12  
Public Cost Per Newly Insured Adult and Per Adult Enrollee  
(Adult and Family Plans)





## **Federal Entitlements vs. State Discretion: Lessons from CHIP**

### **Introduction**

Sheila Burke

In virtually every debate on health care policy, the relative roles and responsibilities of the federal and state governments become a major policy and political issue. These issues of federalism are directly addressed in the enactment and implementation of the Children's Health Insurance Program. A look at CHIP may therefore be highly instructive to future coverage initiatives. What federal/state balance did we achieve in CHIP? How well is it working? What pitfalls and promise does it provide for next steps in coverage expansions? Our exploration of these issues begins with a presentation by Alan Weil on the political compromises that he believes facilitated enactment of CHIP; then continues with observations from Cindy Mann and general discussion on how those compromises are playing out – with gains and losses in achieving expansions of coverage.

### **A Carefully Crafted Compromise<sup>7</sup>**

Alan Weil

The new Children's Health Insurance Program was crafted and enacted in record time for a program of its size. What made that possible? Fundamental to legislative success was a design that reflects a workable, if not ideologically pure, approach to federalism – the federal government setting sufficient parameters and controls to assure accountability; state governments getting enough flexibility and financial incentives to assure participation.

A financing structure that relies on capped and matched federal grants to states is one of two key elements to CHIP's legislative compromise. In considering CHIP, it is critical to note that there is no child covered by this program who could not have been covered by Medicaid prior to CHIP's enactment – if a state chose to take advantage of Medicaid's policy options. The goal and challenge for CHIP, then, was to change the incentives states faced – that is, induce them to provide coverage beyond the Medicaid options they were already using.

CHIP's payment structure is a compromise between two alternatives: open-ended matching (like Medicaid) and block grants. Like Medicaid, CHIP's use of matching grants allows federal spending to leverage or induce state spending. CHIP's enhanced match – more favorable to states than Medicaid's match – should make states more interested in expansions than they were or would be under Medicaid. At the same time, CHIP's closed-ended match limits both federal and state financial exposure. Like a block grant, CHIP entitles states to funds, but does not entitle individuals to service. The matched capped funding structure of CHIP (along with the guarantee of open-ended Medicaid match available above the cap if states choose a Medicaid

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<sup>7</sup>This presentation draws on Alan Weil, "The New Child Health Insurance Program: A Carefully Crafted Compromise," Incremental Health Reform Project, The Henry J. Kaiser Family Foundation, 1999.

structure) made it possible to compromise divergent views on coverage, entitlements and public spending by encouraging states to expand coverage, while limiting both federal and state financial exposure.

The second key to the CHIP legislative compromise is the degree to which important design issues are left to the states. CHIP strives to give federal policymakers confidence that program dollars will go to provide needed health insurance to low-income children while state policymakers have room to design a program that meets local needs. CHIP leaves to states whether to expand Medicaid or create a separate program. This important choice embodies a number of other choices – including whether to provide an individual entitlement to services, whether to provide an extremely comprehensive benefit package and whether to charge premiums to potential enrollees.

Rather than battle over each of these provisions, Congress and the President left these decisions to the states – in a form that is not “either/or” but allows “shades of gray.” States have not been paralyzed by their difficult choices; had the federal government tried to resolve all these decisions for the entire country, paralysis would have been likely.

If states had been denied the opportunity to construct a program with enrollment and budget caps (that is, without an entitlement), and federal funding were fixed, states would have faced unacceptable financial risk – an arrangement they would not have accepted. At the same time, if states could not have structured their programs as entitlements, the option to expand Medicaid would have had no meaning; programs would have had to be separate, with the inefficiencies and coordination problems separate programs entail.

The somewhat surprising fact that most states have chosen, at least in early years, to rely heavily on Medicaid in their implementation of CHIP suggests that financial incentives (the higher matching rate) may have been more important than flexibility in inducing at least some coverage expansion. Medicaid may be a more desirable route to expansion than constructing something new; had its expansion not been an option, many fewer states might have participated in CHIP.

States’ flexibility is nevertheless a critical element of CHIP, specifically in defining how public programs relate to employer-sponsored insurance coverage.<sup>8</sup> That relationship is both a policy and a political problem. The policy problem is that every public dollar that replaces a private dollar being spent is a dollar that fails to achieve the stated goal of providing insurance to the uninsured. The political problem is that this “inefficiency” subjects the program to serious criticism (despite the value of substitution in reducing burdens on low wage workers).

Given the degree of variation across states in employer-sponsored coverage and in willingness to pay for public programs, there is a case to be made that policy decisions on the income levels at which public subsidies phase in and out should be made at the state level. From a pure policy perspective, state level eligibility standards and subsidy structures may lead to less substitution of public for private dollars than national standards would produce. Probably more important, from a political perspective, the willingness of Americans to tolerate the inefficiency of substitution

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<sup>8</sup> For further discussion, see “Crowd Out: Causes, Costs and Consequences” below.

varies from state to state – based on philosophies of government and of financing. Allowing states to determine their own definitions and their own sliding scales helps address this political challenge.

CHIP's flexibility also offers some unanticipated advantages with respect to actual coverage expansions. The degree to which CHIP has promoted experimentation with outreach and enrollment initiatives was a side-benefit of flexible design that was not receiving much attention when CHIP was enacted. Although outreach could have been pursued under Medicaid, CHIP brought this issue to the "front burner."

States' responsiveness to CHIP also has some "spillover" benefits for Medicaid. Outreach efforts are one such benefit. But others include investment in health plan contracting, educating consumers and expanding networks of providers. It does seem possible that Medicaid is going to end up a better program because of political pressure on states to have successful CHIP programs.

At the same time, however, CHIP poses two concerns for the future. The first, and most obvious, is that the high level of state flexibility CHIP allows creates the likelihood of increased variation around the nation in benefits and program. It's an open question whether allowing leadership states to go further forward while leaving some states further behind creates political pressure to bring up the rear (as Weil believes) or creates greater economic disparities.

Second is whether CHIP is a model for future expansions. The way CHIP is working reflects, at least in part, its focus on low income children – many of whom were already covered by Medicaid. Applying the CHIP model to adults, a far smaller share of whom are in Medicaid, could pose very different choices and very different politics.

Finally, although CHIP has its limitations, so do other approaches. Tax policies pose the likelihood of enormous inefficiencies in targeting dollars to the uninsured; Medicaid has the problem of forcing states to put money into a program they complain about. CHIP has one overriding advantage: it was enacted by Congress, signed by the President, and states are overwhelmingly choosing to participate. That political reality offers an important backdrop to the coverage debate.

## **Is CHIP the Model for Future Incremental Reform?**

Cindy Mann

CHIP has strong political and popular support and is likely to provide a model for future incremental reforms. Before proceeding down that path, however, it is useful to review what we know about how well CHIP is working and to consider some unique factors that have contributed to CHIP's early successes as well as issues that have arisen as implementation has moved forward.

In assessing how well the CHIP model works, we first will need to understand whether CHIP is meeting the goal of providing health care coverage to millions of previously uninsured low-income children. On the one hand, there is very good news to report. All states have implemented some coverage expansions with CHIP funds and in many states, those expansions have been quite broad. Since CHIP, 24 states have expanded eligibility for children, either through Medicaid or a separate state program, with incomes up to or above twice the poverty level.

On the other hand, there's a lot that we don't know and may never know about CHIP's effects on children's coverage. CHIP establishes a new federal/state partnership with a broad grant of flexibility but it offers us few tools by which we will be able to examine how that flexibility is working. This could come back to haunt the CHIP program; if data are not available to show that CHIP funds are translating into coverage for previously uninsured children federal support for CHIP and for the CHIP approach could weaken.

Consider the issue of cost-sharing. CHIP accords states that set up separate state programs a fair degree of flexibility with respect to cost-sharing and premiums—this was a very contentious issue as the CHIP legislation was moving through the Congress. Most states have taken advantage of the flexibility and have imposed premiums and copayments for all or most children enrolled in separate CHIP-funded programs. Only four states with separate state programs (including two that have raised eligibility to 200% of poverty) have no cost sharing. (Seven states with Medicaid expansions also have imposed new premiums and cost sharing under federal 1115 waivers).

While there are anecdotes that families prefer to pay something for their children's health care coverage, will we really be able to evaluate how the CHIP cost-sharing provisions are affecting participation and utilization? Will premiums discourage enrollment, particularly among lower income families? Are cost-sharing requirements going to keep children from care? Unfortunately, states are not required to collect and report the kind of data that might shed some light on these important questions. It will be hard to know if the flexibility accorded states under CHIP—in this case with respect to cost-sharing—is promoting or chilling children's access to care.

And before we conclude that the CHIP approach is the best approach for assuring coverage to low-income children or for expanding coverage to other populations, we will need to consider the issue of entitlement and the fact that federal CHIP funding is capped. It is far too early to tell whether capped funding will result in waiting lists, cutbacks in benefits or higher cost-sharing requirements for families. Currently, states are awash in their own revenues as well as CHIP's federal allocations. The real test will arise in an economic downturn when enrollment is likely to grow and states begin to bump up against their capped federal allotment.

Looking beyond the issue of coverage, it is important to also consider whether and to what extent specific features of the CHIP legislation were key to the enthusiastic state take-up rate. Would we have had as many states taking advantage of new federal dollars to expand coverage for children had Congress not designed CHIP the way it did? Although it's impossible to know what might have happened if a different approach had been adopted, it is important to consider the factors extrinsic to CHIP's design that have contributed to states' positive response to the CHIP initiative. First, the federal debate over CHIP exhibited strong and visible bipartisan support for addressing the problem of uninsured children, and that support and sense of mission clearly spilled over to the states. Second, the fact that a group of states made some quick decisions to take advantage of the CHIP funds created a something of a snowball effect. Very soon after CHIP's enactment the debate in most states was not whether to participate in CHIP but what form participation should take. A third critical factor that spurred states on was the enhanced match rate. Coupled with states' robust economies (and tobacco settlement funds), the enhanced match offered states a deal too good to pass up. CHIP came along at exactly the right time.

Although it may be conventional wisdom that the lack of an entitlement has been critical to the success of CHIP, we should be cautious before jumping to this conclusion. Consider that before CHIP was enacted, some 14 states had expanded coverage under Medicaid beyond the federal minimums for children age one and older. An additional 21 states had expanded Medicaid for infants. Of particular note is that in months before CHIP was passed three states—South Carolina, Oklahoma, and Arkansas—enacted broad Medicaid expansions for children. While it is no doubt true that even with enhanced federal matching payments not all states that have taken advantage of CHIP would have expanded coverage under Medicaid had that been their only choice, the rub may be less the issue of entitlement than flexibility. Flexibility to impose premiums and perhaps anti-crowd out policies might be even more important issues for states interested in expanding coverage to somewhat higher income families. The block grant structure is not the only means by which states can be granted broader flexibility in how they design programs for populations with incomes well above those that apply to the traditional Medicaid groups. My point here is simply that we should not assume that only a block grant structure would have brought most states on board.

