

February 1998

## Affordable Health Benefits for Workers without Employer Coverage

Prepared by

**Lynn Etheredge**  
*Consultant*

**Stanley B. Jones**  
*Director*

Health Insurance Reform Project, George Washington University  
Prepared with support from the Robert Wood Johnson Foundation

*Summary: With 42 million individuals lacking health insurance in 1996, an increase of 1.1 million uninsured from the previous year, new initiatives to deal with health insurance problems merit a high priority among domestic policy initiatives. This paper examines the opportunities for assisting full-time workers (and their families) who do not receive employer-paid health insurance—a group that now includes 49 million individuals—by using three policy tools that Congress and President Clinton have already agreed to use in recent healthcare legislation: (a) equitable tax assistance; (b) market reforms; and (c) competition among health plans that offer economic benefits. Estimates for a model plan illustrate that such strategies could make decent private health insurance more affordable and more accessible for workers and their families who want to purchase it; family insurance protection, with guaranteed issue of insurance and large-group-rated premiums, could be offered at potential savings of 42% (or more). Premiums for worker's coverage, after tax assistance, would be below \$1,200 per year, i.e., less than 60¢ per hour. These market-oriented reforms can be accomplished with a limited government role, and, after start-up costs, ongoing federal expenses would be modest, predictable, and controllable. When combined with the new \$24 billion child health initiative to assist low-income families, the proposed plan would provide considerable progress toward universal access to affordable insurance coverage.*

During the last two years, Congress and President Clinton have been able to move ahead with several major initiatives to improve the health insurance market and expand health insurance coverage. These measures include:

- Tax reforms that will allow 16 million self-employed individuals eventually to exclude 100% of their self-paid health insurance premiums from federal income taxes.
- Guaranteed issue, limiting of pre-existing condition exclusions, and portability for the 163 million Americans under age 65 with employer-based health insurance policies.
- Restructuring of the Medicare program to provide an efficient individual-coverage market for its 38 million enrollees to enroll in private health plans.

- A new \$24 billion program of assistance to states, over a five-year period, to provide health insurance benefits for children from families with low incomes.

Congress and President Clinton now have opportunities to use the policy tools they agreed on in these initiatives to assist a particularly deserving and large group: 49 million full-time workers and their families who do not have employer-sponsored health benefits. Due to tax inequities, market problems, and uneconomical benefits, these individuals need assistance to purchase decent health insurance benefits that are more affordable and accessible in a market with the same kinds of guarantees and protections as most other Americans.

- **Tax inequities**—The federal government now provides substantial tax assistance for workers with employer-paid benefits, as well as for the self-employed, to help pay for health insurance coverage. Income tax subsidies can finance 15% to 40% of their health insurance premiums. But no federal tax assistance is provided for workers without employer benefits. There are no apparent equity justifications for not providing the same tax assistance for all workers.
- **Market problems**—The Congress and President Clinton have enacted national laws that guarantee issuance of coverage, and limit exclusions for pre-existing conditions in the group health insurance market. But the 49 million workers and dependents without employer benefits still do not have such guarantees and protections. If they try to purchase insurance, they can be subject to screening of their individual medical records, limits on coverage for pre-existing conditions, premiums set on a person-by-person basis, and rapid premium increases. As of December 1996, only 14 states had guaranteed issue requirements for the individual coverage market, only 17 states had limits on premium variations, and only 25 states banned exclusion of pre-existing conditions.<sup>1</sup>

- **Uneconomical benefits**—The recent Medicare reforms provided 38 million enrollees with an individual coverage market that allows choice among health plans that offer at least Medicare’s basic benefits. Given state-mandated benefits and high insurer administrative costs, workers in the individual coverage market do not have similar access to economical private health insurance coverage.

The population of full-time workers and their families without employer benefits is a generally healthy—and insurable—group that has health care expenditures similar to those of all insured workers. They are working to support themselves and their families, and they have earnings that could be used toward health insurance premiums, if only coverage were available at reasonable rates. An increasing number of American workers find themselves uninsured. The numbers of uninsured have risen from 25 million in the mid-1970s to 42 million in 1996, primarily due to erosion of employer group coverage. Today, full-time workers and their family members are 60% of the uninsured. Neither tax policies nor market reforms have yet given them the same kinds of financial assistance and well-functioning markets as better-organized worker and business groups.<sup>2</sup>

These problems affect more than workers and dependents in the individual coverage market at this time. A worker with group coverage today can lose coverage in the future, e.g., the worker may decide to switch jobs, his or her company may go out of business, or the employee may be “downsized,” “out-sourced,” or laid off.<sup>3</sup> Potentially, many more individuals are at risk of having to seek health insurance in the individual coverage market.

In this paper, the authors outline and assess a model plan incorporating the policy tools Congress and President Clinton have used in recent initiatives. These measures included (a) equitable tax assistance (such as that provided for the self-employed), (b) improved market rules (such as those for employer-group coverage), and (c) an individ-

ual choice market in which private health plans compete to provide economical benefits (for the Medicare population). By using these tools, Congress and President Clinton could, with considerable success, make decent health insurance more affordable and more accessible to workers and their families who want to purchase it.

Under the proposed plan, workers and family members without employer-group coverage—49 million persons—would be able to obtain guaranteed issue economical health insurance, without medical underwriting, at large-group rates. And individuals with employer-based coverage—163 million persons—would also benefit because they would be eligible for this non-group coverage, without waiting periods or pre-existing condition exclusions, if they moved to a job without health insurance benefits or became unemployed.

Workers could obtain this coverage, on a voluntary basis, from competing private plans through efficient marketing, sign-up, and premium-payment arrangements similar to the Federal Employees Health Benefits program (FEHBP). The potential improvements in insurance affordability for a typical family eligible for this model plan would include:

- Savings of 25.2% over national average HMO benefits due to an economical benefits package and cost-sharing.
- Savings of 11% in administrative costs (or more) for these benefits due to efficiencies of the FEHBP model.
- Savings of at least 15% of the model plan premium from allowing workers to exclude 100% of these premiums from their federal income taxes.

Policy initiatives for the working uninsured that combined these strategies of equitable tax assistance, market reforms, and economical plans could realize (net) economies of 42% (or more) lower premiums.<sup>4</sup> The model plan’s premiums for workers, after tax assistance, would be below \$1,200 per year, i.e., less than 60¢ per hour. This economical coverage plan—combined with the new \$24 billion child health benefits for lower-income families—

would go far toward realizing a universal access objective for availability of affordable coverage to all workers and their families.

A fully developed proposal is beyond the scope of this paper; others are invited to build on, borrow from, develop or modify the basic model described below.

**ESTIMATES FOR AN ILLUSTRATIVE PLAN**

To research the potential for extending the strategies that Congress and President Clinton have already used to assist this target population, the authors have developed a model proposal, with the assistance of the Actuarial Research Corporation. The model is intended to highlight the major policy issues involved and to provide illustrative estimates for potential benefits and costs.

**Eligible Population**

For this plan, eligible persons would be individuals who are full-time workers—defined as working at least three days (24 hours) per week—and who do not have an employer health insurance premium contribution. Individuals who receive Unemployment Insurance (UI) benefits would also be eligible, since they are normally part of this full-time workforce.<sup>5</sup> Members of a worker’s family would be eligible for coverage through the worker’s policy.

Based on analysis of the 1996 Current Population Survey, approximately 49 million individuals would be eligible (Table 1).

**TABLE 1  
Eligible Population**

<b>Adults</b>	32.9 million
<b>Children</b>	15.8 million
<b>Total</b>	48.7 million
<b>(Families)</b>	(25.4 million)

All eligible individuals would be able to enroll in participating private plans during a one-time national “open season.” Thereafter, workers could join when they first became eligible by entering the workforce or by leaving a job with employer-sponsored benefits for a job without benefits or when they began to collect UI checks. Eligible individuals who declined to sign up initially would not be allowed to enroll in the future—unless Congress appropriated specific subsidies to cover any additional costs, due to adverse selection, of such new enrollments, or unless their acceptance did not raise the enrolled group’s premiums. These provisions would encourage initial enrollment and discourage subsequent “skimming” or “dumping” into the pool by private insurers and prevent in-and-out switching by individuals. Given the higher expenses of the current individual coverage market and its lack of consumer protections, insurers would find it difficult to offer a better deal for average-risk enrollees through plans offered outside these new arrangements.