A third set of issues has to do with the implications of some of the contradictions and tensions that exist within CHIP. These are particularly important issues as we think about CHIP as a model for future expansions. First is the tension between the invitation to create something new and the requirement to coordinate with the old. CHIP encourages states to experiment—with eligibility, with benefits, with entitlements, with administration. But to guard against substitution (of CHIP dollars for Medicaid dollars) and to prevent cracks in coverage from

emerging, federal CHIP law also requires states to coordinate their new programs with Medicaid. It's not easy to have it both ways.

A second source of tension is that CHIP outreach and enrollment efforts, not unexpectedly, are attracting children already eligible for but not participating in Medicaid. CHIP, however, does not provide states with enhanced matching rates when these children enroll in Medicaid. One of the most troubling aspects of CHIP is that it makes higher-income uninsured children more fiscally attractive to states than lower-income children. This may induce "gaming" by states or it could make states reluctant to pursue strategies, such as unified outreach campaigns and simplified Medicaid enrollment procedures, that would lead to higher Medicaid enrollment. Without such strategies, success in lowering the number of uninsured children will be much more limited than it should be. Moreover, if CHIP leaves Medicaid well behind in terms of system changes, CHIP might even have the unintended effect of depressing participation in Medicaid over time. CHIP has the potential for bringing the Medicaid standard up or for creating a two-tier system of coverage for children.

CHIP has many positive features and presents states with an exciting new opportunity to reduce the number of uninsured children substantially. At the same time, CHIP highlights how difficult it is to shape, enact, and implement incremental expansions of coverage without creating new complexities and potential problems for existing sources of coverage.

## Commentary and Discussion

**Howard Cohen:** A review of CHIP's enactment should start with recognition that CHIP was the first coverage to pass since 1990 – the last time Congress enacted a Medicaid expansion. Its enactment was absolutely bipartisan. Remember that the Clinton Administration originally included in their budget the outline of a program that was a sort of block grant (although with much less money than in CHIP and distributed by formula). And the National Governor's Association (NGA) unanimously endorsed a proposal that was not exactly CHIP, but close. A bipartisan group of governors – not just Republican Governors Engler and Thompson but also Democratic Governors Romer, Childs and Miller – was a key constituency in making the politics of this legislation work.

It's also important to remember that CHIP's enactment was a budget bill – part of a reconciliation. The program had to fit the money available – an amount that shifted from several times, from \$8 billion to \$16 billion and then, at 11:30 p.m. at the end of the conference committee deliberations, \$24 billion. Had the numbers been clear a little earlier, the program may have been a little different.

It's also important to remember why CHIP was enacted rather than an alternative approach. The proposal that did not get enacted – and died in the Finance Committee – would have used Medicaid. First, it would have allowed states, particularly in New England and the Northeast, that had already provided generous coverage to receive federal dollars to “buy out” non-poor children already participating in Medicaid. Second, it would have required states to “go through hoops” to receive new funds: phase-in all children up to age 19 (the “Waxman kids”) and achieve coverage up to poverty throughout the nation. That proposal generated fear for many southern rim states, California, and the poorer states – states where the bulk of uninsured kids live – would not be able to participate in the new funds.

When the vote finally came in the Finance Committee – four Republicans (Chafee, Hatch, D'Amato, and Jeffords) voted for Senator Chafee's Medicaid approach. It looked as if it were going to win. But on the Democratic side, Senators Breaux, Graham and Reid voted the other way, and the proposal was defeated. That vote led to the capped entitlement approach that eventually prevailed.

In all reconciliations, there's always one issue that's the last to resolve and in this one it was CHIP. That is why there is a complicated section of the law – a crafted compromise – to give states flexibility to stay out of Medicaid and go into private health insurance. The legislation had to give the Administration and everyone in Washington the assurance that people were going to get a real benefit package; at the same time, it had to give states the flexibility to design their own benefits, using actuarial equivalents, categories of benefits, and realistic benchmarks like insurance given to state employees, Blue Cross/Blue Shield, or the state's largest HMO.

Some of the Republican governors who, over the years, have been hardest on Medicaid, have in fact chosen to go into Medicaid. It is great that a lot of states have chosen Medicaid; some states have chosen private insurance, and others a combination. The program has worked extremely well, primarily because HCFA got it up and running in under a year. We have forty-eight states participating in an optional program—giving us 100 percent coverage, for all intents and purposes.

**Sheila Burke:** I want us to reflect on two issues that have been raised. One of the success stories Howard suggested in his description of the Finance Committee vote is something that often occurs – odd combinations that cross party lines because of regional issues (whether it's the southern tier states, the northeastern states, etc.) One of the questions for the future ought to be: where are those coalitions that form a base to move something forward?

A second question is: what happens when we hit the recession? Our success with CHIP comes at a time not only of federal largesse but of the states' capacity to pick up and do things that in the seventies or eighties they might well not have done.

Two key issues for the future, then are coalitions and financial capacity.

**Bridgett Taylor:** To add to how we got to the endgame – picking up on Howard's comments: The endgame was clearly bipartisan. But our leadership was going in somewhat different directions. We had some very strong leadership from the President and from both the minority and majority sides of different committees. The fact that we had the common goal of wanting to cover more children ultimately brought us all to the table. (And to spending incredible and interminable hours in the basement of the Cannon Building until we were ready to kill each other. There truly was a point when we were making sausage – as some people like to say about legislation.)

It's also important to focus on the provisions of CHIP that related to Medicaid – including the "hoops" Howard described. These "hoops" had a positive purpose. Mr. Dingell (whom I represent) and Mr. Chafee were concerned that if we had a bifurcated system, that the poorest of the poor (or up to 133% of the federal poverty level) be guaranteed the protections that are built into the Medicaid program. Then put this new program on top. That way, we would avoid the issue of having families in which younger children qualify for one program; while older children qualify for another. We weren't successful in promoting a floor at 133% of poverty; and the states even balked at requiring – as a precondition for receiving new federal funds – the immediate extension of Medicaid for all poor children, regardless of age. But now, all the states have done precisely that; and they did it almost immediately after the law was passed. Maybe instead of a hoop, this requirement was an appropriate way to have two somewhat different programs work together as well as possible.

Further, getting the children who belong in Medicaid into Medicaid programs remains very critical. Despite states' objections, we required that states screen children seeking coverage and enroll Medicaid-eligible children into Medicaid. This provision isn't meant to punish states. Enrolling these very poor children into Medicaid – with guaranteed federal funding as long as children are eligible – protects states as well as very poor children. The poorest of the poor need



this protection; children in higher income families may be better able to cope with a program that may impose waiting lists, if funds are exhausted.

I agree with Howard, that in the original Dingell/Chafee approach we were using money in ways we shouldn't have – buying out the base of children states had already covered through their Medicaid programs. By insuring that we didn't do that in the endgame, we are using our dollars to get more kids covered.

Howard also mentioned the division among us about whether or not to have a defined benefit – how much flexibility to allow the states in benefit design. But, in order to get the program going, we need a more uniform playing field; we have to see whether children are actually getting health insurance. As we move down the road, we may want to look at alternatives.

Finally, as we examine CHIP and consider whether we want to do further expansions like it, it is critical to recognize that the jury is still out on this program. I think staff on both sides of the aisle and in both the House and the Senate are concerned that we don't have enough data to determine what CHIP is actually accomplishing. And, in this or any other joint program, we must not throw out the baby with the bath water. That is, it is critical to keep an eye on Medicaid. In enacting CHIP, we did a lot of things to expand and change Medicaid flexibility – in a bipartisan way. We gave states almost everything they wanted (short of capping the dollars), so the Medicaid program should be easier for states to operate. We should not lose sight of our responsibility to protect the poorest of the poor; and we should not go further, until they're all protected.

**Sheila Burke:** Cindy questioned whether the take-up rate among states and individuals would have been the same, had Medicaid been the only route of expansion. Bridgett calls attention to the importance of preserving Medicaid. A key question for the future is how the inherent bias against Medicaid and its history as a welfare program affects the ability to rebuild the base in Medicaid. If people are unwilling to go into the old program, and now there's a different program without the sort of problems or appearances of the Medicaid program, can you force people back in? or expand that base?

**Trish Riley:** What worries states, as they struggle with the implementation of this complicated program, is that they actions will be too quickly judged as a failure. The law poses some fundamental challenges for states that are worth noting. First, in the law, states are held to reducing the number of uninsured children. But that's an unfair test. We don't even have agreement on the number of uninsured kids. And we don't know what would have happened to the rate of uninsured kids absent CHIP, with a churning and changing marketplace, welfare reform, and other political and economic changes. That makes a reduction in the number of uninsured kids an awfully tough bar for states to meet.

A second challenge in the law is the interest in avoiding crowd-out. States argued early on that one way to avoid crowd-out is to impose premiums in CHIP at the same level as premiums in private insurance; but the law prohibits that by setting a cap. At the same time, the law makes it difficult to directly support employer-based coverage. Buy-ins to employer coverage must be cost-neutral and waivers are not being looked on kindly. The bigger issue is equity: is it fair and

right and decent to subsidize an employer who has chosen not to provide coverage (or a family that does not have coverage), while not subsidizing the competing employer (or another family) who is taking money out of pocket to provide coverage?

A third challenge is the promise of state flexibility. Federal and state governments will, of course, never agree on how much flexibility is flexibility. But states believed that they could design something that looks very different from Medicaid. They're finding that's not really the case. There isn't really a "kid's product" in the insurance market; you can't knock on the door of your private insurer and say, sell me a kids product for my CHIP program. As one state official observed last week: It's interesting. CHIP is trying to create an individual insurance product in an environment in which the individual insurance market is eroding.

Although all of us are very pleased that states have built on the Medicaid base, it is important to recognize that states moved there not necessarily out of rooted convictions but out of the necessity to move fast. Building on a base of an existing program is pretty easy to do. In addition, the cap on administrative costs – what you can spend on outreach, administration, evaluation – (and the fact that you can't spend it until you begin to bring kids in) make it difficult for states to ramp up and develop an independent, separate kind of program. However a number of states have, and many more are looking at that.

The link to Medicaid also complicates flexibility. Although there are legitimate and important reasons to secure Medicaid eligibility for kids who are eligible, requiring states to "screen and enroll" for Medicaid makes the program look Medicaid-ish. And eligibility processes involve not only states, but counties – that states can't control.

Finally, it's true that states could have reached all these kids with Medicaid; we didn't need to create CHIP programs. But I think states would argue that Medicaid is so entrapped in regulation, history, tradition, and county bases, that you really can't just change it; that CHIP afforded us an opportunity to craft separate programs, to test and demonstrate, that really are different from Medicaid. That means without the entitlement. An entitlement program really frightens states. They remember recessions. They have now created rainy day funds, but, nonetheless, worry about their balanced budget requirements.

In new programs, if states make mistakes, they can make changes much more quickly than in a Medicaid-kind of program. And the richness of Medicaid's benefits is an issue that plays out in many states. Remember that state legislators are citizen legislators. These folks don't make much money and they look at this program – with eligibility at 200% of poverty – and say, gee, somebody's eligible for this program who makes more than I do; who makes more than teachers in our state. Legislators believe cost sharing should be a part of programs serving these populations but cost sharing is restricted in Medicaid.