Since enrollment after the initial open season is subject to medical underwriting or congressional legislation (and appropriations) for a new open enrollment period, the ongoing costs will be predictable and controllable. Congress would be advised on the expenses, policies, and financing for new enrollees by the program’s actuary or by an actuarial board.

**Benefits**

The Medicare program’s benefit package is the basis for the model plan. These benefits would be modified only by adding a package of pre-natal, maternity, and preventive care for mothers and children.

The Medicare program’s benefit package is an economy plan, but it offers good insurance protection for most hospital and physician expenses. Thirty years ago, it was typical of the most widely sold products in the group health insurance market. In today’s employer-based group market, it is considered to be a “10th percentile” plan; it lacks coverage for prescription drugs as well as catastrophic insurance protection/limits on out-of-pocket expenses, and it

has substantial deductibles and copayments. But, as a basic benefits design, it is a good starting point for analyses, and it would be difficult to establish a higher national benefits benchmark unless there were also an upgrade to the Medicare program's benefits. Most states have mandatory minimum benefit laws that would now preclude offering these benefits in the individual coverage market.

The premium estimates for these benefits were developed by starting with the average premium of the most widely sold HMO policies. The membership of these plans is representative of the working population and comparable to the model plan's eligible population. The potential savings due to an economical benefit package were calculated by reducing these private rates to take account of Medicare's narrower benefits and higher cost-sharing—but leaving the maternity, pediatric, and preventive services of private plans. The estimates assume HMO price discounts will also be obtained for this population. The benefits would be provided by competitive private health insurance plans under contractual agreements with the program's administrator.

Table 2 summarizes the model plan's benefit costs. It indicates that these Medicare-derived economical benefits could be provided for about 25.2% less than national average HMO benefits.

**TABLE 2**  
**Illustrative Annual Benefit Costs, 1998**

	<i>Typical HMO benefits</i>	<i>Model plan benefits</i>	<i>Savings (25.2%)</i>
<b>Adult</b>	\$1,719	\$1,286	\$433
<b>Adult/Child</b>	2,798	2,093	705
<b>Couple</b>	3,510	2,625	884
<b>Family</b>	4,752	3,554	1,197

### Administration

To design an administrative system that is as simple and efficient as possible, the model

plan incorporates key features of the Federal Employees Health Benefits program for government officials and employees. Information on available private plans would be distributed at the worksite, and employees could pay their premiums through voluntary withholding from their paychecks. Employers should find these arrangements easy to administer, since they already do employee payroll withholding for Social Security and Medicare (OASDHI); worker health insurance premiums could be remitted in the same manner, if an employer preferred, or sent directly to the employee's chosen insurance plan. For the unemployed, the UI insurance offices would be the administrative mechanism for plan selection and withholding from UI checks. These arrangements would substantially reduce marketing, commission, billing, and collection costs. Employers would not be required to make any premium contributions and would find that they would be able to make health insurance benefits accessible with minimal burden.

To make administration easier, to expand coverage, and to reduce adverse selection, eligible workers would be signed up automatically for basic coverage, unless they specifically declined such payroll or UI benefit withholding. This type of "default" enrollment, with premium withholding from Social Security checks, has been a successful feature of Medicare Part B, the Supplementary Medical Insurance program.<sup>6</sup>

The estimates for the model plan show significant marketing and administrative savings can be achieved by adopting these arrangements; the model plan's 7.5% estimated administrative cost is similar to the 7.2% FEHBP expenses and the 5% margins for large employer group insurance. In contrast, HMO, Blue Cross/Blue Shield plans, and commercial insurers typically incur higher—sometimes much higher—expenses in the individual coverage market. Among the variables that affect these expenses are the high costs of one-on-one marketing and individual medical underwriting, the small number of purchasers, high costs of commissions and associated expenses,

high turnover rate of enrollees, service costs, individual premium collection (and non-payment) costs, and risk premiums/profit margins. Table 3 shows varying administrative costs and load factors for different types of insurers, which add to the burdens of self-pay coverage, expressed as a percent of incurred benefit costs.