The one fundamental issue in Medicaid is that the states and the federal government don't really share the program. We haven't found a way to truly govern this program in a coordinated fashion between the two levels of government. I suspect CHIP will give us an opportunity to keep looking for answers that will benefit Medicaid.

**Karen Nelson:** A few comments: First, I want to point out the political dilemma we're in – one that makes us willing to give a greater level of federal support per child to higher income people than to lower income people. We're there because we wanted to encourage states to move ahead when they were otherwise not willing to put in that money. If we want to move them up even higher, we might have to give them an even greater level of federal support.

Second, as everybody has said, we don't know what's really going to happen to this program when the economy changes. We might find it's not nearly as successful as we had hoped. Even more serious, we might find that the program that is really hurt is Medicaid – because there really isn't anything that says that states must keep their Medicaid commitment. They might be happier keeping up CHIP, because it serves higher income people, is somewhat more popular and receives greater federal support.

When the next crunch comes, then, the place that people may really suffer is down there in the Medicaid program. It doesn't even have to mean a direct cutback in Medicaid. As we all know, it can mean cutting provider reimbursement, putting people in managed care with less adequate payments, whatever.

And I'm struck by the statements we've heard, here and other places, that people want to come into CHIP. They didn't want to come into Medicaid; and if we find kids who might be Medicaid-eligible, they say they want to be in CHIP. We have to think about this phenomenon, including those of us who are very favorable to Medicaid. But what exactly is going on here? What makes Medicaid less attractive to people who are entering the program? Is it maybe a more complicated eligibility form? Is it harder to get in? Is that necessary in the Medicaid program, or could we simplify it? Is it that not many providers participate? that people know that when they're in Medicaid they're going to have worse or fewer providers?

If that's the issue, it ought to make us step back and say: Wait a minute. Why aren't we fixing Medicaid so it works as well? What is the justification to pay providers more under CHIP than we do under Medicaid, for example? What is the justification to give them more choice? There are a lot of complicated issues we need to think about.

**Nancy Cobb:** CHIP is facilitating change in Indiana's Medicaid program. The first phase of CHIP was an expansion of Medicaid up to 150 percent of the federal poverty level. Without CHIP, that expansion never would have happened in Indiana. And now we're in the second phase and there's bipartisan support for going up to 200 percent of poverty with CHIP.

Indiana now has a unified, simplified, two-page application for both Medicaid and CHIP. The simplified enrollment system is the same for families whether they will participate in CHIP or in Medicaid. The combined program is called Hoosier Healthwise, and so, they apply for Hoosier Healthwise.

Indiana has made a concerted attempt to destigmatize Medicaid as a result of the CHIP expansion. Indiana's goal is to encourage families and providers to look at this as health insurance, something every child deserves. Marketing efforts do not use the terms "Medicaid" or "federal poverty level." Instead we talk about "Hoosier Healthwise" and "income guidelines."

**Mark Reynolds:** Looked at from the vantage point of Massachusetts, it seems to me CHIP really had an impact on states in a very short period of time. Any incremental change that relies on federalism relies on another partner participating, has to create opportunities for change at the state level and an alignment of federal and state interests. CHIP did that.

It did it with a combination of things: the combination of the political window that was created that put pressure on state legislators, increases in federal payments, increases in flexibility, the cutback of the entitlement. Without that, I don't think states would have acted so rapidly. Creating that political window is important in a federal system.

CHIP also created an administrative window of opportunity. States really have seen the barriers to getting coverage and they're working very hard to change those barriers – not just for CHIP but for Medicaid. They're shortening applications, making them easier to read; changing outreach strategies, not waiting for people to come in but working with community representatives.

If we'd simply had a modification of Medicaid, I'm not sure this would have happened. I don't know if the political window would have changed. The change had to be bipartisan to convince state legislators that it was OK to do this; that it was smart, politically. I don't think we would have seen that without having something new on the federal agenda. That's a lesson for future expansions that rely on federalism.

**Larry Levitt:** I agree that the structure of CHIP probably did provide an impetus to governors and state legislators to act and act fairly quickly. In particular, I think it gave governors something they could own as a new program – creating a political impetus. But I think the potential problem that remains to be seen – especially as a recession may come – is what happens to Medicaid with the creation of a new separate program.

Certainly there's a potential that CHIP could energize states to reframe and de-stigmatize their Medicaid programs. But certainly the opposite could happen as well – particularly as states look at an enhanced match for higher income kids and an un-enhanced match for Medicaid.

It's true that states have acted very quickly to cover children (although participation rates are quite low in many states). But if that comes at the cost of an even more stigmatized Medicaid program, we may not have made a net gain in the end.

## **Tax Preferences vs. Direct Subsidies: Reaching the Uninsured**

### **Introduction**

Judith Feder

Policy analysts across the political spectrum agree that the reason people lack health insurance is that they cannot afford it. Addressing the affordability problem requires public subsidies. Analysts disagree, however, on how best to deliver these subsidies. Some would use the tax system to subsidize coverage, through a variety of tax preferences. Others would rely on direct subsidies, provided through public programs. Although both mechanisms can be used to expand coverage, tax approaches have an additional goal. Proponents of policies that would extend tax preferences beyond employer-provided coverage (through proposals ranging from the extension of tax deductibility to individually purchased insurance<sup>9</sup> to replacement of the tax preference for employer-provided health insurance with a refundable tax credit for the purchase of insurance<sup>10</sup>) seek not only broader coverage by greater equity (and, in some cases, progressivity) in the tax system. When it comes to coverage, however, tax policies work differently from direct subsidies. Although analysts recognize that the two mechanisms can be combined,<sup>11</sup> depending on their design they may have very different effects.

The following presentations by Mark Pauly and Linda Blumberg explore the issues associated with tax preferences as compared with direct subsidies in promoting health insurance coverage. Commentary and discussion follow.

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<sup>9</sup> Gail Wilensky, "Extending Health Insurance through Incremental Reform" Incremental Health Reform Project, The Henry J. Kaiser Family Foundation, 1999.

<sup>10</sup> Stuart Butler, "Expanding Health Insurance through Tax Reform," Incremental Health Reform Project, The Henry J. Kaiser Family Foundation, 1999.

<sup>11</sup> Mark Pauly observes that the tax credit could be used for the purchase of public insurance like Medicare, for example, as well as for private insurance. Other experts developed proposals for this project that explicitly tied credits to public programs. See Linda Blumberg, "Children's Health Insurance Coverage Tax Credit and Publicly Sponsored Children's Insurance Pool," and Wendell Primus, "Analysis of a Specific Tax/Health Credit that Provides Insurance to All Children," Incremental Health Reform Project, The Henry J. Kaiser Family Foundation, 1999.

## Extending Health Insurance through Insurance Credits

Mark Pauly

While the usual lament is that health care problems are complex and puzzling, the analytical problem of the uninsured is not so difficult. Common sense and empirical evidence tell us that people fail to become or stay insured because they lack the means and/or the motive to obtain insurance. A direct and simple solution to this problem is to provide refundable publicly financed credits for the purchase of health insurance.

The fundamental notion of a credit is a simple one: a person gets a fixed amount of additional purchasing power in return for obtaining health insurance in excess of some specified amount. If they don't get the insurance, they don't get the credit. In this way, the person is directly and transparently provided with the means and the motive to buy insurance.

Who gets the credit, for what kind of policy, and how much it's worth are key design issues that will affect the impact credits have. A comparison of two approaches reveals the tradeoffs in design. One option is to provide a flat dollar tax credit, available to a specific population – for example, a \$500 tax credit to all households with children and incomes below 500% of the federal poverty line – for purchase of a policy with a premium or actuarial value of \$500 or more.<sup>12</sup> Another option is to set the tax credit based on the cost of a minimum required insurance policy and vary the amount provided with a household's income – for example, full cost of the policy for people with incomes below 150% of the poverty line, phasing out to zero at incomes of 450% of the poverty line.

Providing families \$500 to acquire \$500 worth of coverage should lead to universal coverage of virtually all income-eligible children. However, \$500 is not enough to cover the cost of comprehensive coverage. This policy achieves virtually universal coverage in the sense that almost all children will have some insurance, but the level of coverage would probably entail high cost sharing. The alternative approach would offer strong incentives for lower income individuals and families to obtain coverage. However, because families at somewhat higher incomes would be required to pay most of the premium themselves, it would not lead to virtually universal coverage.

What are the benefits of providing some coverage to all versus achieving appropriate coverage for some? Logic would dictate that efficiency is improved by spreading any given subsidy over the widest population even if the additional coverage would still be quite incomplete, rather than inducing full coverage for some and none for others. But the choice ultimately depends on political preferences.

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<sup>12</sup> See C.E. Steurle, "The Search for Adaptable Health Policy Through Finance-Based Reform," in R. Helms, ed. *American Health Policy: Critical Issues for Reform*. (Washington, D.C.: AEI Press, 1993). In the simulations conducted under this project, all proposals were held to a roughly similar standard of coverage. Hence, this proposal was not modeled; instead, the project estimated the impact of providing the \$500 credit toward a policy with costs substantially higher than \$500.

What are the benefits of providing subsidies to all versus subsidies targeted by income? Both theory and empirical evidence suggest that additional insurance coverage will do the most good when provided to previously uninsured low income persons at high risk. But if subsidies are cut as incomes rise or as health status improves, strong incentives are in place against earning additional income. Both problems can be avoided if the subsidy is kept high and uniform for all. But the dilemma is that doing so will require higher taxes, which, in turn, will also discourage work effort.

To keep public expenditures lower, it may be desirable for the credit to be set at a level below the premium for the lowest cost plan; people will therefore potentially have to pay part of the premium themselves. A benefit from such an arrangement is that people may obtain satisfaction from knowing that they have accepted responsibility for covering their family and, having paid the premium, may resist efforts by government to over-regulate the coverage purchased. A cost of such an arrangement is that some people may decline the coverage and remain uninsured.

How will private insurance markets function in either of these approaches? Provision of information about insurance is clearly essential. Less necessary, but still desirable are some measures to even out some of the variation in premiums associated with individual risk. Credits per se will not improve the functioning of private insurance markets. However, if it were administratively feasible to offer higher credits to people with costly chronic conditions, there would be less need to worry about the segmentation of risks in the private health insurance market. That approach would eliminate the need for inefficient and inequitable community rating.

Concerns about participation and about risk selection issues in private insurance could be mitigated if a new tax credit were accompanied by a mandate to use the credit. That is an option that can also be considered.

Probably the most difficult design issue in establishing a new tax preference is the treatment of current tax subsidies. Should the current exclusion for employer premium payments be abolished entirely, or at least discouraged? Politically, it is surely going to be difficult to abolish such a long-standing loophole as the tax exclusion for employer premium payments. But reliance on the exclusion can be discouraged by offering people an either-or choice: to get a credit, you have to give up the right to any tax shield. Rather than abolish a much-beloved loophole, an exchange strategy “surrounds” this policy, rendering it irrelevant at the margin. Any money saved by requiring people to make a choice could be used to increase the credit closer to what's required to provide adequate coverage. (However, if setting credits and subsidies roughly equal to each other requires some reduction in current subsidies, there will still be objections from those now benefiting.)

Further, the offering of a tax credit should not lead employers currently paying part of the premium for insurance from continuing to do so. Government provision of a credit simply reduces employees' taxes (and possibly entitles them to a refund). That is, a tax credit is, as the name implies, just a tax cut. No logic suggests that a tax cut will lead employers to cut health insurance, other fringe benefits or money wages.

Credits provide a simple and exceedingly flexible solution to the problem of reducing the number of uninsured people. Although they do not fix the private market for insurance, or propose wonderfully inventive cost-effective ways for delivering care or solve other social problems, credits offer a minimally intrusive public intervention to help people afford the insurance they ought, in the opinion of their fellow citizens, to have available.

### **Are Tax Credits the Right Tack to Take?**

Linda Blumberg

Although there are theoretically an infinite number of ways to design a tax credit for health insurance coverage, the political appeal of these mechanisms is tied to the administrative efficiencies associated with the more simplistic approaches (such as fixed dollar credits) and the horizontal equity – treating people in similar economic circumstances in similar ways – and accuracy of income verification that's part of the tax system.

But the test of whether or not a tax credit is the appropriate mechanism for expanding coverage should be whether it best fills the objectives of reform: increasing health insurance coverage; target efficiency – spending as high a percentage of new public dollars on the target population as possible; and horizontal equity. I define the target population as the low income population. Although we could define the target population as the low income uninsured, that definition would be in direct conflict with the goal of horizontal equity. Including the currently insured low income population in the target group recognizes their financial vulnerability to uninsurance as well as the inequities and distortions of incentives that come from trying to exclude them. If we think about a health insurance subsidy as an income transfer, a transfer to all low income people allows some to purchase insurance they don't have and gives financial relief to others who have been struggling to pay for it.

Tax credits can be effective tools for achieving horizontal equity. Tax credits can be designed to address inequities in the current employer-based system. And, because the tax system is the most effective way to verify income over a particular year, it is probably the most effective way to ensure that individuals or families in particular income categories are treated the same way for subsidy purposes. Some recent tax credit proposals, however, by conditioning eligibility on past insurance status (e.g., being uninsured, as I already mentioned) or on employer behavior (e.g., not having an employer offer of coverage) would introduce inequities and inefficiencies that the overall approach was intended to solve.

Strategies for moving us in the direction of the goals of coverage and target efficiency should income-relate subsidies, directing them to the low income population where the bulk of the coverage problem exists. By contrast, a fixed-dollar credit to persons of all incomes poses a number of problems. Take for example, the \$500 credit for everyone, regardless of income, that some have suggested. It is important to consider what kind of a policy a person could actually buy in the non-group market for \$500. According to estimates by the Actuarial Research Corporation, a five hundred dollar children's policy in the current non-group market would be roughly equivalent to either a policy with a \$10,000 deductible or a policy with first dollar coverage with a \$1,600 benefit maximum. The options for adults are more extreme. A credit of



\$500 would buy an adult a catastrophic policy with a \$67,000 deductible or first dollar coverage with a limit of \$840 in benefits. It seems clear that low income people would not bother to purchase these policies; they could never afford to meet these deductibles. And, even if they could, high deductible policies would merely serve as substitutes for uncompensated care that the low income would receive in the event of a catastrophic occurrence, making the policies of little value to this group. In considering the option for front-end coverage, we should question whether insuring people for a very limited number of predictable (essentially non-insurable) events warrants paying insurers' administrative loads of 35 percent or more. Putting funds into direct services would make more sense.

You can improve upon the fixed-dollar approach by increasing the dollar amount of the credit somewhat. However, research evidence indicates that high levels of participation among the low income population will require subsidy amounts that are tied as closely as possible to the cost of a policy. Consequently, if we really want to expand coverage among the low income population as much as possible within a budget constraint, we would provide each low income person/family with a larger credit by not using limited resources on credits to higher income persons who are likely to purchase coverage even without a subsidy.

Another important issue to remember when designing a subsidization approach is that the vast majority of uninsured workers (about 80%) are in firms that do not offer coverage. Although a small subsidy might be effective in inducing some of the small share of the uninsured workers in offering firms to take-up employer coverage, the bulk of the uninsured will be left to purchase their coverage in the non-group market. Uninsured workers (along with nonworkers) are not well served by an unreformed individual insurance market. Only 13 states currently have guaranteed issue of health insurance of any kind in the non-group market and only 19 have some type of rating bands in effect. As a result, risk pool problems can become dominant, with individuals potentially unable to get access to this market and others potentially unable to pay its premiums.

In addition, large administrative loads (on the order of 35 percent to 40 percent) can eat up a big portion of any credit. Research evidence indicates that most low-income individuals are unlikely to purchase coverage in the open non-group market if the subsidy is small. We also know that we couldn't promise a credit sufficient to cover the cost of just any policy in the open market. The credit would have to be tied to a premium available for a lost cost plan of acceptable quality available in a broad-based risk pool.

Can we work through the tax system to provide a subsidy that will actually assure access to an insurance product of acceptable quality for low income people? Yes, but the design features necessary to achieve these goals make the administration of the credit more difficult and challenge the basis on which people favor it in the first place. First, assuring access to an affordable, accessible product means that the IRS would have to coordinate information about insurance premiums and options in a given area with an individual's tax return. Second, actually getting the credit to the low income and making sure people take-up insurance poses a number of problems. In particular, providing low income people with the liquidity they need as their premiums come due while still reconciling the amount of their subsidy with their incomes at the end of the year (as determined on their tax returns) would be a tremendous undertaking.

If we want low-income people to buy insurance, we have to give them the liquidity to do that – with prepayment of the tax credit or subsidy throughout the insurance year. Tax credits can be designed to do that; the Earned Income Tax Credit (EITC) is an example. The trouble comes, however, when you try to reconcile the pre-payment with the actual subsidy owed based on the recipient’s actual income during the year. (Reconciliation wouldn’t be a problem if the subsidy isn’t income related; but if we want target efficiency – that is, to effectively reach the low income population within a given budget constraint – it should be).

The “trouble” has two parts. First, low income people who need the added liquidity of the up-front credit are less likely to take advantage of a credit if its value at the year’s end is uncertain. The General Accounting Office (GAO) determined that fears of owing the IRS money at the end of the year were important in explaining the extremely low take-up rate of advanced payments under EITC. Second, EITC has also taught us that it’s hard to reconcile advance credits at year’s end. The same GAO study found that, of those individuals who might have received advance payment, almost half did not file tax returns at the end of the year. Equally important, almost half of those who had received the credit and filed a tax return, did not report the credit. The costs associated with correcting these errors are likely to exceed the benefits gained from increasing collections, since the dollars are small by IRS standards. In other words, the costs of achieving reconciliation may exceed its benefits.

However, if reconciliation isn’t worth doing, then using a tax credit to subsidize coverage loses much of its appeal. A major appeal of the tax system as a tool for providing subsidies is its ability to accurately determine income. If we aren’t using it for that (by not reconciling), direct subsidies become more attractive, since they allow us to avoid relying upon employers and the IRS for eligibility determination and delivery of the subsidy.

The goal of high rates of coverage for low income people also requires careful attention to the emphasis in many tax credit proposals to a redistribution of subsidy dollars currently provided through the tax system. The standard here should be “Do no harm to low-income people.” Although the current employer-based tax subsidy has its problems, it is likely inducing at least some people with low incomes to take up insurance for themselves and their families. Depending upon the design, a redistribution of current subsidies to new credits might leave these low income workers with smaller post-reform than pre-reform support, leading them to drop coverage. Mark Pauly would allow people to choose which subsidy is more valuable to them (the new or the old), but not all proposals do this.

To sum up these thoughts:

First, a desire for target efficiency calls for a separation of trying to solve current tax system inequities from trying to expand coverage to the currently uninsured and economically vulnerable. The impulse to extend credits to high income people is understandable, since the money for the credits in some proposals comes from the elimination of the employer-based subsidy they currently receive. But it is not an effective way to achieve coverage for the low income population that is most in need.

Second, end-of-year reconciliation of subsidies for the low income population may just not be worth it. And, if that's the case, then a decision to subsidize through the tax system becomes questionable – especially when the need to assure access to an affordable policy of acceptable quality is taken into account.

And third, if we give highest priority to expanding coverage among low income people – where we find the bulk of the uninsured – we may have to sacrifice some degree of horizontal equity. A subsidy system that isn't reconciled through the tax system will mean that some people with annual incomes above the eligibility threshold (like families with limited periods of low income during the year, due to some unemployment) will get some benefits we don't intend. But since we cannot do a perfect job of simultaneously meeting all three objectives – coverage, target efficiency, and horizontal equity — this seems to be a desirable trade-off.

### **Commentary and Discussion**

**Julie James.** I remember after the health reform wars of 1994 were over and there was a consensus that we had to approach the problem incrementally, I was facing the question: what's a good way to start out. The same question applies to this discussion. It seems to me that in order to do something incrementally, you need to know where you're going. And I don't think there's any consensus on what the end game looks like.

That raises another question: the difference between “coverage” and “insurance.” Some people think of health insurance as the typical model of insurance; they say the public ought to protect people against catastrophic loss and leave the rest alone. That's different from a prepaid health care model, in which people are expecting to use their coverage. Choosing between the two comes back to the end goal. Is it really everybody having insurance? Or, is your concern really that people are getting the care they need?

That takes me back to revisiting CHIP – the whole discussion about, if you're going to use this money, is the best way to use it for insurance or should you allow its use for direct services? Do you want to build an administrative burden in providing insurance for predicted expenses when that burden may not be necessary?

Finally, I think the tax equity issue is very powerful. And when you talk about tax equity versus subsidies for low income people, you have both very different discussions and discussions with very different people on Capitol Hill. And when Mark Pauly talks to the tax staff on Capitol Hill about risk-adjusting tax credits, I'd really like to be in the room.

**Chris Jennings.** I'd like to start by saying that anyone who tries to expand coverage and is willing to take the heat for trying should be welcome in any discussion of health care. We noted in 1993, 1994, and 1995, it's a lot easier to tear down than to build up. So, whatever the options being offered, they should be welcomed and appreciated.

The big challenge we face is deciding what's important to us. What are the tradeoffs? The issue of tax equity is an important one to the Congress. It always has been. The reason we spent billions of dollars to do a 100% tax deduction for the self-employed was not to expand coverage; it was to address the fact that it wasn't fair that the self-employed had a 25% deduction while everyone else employed had 100%. But I don't think even when we did that that people argued the change would have a significant impact on coverage expansion. One of the dangers now, however, is that every insurer in America is coming to me saying they have a new expansion policy and they are all rooted in tax initiatives.

I think it's a very dangerous approach because they're suggesting that these initiatives will significantly expand coverage in an affordable way. Once Treasury, the Joint Tax Committee, and CBO examine and score some of their proposals and how many uninsured people they cover, I think those claims will be challenged. And I think the dollars are going to scare some people away. The estimators on Capitol Hill make it clear that the only way we're going to get significant coverage expansion is with very, very significant subsidies (subsidies of 90% of premiums will be needed to get significant take-up rates).

I also think that these tax proposals will have a significant impact on the private insurance market. If the tax assistance is out there, I think there will be incentives for employers to no longer provide coverage. There will also need to be reforms in the individual marketplace. Historically, however, not a lot of people have come to me suggesting significant insurance reforms along with new tax incentives.

Finally, in deference to my Treasury colleagues, they will say that it would be extremely difficult to administer tax credits, especially if we're going to have risk-adjusted credits. Especially a year after they wanted to eliminate the IRS, I think there are political administrative issues we'll have to deal with.

To sum up, in terms of tax equity we may want to start contemplating some tax changes. But I don't think we should suggest they will necessarily have a significant impact on coverage. And, to the extent it does, we're going to have to overlay significant regulatory reforms that I don't think this Congress is likely to undertake. In that case, I'm not sure it would be worth the cost the subsidies will require. That leads me more toward looking at different subsidy approaches, maybe in combination with tax approaches. That's because I think the end game continues to be to cover more people. And probably the most efficient way to deal with coverage expansions involves mandates – as Mark Pauly has suggested. Whether they are Medicaid mandates, individual mandates, employer mandates or tax mandates – if people want to start talking that way in Washington again, I think we will be talking about the most efficient way to achieve expanded coverage with limited public dollars.

**Sheila Burke:** It's not clear to me that we should assume that tax subsidies and direct subsidies are mutually exclusive. It seems to me that you might use both, depending on the population you're discussing. The problem of timing has always seemed to me a major issue with the tax approach – providing the subsidy in advance rather than having the individual (especially the low income individual) carry the burden to the year's end. I'd like Mark Pauly to comment on how this problem could be addressed.

**Mark Pauly:** Our solution – in the income-related tax credit we advocate – was to treat the tax credit like any other tax payment over time – that is, through withholding. For employed people, your withholding would be adjusted to reflect the net tax you expect to have to pay at the end of the year. For most workers, that would mean that money that is now taken out of their paycheck for taxes would instead be directed – for low income workers – toward the insurance plan of their choice: straight from their paycheck to the insurer. We also proposed to have a fallback insurer for people who did not choose an insurer. That was with a mandate for participation, but it seems a good idea regardless.

You still might run into a problem for someone who has no income. But I think Medicaid or some kind of welfare plan has to pay 100% for them. For the population that I regard as the most important target population now – people whose income is too high for them to be poor but too low for them to be able to afford insurance – use of the tax system seems to me perfectly feasible.

On the risk adjustment: We do believe as researchers that there are some feasible risk adjustment mechanisms (although we may be fooling ourselves). My simplest version of this is to imagine that people could identify themselves as high risk, very much the way they do now to participate in a high risk pool. That is, if they're quoted high premiums by three insurers because of their diabetes, for example, they could get their credit bumped up to reflect that.

And on scoring: If scoring makes these kinds of proposals look bad, I guess so much the worse for scoring. Currently, a slim majority of low income people have private insurance. Some people worry about the cost of giving these people a tax credit, thinking they don't "deserve" it. I think of it as a lower middle income tax cut. I think that makes sense, even if they're already insured.

**Kathy Means:** I was reminded in listening to Mark Pauly's and Linda Blumberg's remarks that you cannot assume where somebody stands based on where they sit. I listened to Linda's critique of the tax approach and it could have been the remarks we made in Senator Durenberger's floor statement arguing against Senator Bentsen's health insurance tax credits for children. They had a very lively debate. The debate led to legislation that not only provide Medicaid expansions for children but also tax credits for children that have not survived the decade – for some of the same complications Linda identified.

During the CHIP debate, I was at the Health Care Leadership Council and people asked about EITC and health insurance – could you use that approach. We had two problems with that. One is quite a bit of information coming out on fraud in the EITC – people registering with multiple identities and mailing addresses. Secondly, we had calls from both Democrats and Republicans about whether or not it's really appropriate to consider health insurance purchases a higher priority than some other things you want a tax credit to be used for, especially for low income people – like housing, food, clothing or other essential purposes. I raise this issue because I don't know how you provide tax credits for health insurance in a budget neutral way that doesn't take people's incomes away from these other purposes. I'm on the side of "welfare

maximization” – leave it to the individual to decide what their principal needs are; health insurance may be low on their list.

Finally, on tax deductibility – going back to the material Judy Feder presented earlier. I understand that extending tax deductibility to individually-purchased insurance doesn’t work successfully for low income people. But you could argue that for lower to middle income people, that approach allows for the geographic and other differences people face in the cost of insurance. It allows for an implicit risk adjustment.

**Judy Feder:** It’s important to recognize the difference between tax deductibility and most of the other policy options we’ve been discussing. Tax deductibility essentially offers a discount in the price of insurance. That’s very different from a subsidy that for a specified population covers the full cost of insurance. Given what we know about the need for significant subsidies to induce the purchase of insurance, the “discount” is likely to induce very little new purchase – providing most of its benefits to people who already purchase insurance. That’s very different from the impact of the more extensive subsidies in income-related tax credits like those Mark and Linda described or from direct subsidy approaches.

**Mark Pauly:** To Kathy’s point about “why tie a tax credit to health insurance?” I hear the point about not focusing on health insurance for people with incomes below the poverty line who have lots of needs for the use of a refundable tax credit (like EITC). But the target population above that line has incomes adequate to afford decent housing. The thing that kills them is the bill for health care that they weren’t expecting. Partly they don’t buy health insurance because there’s a safety net through free care in the emergency room. (But I would argue they should buy insurance).

**Mark Merlis:** On risk adjustment: You could limit the ways in which insurers could vary premiums to the very factors you want the tax system to take into account. For example, if all you could feasibly do is put age on the tax form (since I assume people aren’t going to start submitting medical underwriting answers on their Form-1040s), you would then tell insurers they could only vary the rates by age. But once you’ve done that, you’d have to ask: what is the social utility of a system in which insurers are quoting different rates by age and then you make it up with tax credits? How is that superior to a flat rate and a flat tax credit for a given income level?

**Mark Pauly:** Personally, I’m not in favor of offsetting the effect of age. If you’re at a reasonably decent income level, you ought to be able to afford premiums that creep up with age. The most important risk that you’d like to protect against, I think, is the risk of a long-term chronic illness. And the reason to do that with an adjustment to the credit rather than through community rating is that the latter causes insurers to avoid high risks and raises premiums for the healthy, so they drop coverage.

**Judy Feder:** There's some debate about that – about the effects of community rating or other rating roles on the scope of coverage. I call your attention to two papers prepared for this project: Mark Merlis, “Public Subsidies and Private Markets: Coverage Expansions in the Current Insurance Environment,” and Nicole Tapay and Judy Feder, “Impact of the Current Individual Insurance Marketplace on Coverage Expansion Proposals.”

**Karen Davis:** From the point of view of economic theory, there is a lot of advantage to using the tax system. It is certainly good for equity purposes; and it is good for administrative simplicity. Twenty years ago, when I dealt with Treasury, they got apoplectic about the extra administrative burden of low income people filing tax returns. We got beyond that hurdle with the EITC. So we can talk about using the tax system to target subsidies toward low-income people. And we can get past issues like timing of receipt of tax subsidies and payment of insurance premiums and substitution of private coverage for the already insured.

To me, the principal flaw when we go from theory to reality is the insurance mechanism through which people get their coverage. Medicare, large employers, states through Medicaid or CHIP, and state and federal governments as employers are able to provide good coverage for their populations because they are big purchasers. They get good premiums. They get decent plans. They get a decent choice of plans for their enrollees. They get lower administrative costs. They get stability of coverage. So whichever one of these mechanisms appeals to you – federal employees, small business purchasing coalitions, HIPCs – until I see a tax credit tied administratively to a mechanism like this in which people can get decent health insurance for a decent price, I can't get enthusiastic about it.

If we could get over that hurdle, I think we could get over some of the other issues. So take your favorite. If you want to take state public employees as your favorite mechanism, there could be a way to direct IRS to give a line of credit to the state employees' plan for your premium. On an interest free basis, you could pay them back at the end of the year when you file your tax return. When you think about who's writing the check to whom, how people are going to get their booklets about the choices, who's going to transmit the premium to the insurance plan, how they will handle a divorce or a move out-of-state – you have to go beyond just thinking about a tax credit to thinking about how to design an ideal insurance mechanism wedded to it. That would make the idea more politically realistic and viable.<sup>13</sup>

**Mark Pauly:** My own vision for a tax credit is it would encourage a lot of uninsured individuals who are working for big and small firms that don't now provide coverage to be offered coverage in response to a credit. Workers would line up at their benefits office and say: organize a group for us.

**Linda Blumberg:** I think you might find a little of this reaction among employees. But you have to remember there are lots of reasons why employers don't offer coverage. And part of it is they have high rates of labor turnover. And, since the variance of premiums in small firms is substantial, they worry about providing something now they might have to take away later. And, of course, they also face administrative costs they may prefer not to incur.

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<sup>13</sup> See expert proposals like Blumberg's and Primus' that tied tax credits to public insurance arrangements.

More broadly – looking at our overall discussion: A lot of the debate over different approaches has to do with trading off different evils. Every proposal has its own evils. If you are worried about work disincentives at the margin, you take subsidies way up the income scale. But the tradeoff is, you have to spend a lot more money on higher income people and you have less available for the low income. If you worry about error rates, as Treasury is currently required to do, then you have to reconcile at the end of the year; that's the most effective way to reduce error rates. But the tradeoff is higher administrative costs, along with lower participation and coverage.

We have to decide what kind of errors we can tolerate. Am I willing to tolerate some error as we do in the Medicaid program or CHIP--doing whatever verifying we do of income and wages up front? In essence, this would mean giving people a subsidy and sending them on their way; we wouldn't worry so much about trying to get it back. We have to decide if we really want to aggressively pursue modest income people at the end of the year and say: "We gave you a nice big subsidy; but as it turns out, your income was a little higher than you expected, so give it back!"

These are some of the tradeoffs. I think it is extremely important that we decide how much it makes sense to obsess about waste.



## **Crowd-Out: Causes, Costs and Consequences**

### **Introduction**

Diane Rowland

Whenever the focus is on incremental not universal coverage, proposals inevitably target some group for support. One of the key issues in targeting to a group with a limited amount of dollars is a reluctance to pay for somebody who already has health insurance coverage. The previous discussion addressed this issue with respect to tax policy. We also face it in direct subsidies. [Here it's more often referred to as crowd-out than as equity, but it's the same issue.] As we did in CHIP, we worry in any expansion about how to keep people with private employer-based coverage in that coverage, in order to minimize new public costs and use every available dollar for uninsured people, rather than replacing existing coverage for people who are already insured.

From an equity perspective, it is important to recognize, however, that some of the people who have insurance today acquire it at great personal cost. Whether we're considering redistribution of Medicaid dollars or redistribution of tax credits, we have to consider what to do to be fair to individuals, to employers or to states that have already gone the route of insuring.

The following presentations by John Holahan and Kip Piper address some of the issues and tradeoffs that arise in what, in the expansion of direct subsidies, is typically referred to as crowd-out. Commentary and discussion will follow.

### **Children's Health Insurance: The Difference Policy Choices Make**<sup>14</sup>

John Holahan

The Children's Health Insurance Program allowed states a variety of ways to implement expanded coverage. To assess the implications of alternative implementation strategies, we modeled the impact on coverage and costs of three different approaches: a Medicaid approach with no premiums, a state-based approach with very low premiums (\$250 per year for families with incomes at two hundred percent of poverty) – similar to what most states are adopting; and a state-based approach with premiums set two to three times higher (at one percent of income for one child and two percent of income for two or more children). For all three options, we examined eligibility up to 150 percent of poverty, 200 percent of poverty, and 300 percent of poverty--the latter an option since states can “disregard” income to establish eligibility levels above the 200 percent of poverty specified in the law.

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<sup>14</sup> This presentation draws from John Holahan, Cori Uccello and Judith Feder, “Children's Health Insurance: The Difference Policy Choices Make” Incremental Health Reform Project, The Henry J. Kaiser Family Foundation, 1999.

The key outcomes we looked at were participation by the currently uninsured, displacement or crowd-out of private coverage (which the rules prohibit but may nevertheless occur, if individuals benefit) and the level of public expenditures.

Consistent with Judy Feder's presentation earlier, our analysis required some key assumptions. With regard to likely participation rates based on price and income, we relied on the literature, principally the work of Steve Long and Susan Marquis. With respect to barriers to participation in public programs, we relied on experience--and assumed that roughly twenty percent fewer people would participate in Medicaid that could be expected to participate in private insurance; and that fifteen percent fewer would participate in a somewhat more attractive new state-based program. The modest difference reflects our view that if applicants still have to prove their income and if states, by and large, tend to rely on the same set of providers, then Medicaid and state-based plans will not be very different--here, five percent different--in their ability to attract enrollees. On the likelihood that individuals who already had employer-based coverage would shift to Medicaid--the crowd-out effect--we also relied on the literature, as reviewed by Lisa Dubay.<sup>15</sup>

I will briefly summarize our key results related to eligibility under alternative proposals, participation, public expenditures and crowd out.

First, we looked at eligibility. The key finding here is the number of potential eligibles, that is both the uninsured and the insured who meet the income eligibility standards, increase rapidly as eligibility levels are extended further up the income distribution. We found 2.6 million eligibles at 150 percent of poverty, 7.2 million at 250 percent of poverty, and 18.3 million eligibles at 300 percent of poverty. Of this last group, 80 percent now have private coverage; if you go down to 250 percent of poverty, a smaller proportion--about 68 percent--have private insurance. So, the more you go up the income distribution, the greater the problem of crowd-out becomes.

Second, we looked at participation of the currently uninsured. Again, this is based on the assumptions which we argue are grounded in the best literature that we could find. The central finding here is that in the no-premium plan, or even the low-premium plans, there are relatively high levels of crowd-out; this is because the public plans are available at such low costs relative to what people are now paying for their contribution to their employer's plan. There's much less crowd-out in the high premium plans. As income goes up, premiums increase and the contribution to CHIP plans approach or even exceed the typical employee contribution and families are less likely to switch.

What this means, then, is that a Medicaid or a zero premium plan would have the highest participation rates of the uninsured, but also the highest displacement of private coverage. Plans with high premiums would have the lowest participation by the uninsured, but the least crowd-out. Low-premium plans are somewhere in the middle. They have less participation relative to Medicaid of the currently insured, but also have high displacement of current coverage much like Medicaid.

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<sup>15</sup>Lisa Dubay, "Expansions in Public Health Insurance and Crowd-Out: What the Evidence Says," Incremental Health Reform Project, The Henry J. Kaiser Family Foundation, 1999.

The third point is that premiums reduce public expenditures but there's less of an impact on expenditures than there is on participation. We found that in an expansion to 200 percent of the poverty line, high-premium plans resulted in a 12 percent reduction in expenditures relative to Medicaid. That is, if you compare high premium plans to Medicaid, the high premium plans are 12 percent less costly, but they cover 25 percent fewer participants. The reason for this is the premiums result in adverse selection. That is, those who need it the most are more likely to pay the premiums. The higher the premiums, the more adverse selection and the higher the cost per child. This could be viewed as effective targeting—that we're allocating scarce dollars on those who are sick, but nonetheless, the costs per covered child are higher than they would be if there were broader coverage. One implication of this is that the marginal cost of a broader expansion, a plan that had lower premiums would be relatively low. There would be more participants, but the broader expansion would bring in lower cost people so that the incremental costs of broader expansion would be surprisingly low.

The fourth point is that there are benefits to crowd-out. Those who give up private for public coverage pay less. These are more likely to be families who are now paying a high share of their premiums. Firms will also pay less, at least in the short run; this could obviously be shifted back eventually to the workers themselves in higher wages. We estimated that the benefits were about a thousand dollars to families and about nine hundred dollars to the firms. So there is a lesson here about target efficiency, if the uninsured are the target, then crowd-out means that you have a fair amount of inefficiency. The amount you're spending for newly covered persons is relatively high. But, if you think of the target as the uninsured plus low-income families that are now paying a lot for coverage and who may drop in the near future, then crowd-out really isn't as target inefficient as it may seem. Moreover, you're really introducing some horizontal equity into the program.

I think the key question here is: what does this say about how much states should rely on premiums. States are faced with a dilemma. The higher the premiums the more they're really giving people something that looks like mainstream coverage. There's less of a notch as income increases; people would find it easier to move into an employer-based plan. They have lower expenditures and there's less crowd-out. You could even argue because higher premiums result in more enrollment of those people with more health problems, that you're really getting more effective targeting. But on the other hand, there is substantially less participation of the currently uninsured. A broader expansion with lower premiums would bring in more participants, including some who now have employer coverage, at a relatively low marginal cost per new participant. That's the trade-off that states are going to have deal with and something that I think is shown pretty clearly in our paper.

## **Politics and Program Design**

Kip Piper

Much of the discussion at this conference has been about architecture – how to design a program to address the vast set of issues related to efficiency and equity. But, above architecture in issues of program design is politics. A lot of what’s going on in individual states is fundamentally political, with the crowd-out issue itself used as a guise – a sort of sheep’s clothing – for other issues. The real impact of a proposal may matter less in getting something passed than appearances. It’s only after something is implemented that a lot of states examine research like John Holahan’s and say: “oh my goodness; look what we did.”

Crowd-out is that kind of issue. CHIP’s rules are artificial – essentially dictating that crowd out will not happen. But we all know that it does happen and that, to a degree, that’s reasonable and acceptable. What we have to figure out are the positive benefits that make this “inefficiency” acceptable. And that will be easier in some states than in other. For example, Massachusetts used a little judo to make crowd-out an advantage; that is, to come up with a system that blends both Medicaid and CHIP. In other states, budgets will make crowd-out an issue – probably a few years from now. You can’t look at crowd-out – or any other design issue – in a vacuum. It has to be considered in the context of the economics and politics of particular states.

CHIP offers us the possibility to look at the way different states handles this and treat the differences as experiments. We can compare and contrast different practices over time. And states are pretty pragmatic. They may not always appear that way; they may appear very political and partisan. But if you can provide them with tools to use and the encouragement to be creative, they are more likely to succeed – in this case, to get people covered in their own political environments.

## **Commentary and Discussion**

**Karen Davis:** So far today we’ve talked about the evils—or as Mark Pauly prefers—the imperfections of incremental reform. One imperfection is inequity; another is administrative complexity; and a third one, that we’re now focusing on is substitution for existing coverage. I think we have to recognize that these “imperfections” are issues inherent in any incremental proposal. If you find them overwhelming and you want to do something about uninsurance, you’ve got to be for universal coverage.

But there are also positive aspects of incremental reforms. They are less expensive than universal reform. They can be targeted on the most needy. They’re less disruptive of the current system and they create fewer winners and losers. And it’s possible to build on existing insurance mechanisms rather than create something brand new. We didn’t move forward with universal coverage. We did move forward with CHIP.

What we need to do, then, with incremental coverage is remind ourselves what are its objectives, and, of those objectives, what kind are first order and what kind are second. We may differ in the weight we give to different objectives. But it’s useful to put on the table what matters a lot, what matters some, and what matters not at all.

The primary objective of incremental reform is to cover those who are most vulnerable. If we're focusing on getting that coverage to assure financial access to needed services, that gets into the benefit package; it has to cover prescription drugs, for example, if we want to assure appropriate services to people with chronic conditions. If we're focusing on protecting against the financial burden of health expenses, we may be less concerned with crowd-out. If someone now pays forty percent of income to get insurance and they can get coverage that reduces their obligation to five percent, that achieves the goal of better financial protection.

What are the secondary objectives of incremental reform? Equity, defined in at least three ways, is a second order objective. Defined in terms of income, horizontal equity means treating everybody with the same income the same way. Across incomes, equity means at worst that everybody pays the same percent of income; or, if we differentially favor low income people, they pay a lower fraction of their income for health care and health insurance than higher income people. Second is geographic equity, to which we need to pay more attention; a family living in one state that gets a much better deal than a family living in another state should concern us. Third is equity across the sick and the well. If we're driven by protection against financial burden, we don't want the sick to have to pay a lot more than the well, in a given income class.

Other secondary objectives are efficiency – getting the most improved protection per dollar spent; budget predictability; and avoiding substitution. These are all things we want. But we have to keep reminding ourselves that these are second order goals; the first order is to see that people get care and are protected from financial expenses.

On crowd-out – our obsession with it is not warranted and is counterproductive. Some argued that providing public coverage would crowd out private coverage. So, to meet that argument, we built into CHIP provisions to avoid substitution. Now those provisions are creating problems that have to be addressed at some point. The first problem is that it is easier to collect a premium if you have a check to deduct it from. In Medicare, for example, you don't have to collect the Part B premium. You take it away before they get Social Security. And employers don't collect the employee's share of premium. They take it out of paychecks before employees get it.

When you talk about low income families, who are not on welfare and have no relationship with state government, there is no check from which to deduct. These people don't have checking accounts and they don't have other ways in which they're coming to you regularly to pay the \$20 – the “low” monthly premiums John Holahan described. So we can talk about the beauties of premiums, but it's a tough thing to collect premiums when there's no check from which to deduct them.

Another thing to think about when it comes to crowd-out is the uncertainty of its magnitude. There's evidence from Minnesota that only four percent of people newly covered used to have employer coverage and only three percent used to have individual coverage. It's one thing to talk about economic theory, but people are motivated by other things – convenience, being treated like their peers, their fellow workers, their neighbors, or their children's friends. Even if it's economically advantageous for them to switch from employer to public coverage, they're going to stick with employer coverage because that's where their fellow workers are.

Remember, there's not a lot of employer-based coverage to crowd out below 150% of the poverty level. For this and the other reasons I've laid out, we shouldn't be obsessed with crowd-out.

If we are substituting for employer coverage – or worried that employers will stop covering children, the way to solve that is to require a contribution from employers who don't cover dependents. In economic terms, if we're worried about a "free rider" problem, require all employers to contribute in some way. If we're substituting for individual coverage, I think that really doesn't matter, since we're reducing financial burdens – one of our first order objectives. And if we're substituting for Medicaid, I think we really shouldn't worry about it. It matters now, with incentives to favor one program over another and entitlements in one program and not another. We want to be sure that the most vulnerable are covered no matter whether we're in good economic times or bad economic times; providers will see that benefit packages are equal; and states will probably equalize provider payment rates between Medicaid and CHIP over time.

The bottom line is that we want something that works. We want children covered, whether it's Medicaid or CHIP, and we don't want to leave them vulnerable in bad times when it's not as easy for state governments to come up with the money to pay for their coverage.

That means the focus in CHIP ought to be on two things. One is how to make CHIP work better. At some point that means looking at the different matching rates in Medicaid and CHIP, even if that's politically difficult. Another is to look at the different matching rates for states that had generous eligibility before CHIP and states that did not. And another is letting people choose the program they prefer, even if they're technically eligible for one program (Medicaid) and not the other.

The second issue is how to build on the CHIP experience to expand coverage to adults, particularly the parents of these children. We need to move forward to family-based coverage and federal matching rates to expand coverage beyond children to their parents.

**Kathy Means.** The crowd-out issue, raised in the context of the CHIP legislation, was indeed a matter of public expenditures. It was raised in the context of the magnitude of overall funding proposed for CHIP and had to do with whether the amounts of money involved were much larger than states could effectively absorb and the incentives they might be given to draw down this money. And [reactions to this concern] had some unintended consequences.

In developing the CHIP legislation, there were discussions with states (like Florida, Pennsylvania, and a couple of others) that had programs in place with more of a private component. It was these states that came forward, saying they were a little bit concerned about the design of the program and about crowd-out – that is, about substitutions of public for private spending. At the same time, however, it's true that there's some level of inefficiency we should tolerate here.

**Karen Nelson.** Crowd-out isn't just a phenomenon related to incremental programs. You might say that a publicly financed universal health insurance system is the ultimate crowd-out: it's been totally crowded out by an employer-based system, of course.

Crowd-out becomes particularly relevant when you're trying to decide what your priorities are. When you develop an incremental program, you presumably have limited dollars; that means thinking about how many people in a group are already covered. You don't want to jump into a place where sixty or seventy or eighty percent of the group are already covered.

Crowd-out is often used as an excuse to do nothing, and it will continue to be used that way. The more we're sort of "fixated" on it, the more we kind of dig a hole we can't get out of; you're always going to have a lot of people who have coverage somewhere.

Once we've decided what we want to do and set our priorities, then I would hope we would not use crowd-out as an excuse to undermine the key goals of the program we've put in place. If our goal in CHIP is to try to make sure all low-income children are covered, I'd rather make sure we get kids in than be concerned that somebody who used to have coverage – adequate or inadequate – somehow creeps into the program. Things like waiting times, higher premiums, less attractive benefits – all of these things are aimed at keeping people out. In the end, they ill serve the very people we are trying to get in to our programs.

**Diane Rowland.** I agree. We talk as if people have stable sources of insurance coverage; as if the person who has employer-coverage today will always have that coverage. Yet we know that there is incredible churning going on in the employer-based system. In the Medicaid system, the average person is barely enrolled for a year. When we have a system in which people are moving across different sources of coverage, the concept of crowd-out becomes a little odd. You're not really replacing a single source of insurance with another source; you're adding a new option to the mix.

Administratively, putting the burden on states to make sure that no one who has private insurance goes on to CHIP means a very difficult burden of trying to assess who had what kind of coverage. Administratively, as in other ways, it's really difficult to target enrollment and outreach efforts to just a narrow group of people that currently don't have insurance, or haven't had it in the last six months.

**Jennifer Baxendell:** HCFA and the states have done a very good job in prioritizing crowd-out prevention strategies. But no one has explicitly stated the real problem: no one knows what we're supposed to be doing to prevent crowd-out. So we have no real strategy. Maybe some combination of waiting periods and ongoing evaluation will keep us from looking like we've fallen asleep on the job. But we ought to make it a priority to come up with data on how various combinations work – rather than just trying to get HCFA approval. Right now states have a good sense of what they need to do to get approved. But we're missing the development of a better way to get data and evaluate what states are doing.

**Deborah Chollet.** Crowd-out has two aspects, and it might be useful to separate them. One aspect is budgetary. Part of the appeal of a tax credit is that it would facilitate new public spending for health care by reorganizing existing public spending. The budget issues underlying concern about crowd-out then evaporate. By contrast, the prospect of new public programs without restructuring tax preferences leaves the budget issue squarely in front of us.

The other aspect of crowd-out is the insurance industry's issue: replacing a product that is privately marketed with a public program. To the extent that a public program is buying private insurance products--that is, contracting with managed care plans--the insurance industry simply does not want to contend with a monolithic buyer. They don't like the public sector as buyer in the same way the pharmaceutical industry dislikes the idea of Medicare as a buyer of prescription drugs.

It's important to separate the budget issue from the monolithic buyer issue. If you solve the first issue but fail to solve the second, the industry will oppose you. For example, if we gave everyone a tax credit and sent them out into the market, what would we have them buy? I would say, maybe we would have them buy something like the Washington Basic Health Plan. That's a pretty good model for a public insurance program: in effect, it's a purchasing cooperative for individuals. It could be a much larger buyer if its enrollment were permitted to grow, and there is a long waiting list of applicants to buy into the program. But perhaps one reason that it works politically is that it's limited, and the insurance industry can at this point afford to ignore it.

**Mark Pauly.** I don't lie awake nights worrying about crowd-out, but if I did, I'd worry about efficiency. The right efficiency question is: Is the insurance policy that people end up with when they move from the private to the public sector a better or more appropriate policy than the one they had before? The question is the net benefit -- the value in relationship to the cost of each of the two policies. I suspect some people will stay in the private sector because they like the policy they get there and they don't want a policy bureaucrats pick for them. But others would be just as happy to move to the publicly administered or contracted program -- and there is a potential gain there. Crowd-out, after all, only transfers cost.

What really matters is how much diversity of preference there is and how close the public competitor can come to what the private sector is doing. Insurers will complain, but if they want to fight for the poorest twenty percent of the population, they can offer a good deal or not get it.

**Judy Feder:** The discussion of crowd-out in public programs seems a lot like the discussion of equity in tax policies. Proponents of "equity" argue that it shouldn't matter or that equity means we ought to provide people the same benefits, regardless of their insurance status. But it is interesting that we refer to the issue in terms of "equity" when we talk about taxes and we call it "crowd-out" when we talk about public programs. In both cases, it's substitution of public for private dollars.

The concern that I think this substitution raises--whether in tax policy or with respect to CHIP or other public programs--is whether we really are treating all people in a given income group equally. Instead, we may be favoring one population over another. If we design our initiatives in such a way that the higher income or already insured find it easier to use or to get than the lower



income or uninsured population—and if we're not making a sizable and effective effort to get low income, uninsured people enrolled—then we're skewing our money and our support away from the population that needs it most.

The decision to charge premiums in CHIP raises exactly that issue. If premiums deter participation in CHIP by the uninsured more than they deter participation by the already insured, charging premiums skews coverage in the wrong direction. (That's what John Holahan's analysis shows). Similarly, if we use CHIP funds to cover employees' share of employer premiums, as some would like (and virtually everybody would like, if we have the money), it again makes it easier for a population that already has coverage to take advantage of it. If we don't at the same time make it easy for the uninsured to enroll—and get them enrolled—we've again skewed our resources to more rather than less advantaged parts of our population.

**Rick Curtis.** Changes in the way we structure tax subsidies may well be our best hope politically of getting major investments in covering the uninsured. That's on the one hand. But on the other hand, our current tax structure has leveraged employer coverage and contributions. In effect, it has drawn a very high matching rate from employers. Labor economists posit that, in the long run, what employers pay comes out of the pockets of employees. Whether or not that's true, from the point of view of an individual employee, the employer's contribution is money available for, and in most cases only available for, health insurance. (The net perceived price for health insurance is thus much lower, increasing the number who participate.)

We cannot simply redistribute current tax dollars and necessarily come up with nearly as much money earmarked for health insurance as we now have available through employer coverage; the employers' contributions are bigger than the tax expenditures (Employer contributions grew greatly as a result of tax incentives. They seem likely to decline greatly if there is no tax incentive for employer-based coverage.) I don't think we're going to see the kind of increase in tax expenditures we would need to both replace employer contributions and add substantially more tax expenditures to reach the uninsured.

If the subsidy isn't that large, more people, even moderate income people, won't buy insurance, and the uninsured rate could well rise. The challenge then is to find ways to structure tax policy to allocate dollars more effectively to reach the uninsured and be more progressive or, at least neutral with respect to income—and still leverage contributions from employers.

## **Appendix A—List of Expert Proposals and Conference Papers**

### **Expert Proposals**

Extending Health Insurance Through Insurance Credits

Mark Pauly

Analysis of a Specific Tax/Health Credit that Provides Insurance to All Children

Wendell Primus

Children’s Health Insurance Coverage: Tax Credit and Publicly Sponsored Children’s Insurance Pool

Linda Blumberg

A Premium Subsidy Program for Modest Income Children

Mark Merlis and Richard E. Curtis

Children’s Health Insurance: The Difference Policy Choices Make

John Holahan, Cori Uccello and Judith Feder

Expanding Health Insurance Through Tax Reform

Stuart Butler

Extending Health Insurance Through Incremental Reform

Gail Wilensky

Subsidizing COBRA: An Option for Expanding Health Insurance Coverage

Thomas Rice

Medicare Buy-In Proposal

Pamela Loprest and Marilyn Moon

Medicaid Expansions for Low-Income Adults

John Holahan and Cori Uccello

### **Issues in Incremental Reform**

An Assessment of Strategies for Expanding Health Insurance Coverage  
Sherry Gleid

Incrementalism: Ethical Implications of Policy Choices  
Ruth Faden and Madison Powers

The New Child Health Insurance Program: A Carefully Crafted Compromise  
Alan Weil

Children's Health Insurance: The Difference Policy Choices Make  
John Holahan, Cori Uccello and Judith Feder

Expansions in Public Health Insurance and Crowd-Out: What the Evidence Says  
Lisa Dubay

Public Subsidies and Private Markets: Coverage Expansions in the Current Insurance  
Environment  
Mark Merlis

Impact of the Current Individual Insurance Marketplace on Coverage Expansion Proposals  
Nicole Tapay and Judith Feder

## Appendix B- Summary of Health Insurance Plans –Children’s Plans

Plan	Population	Other Categorical Eligibility	Financial Eligibility	Subsidy/Benefit	Insurer	Administration and Flow of Funds
<b>Tax Credit Proposals</b>						
<b>Fixed Dollar Tax Credit</b>	Children	Medicaid <u>enrollees</u> are ineligible	500% PL (AGI)	<ul style="list-style-type: none"> <li>§ Fixed Dollar Tax Credit</li> <li>§ Refundable</li> <li>§ \$500 per child</li> <li>§ No limit on the number of children</li> <li>§ Full credit available for families with incomes below 450% of poverty, phasing out linearly to 0 at 500% of poverty</li> </ul>	Individual Chooses in Unrestricted Market	<ul style="list-style-type: none"> <li>§ IRS</li> <li>§ Employer responsible for reporting coverage and policy value to IRS</li> <li>§ Timing: Annual, Retrospective</li> <li>§ Full federal funding; funds flow to families</li> </ul>
<b>Income Related Tax Credit (Pauly)</b>	Children	Medicaid <u>enrollees</u> are ineligible	<500% PL (AGI)	<ul style="list-style-type: none"> <li>§ Income related tax credit to substitute for tax-shielded employer-paid premiums</li> <li>§ Refundable</li> <li>§ Amount tied to cost of managed care policy</li> <li>§ Full credit available for families with incomes below 150% of poverty, phasing out linearly to 0 at 500% of poverty</li> </ul>	Individual Chooses in Unrestricted Market	<ul style="list-style-type: none"> <li>§ IRS</li> <li>§ Employer responsible for reporting coverage and policy value to IRS</li> <li>§ Timing: Annual, Retrospective</li> <li>§ Full federal funding; funds flow to families</li> </ul>
<b>Combination (Credit/Subsidy/Program) (Primus)</b>	Children	None	All incomes	<ul style="list-style-type: none"> <li>§ Elimination of current child exemption</li> <li>§ For people who insure their children, a tax credit up to \$800 per child<sup>1</sup> plus an income related premium subsidy</li> <li>§ Subsidy limits family contributions to 10% of earnings above threshold.</li> </ul>	Individual Chooses State Plan or Group Market	<ul style="list-style-type: none"> <li>§ IRS</li> <li>§ State welfare/ Medicaid offices</li> <li>§ Employers responsible for reporting coverage to IRS</li> <li>§ Full federal funding; funds flow to families and to states</li> </ul>
<b>Combination (Income Related Tax Credit/ State Administration) (Blumberg)</b>	Children	Federally mandated Medicaid <u>eligibles</u> are ineligible <sup>1,2</sup>	<300% PL (AGI)	<ul style="list-style-type: none"> <li>§ Income related tax credit</li> <li>§ Refundable</li> <li>§ Amount tied to a kids only premium</li> <li>§ Full credit available for families with incomes below 133% of poverty, phasing out linearly to 0 at 300% of poverty</li> <li>§ Credit applied to child portion of premium only</li> <li>§ Credit is applied first to worker premium share, with any excess applied to employer share</li> <li>§ 100% of credit can be received up front</li> </ul>	Individual Chooses State Plan or Private Group Market	<ul style="list-style-type: none"> <li>§ State welfare/ Medicaid offices and other certified offices</li> <li>§ Option for partial advance with IRS reconciliation</li> <li>§ Employer responsible for reporting coverage and policy value to IRS</li> <li>§ Full federal funding; funds flow to states or to employers/insurers in transferable tax credits</li> </ul>
<b>Subsidy Proposals</b>						
<b>State Subsidy Program (Merlis and Curtis)</b>	Children without access to ESI	Federally mandated Medicaid <u>eligibles</u> are ineligible	<300% PL (family income)	<ul style="list-style-type: none"> <li>§ Income related premium subsidy</li> <li>§ Amount tied to "kids only" premium</li> <li>§ Full subsidy for families with incomes below 133% of poverty, phasing out linearly to 0 at 300% of poverty</li> </ul>	State approved child health plan (single private carrier or purchasing cooperative)	<ul style="list-style-type: none"> <li>§ State Welfare / Medicaid Offices</li> <li>§ Advance payments with IRS reconciliation</li> <li>§ Full federal funding; funds flow to states</li> </ul>
<b>CHIP Low Premium (Holahan, Uccello, Feder)</b>	Children with access to ESI	Federally mandated Medicaid <u>eligibles</u> are ineligible	<300% PL (family income)	<ul style="list-style-type: none"> <li>§ Income related premium subsidy</li> <li>§ To promote retention of employer plan, extra subsidy available for families with access to ESI</li> </ul>	Employer plan only	<ul style="list-style-type: none"> <li>§ State Welfare / Medicaid Offices (or IRS)</li> <li>§ Full federal funding; funds flow to employers</li> </ul>
	Children	Federally mandated Medicaid <u>eligibles</u> are ineligible	<300% PL (family income)	<ul style="list-style-type: none"> <li>§ State plan</li> <li>§ 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).</li> </ul>	State plan	<ul style="list-style-type: none"> <li>§ State welfare offices and other certified offices</li> <li>§ Federally and state funded; federal funds flow to states</li> </ul>
	Children	None	<300% PL (family income)	<ul style="list-style-type: none"> <li>§ Medicaid coverage</li> <li>§ Full subsidy for families with incomes below 300% of poverty</li> </ul>	State Medicaid	<ul style="list-style-type: none"> <li>§ State welfare/ Medicaid offices</li> <li>§ Federally and state funded; federal funds flow to states</li> </ul>
	Children	None	Varies by State*	Varies by State (Medicaid/State Plans)	State plans or Medicaid	<ul style="list-style-type: none"> <li>§ State welfare/ Medicaid offices</li> <li>§ Federally and state funded; federal funds flow to states</li> </ul>

\* 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

<sup>1</sup> An \$800 credit was modeled, rather than the \$900 credit indicated in the Primus proposal.

**Summary of Health Insurance Plans  
Individual and Family Plans**

Plan	Population	Other Categorical Eligibility	Financial Eligibility	Subsidy/Benefit	Insurer	Administration and Flow of Funds
<b>Tax Credits</b>						
<b>Tax Credit for Premiums and Medical Expenses</b> <b>(Butler)</b>	Individuals and Families	None	All Incomes	§ 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	§ 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
<b>Income Related Tax Credit</b> <b>(Pauly)</b>	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 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
<b>Expansion of Health Insurance Premium Deductibility</b> <b>(Wilensky)</b>	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
<b>Subgroups</b>						
<b>Subsidize COBRA</b> <b>(Rice)</b>	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
<b>Subsidized Medicare Buy-In</b> <b>(Loprest and Moon)</b>	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
<b>Low-Income Adults</b>						
<b>Expansions for Low-Income Adults</b> <b>(Holahan)</b>	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

## **Selected Contributors and Participants**

Drew Altman is President and CEO of The Henry J. Kaiser Family Foundation.

Jennifer Baxendell is a Health Analyst for the Senate Finance Committee.

Linda Blumberg is a Senior Research Associate at the Urban Institute.

Sheila Burke is Executive Dean of the Kennedy School of Government, Harvard University.

Deborah Chollet is a Vice President at The Alpha Center.

Nancy Cobb is Director of the Children's Health Insurance Program in the State of Indiana.

Howard Cohen is with Greenberg Traurig.

Rick Curtis is President of the Institute for Health Policy Solutions.

Karen Davis is President of The Commonwealth Fund.

Judith Feder is Dean of Policy Studies at Georgetown University.

John Holahan is Director of the Health Policy Center at the Urban Institute.

Julie James is Principal, Health Policy Alternatives.

Chris Jennings is Deputy Assistant to the President for Health Policy, White House.

Larry Levitt is Director of the Changing Healthcare Marketplace Project, The Henry J. Kaiser Family Foundation.

Cindy Mann is a Senior Fellow at the Center on Budget and Policy Priorities.

Kathy Means is Chief Health Analyst, Senate Finance Committee.

Mark Merlis is Senior Fellow, The Institute for Health Policy Solutions.

Karen Nelson is Senior Health Advisor in the Office of the Honorable Henry Waxman.

Mark Pauly is Professor of Health Care Systems at the Wharton School of the University of Pennsylvania.

Kevin (Kip) Piper is a Vice President at The Alpha Center.

Mark Reynolds is Deputy Commission with the Division of Medical Assistance in Massachusetts.

Trish Riley is National Academy for State Health Policy.

Diane Rowland is Executive Vice President, The Henry J. Kaiser Family Foundation.

Bridgett Taylor is Minority Professional Staff Member, Commerce Committee Democratic Staff.

Alan Weil is Director of the Assessing the New Federalism Project at the Urban Institute.

## Conference Program

### **OPTIONS FOR EXPANDING HEALTH INSURANCE COVERAGE: WHAT DIFFERENCE DO DIFFERENT APPROACHES MAKE?**

**A Conference Sponsored by the Kaiser Family Foundation  
The Hotel Washington, Washington, D.C.  
February 17, 1999  
8:45 am - 2:30 pm**

The purpose of this roundtable is to engage congressional and administration staff, other federal officials, state policymakers and selected members of the press in a discussion of the trade-offs and controversies associated with alternative approaches to expanding health insurance coverage--all of which are either under consideration (tax preferences vs. direct subsidies, use of the CHIP model for adults) or in the process of implementation (new state programs vs. Medicaid under the Children's Health Insurance Program or CHIP).

A series of topics will be used to guide the discussion. Each topic is developed or further explored in papers commissioned under the Kaiser Commission Project on Incremental Health Insurance. Copies of the papers will be distributed at the conference.

<b>8:45-9:15 am</b>	<b>Continental Breakfast</b>
<b>9:15-9:30 am</b>	<b>Welcome by Kaiser Family Foundation</b>  Drew Altman, President and CEO The Henry J. Kaiser Family Foundation
<b>9:30-10:00 am</b>	<b>Overview of Tradeoffs raised by Expansions</b>  Judy Feder, Dean of Policy Studies Georgetown Public Policy Institute Georgetown University  Sheila Burke, Executive Dean Kennedy School of Government Harvard University

**10:00-11:00 am**

**Federal Entitlements vs. State Discretion: Lessons from CHIP**

Chair: Sheila Burke

Speakers: Cindy Mann, Senior Fellow  
The Center on Budget and Policy Priorities

Alan Weil, Director, Assessing the New Federalism  
The Urban Institute

Lead comments: Howard Cohen, Share Holder  
Greenberg Traurig

Bridgett Taylor, Minority Professional Staff Member,  
Commerce Committee Democratic Staff

Trish Riley, Executive Director  
National Academy for State Health Policy

**11:00 am-12:00 pm**

**Tax Preferences vs. Direct subsidies: Reaching the Uninsured**

Chair: Judy Feder

Speakers: Linda Blumberg, Senior Research Associate  
The Urban Institute

Mark Pauly, Professor of Health Care Systems  
The Wharton School  
University of Pennsylvania

Lead Comments: Chris Jennings, Deputy Assistant to the President for  
Health Policy  
White House

Julie James, Principal  
Health Policy Alternatives

**12:00-1:00 pm LUNCH**



**1:00-2:00 pm**

**Crowd-out: Causes, Costs and Consequences**

Chair: Diane Rowland, Executive Vice President  
The Henry J. Kaiser Family Foundation

Speakers: John Holahan, Director, Health Policy Center  
The Urban Institute

Kevin Piper, Vice President  
Alpha Center

Lead Comments: Karen Davis, President  
The Commonwealth Fund

Kathy Means, Chief Health Analyst  
Senate Finance Committee

Karen Nelson, Senior Health Advisor  
Office of the Honorable Henry Waxman

**2:00-2:30 pm**

**Wrap-Up**

Sheila Burke and Judy Feder  
Drew Altman



**The Henry J. Kaiser Family Foundation**  
2400 Sand Hill Road  
Menlo Park, CA 94025

650-854-9400 Facsimile: 650-854-4800

**Washington Office:**  
1450 G Street N.W., Suite 250  
Washington, DC 20005

202-347-5270 Facsimile 202-347-5274

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