**TABLE 3**  
**Administrative Costs and Load Factors**  
**(as a % of benefits incurred)**

<b>Model Plan</b>	7.5%
<b>HMO individual policies</b>	18.5%
<b>Blue Cross/Blue Shield individual policies</b>	19.5%
<b>Commercial insurance individual policies</b>	78.5%

The insurance industry sometimes makes another comparison, the "loss ratio" (benefits as a percent of premiums), when describing relationships of premiums, benefits, and administrative expenses. On this basis, the model plan's loss ratio would be 93%, HMO and Blue Cross/Blue Shield loss ratios would be 84%, and commercial insurers' loss ratios would be 56%.<sup>7</sup>

The model plan's sign-up and premium collection arrangements offer the potential for significant administrative savings for enrollees compared to the costs incurred if the same benefits were provided, even with today's more economical individual market arrangements. Table 4 illustrates these cost differences.<sup>8</sup>

In offering the model plan's economical benefits through these FEHBP-type arrangements, insurers could sharply reduce many of their current administrative expenses (market commissions, medical underwriting, premium collection) and potentially reverse the dramatic shrinkage of their individual coverage markets. Individual coverage by Blue Cross/Blue Shield and insurance companies peaked at 36 million enrollees in 1978 and fell to 7 million enrollees in 1994.<sup>9</sup>

**TABLE 4**  
**Annual Administrative Costs for**  
**Model Plan Benefits**

	<i>Adult</i>	<i>Adult/ Child</i>	<i>Couple</i>	<i>Family</i>
<b>Model plan</b>	\$96	\$155	\$197	\$267
<b>HMO individual coverage</b>	238	387	486	658
<b>BC/BS individual coverage</b>	251	408	512	693

#### **Tax Assistance**

Since the 1940s, federal tax policy has strongly encouraged growth of employer-based health insurance coverage. Its major policy tool has been to exclude employer-paid premiums from the taxable income of workers, for both the income and payroll taxes, and from the employer's share of payroll taxes. In 1998, these federal tax expenditures are estimated to be \$76 billion from the income tax.<sup>10</sup> Table 5 shows the potential federal income tax subsidy for families at different earning levels.

**TABLE 5**  
**Federal Income Tax Subsidy for**  
**Health Insurance Premiums**

<i>Income</i>	<i>Income tax rate</i>	<i>Subsidy/\$1,000 of employer premiums</i>
<\$32,150	15.0%	\$150
\$32,150-\$83,050	28.0%	\$280
\$83,050-134,500	31.0%	\$310
\$134,500-\$263,750	36.0%	\$360
\$263,750+	39.6%	\$396

For a \$5,600 family premium payment, these federal income tax subsidies would range from \$840 to \$2,218. The OASDHI payroll tax subsidy would be an additional 15.3% for a worker's earnings up to \$62,700 and 2.8% higher thereafter (based on 1996 rates). Thus, the combined federal income and OASDHI

tax subsidies for a \$5,600 family premium would range from \$1,697 (30.3%) to \$2,374 (42.4%).

The Balanced Budget Act of 1997 took a major step toward tax equity for workers without employer-based health insurance. It included a (phased-in) provision to allow self-employed individuals to exclude 100% of their health insurance premiums from their federal income taxes (but not from their Social Security taxes).<sup>11</sup> Most of the workers without employer-paid benefits, however, are not self-employed and do not receive any federal tax subsidy for their self-paid health insurance premiums.<sup>12</sup>

The eligible workers would have the same tax benefits as self-employed persons; they would be able to exclude 100% of their health insurance premiums from income taxes.<sup>13</sup> For illustration, it is assumed that eligible workers would typically be in the 15% tax bracket and that, if their incomes were below this amount, minimal assistance equal to 15% of the total premium (e.g., a refundable tax credit) would be provided.

Estimates for tax assistance, based on the model plan's benefits and administrative costs, are shown in Table 6.

**TABLE 6**  
**Illustrative Federal Income Tax Assistance<sup>14</sup>**

	<i>Adult</i>	<i>Adult/ Child</i>	<i>Couple</i>	<i>Family</i>
<b>Model plan premium</b>	\$1,382	\$2,250	\$2,822	\$3,821
<b>Tax assistance (15%)</b>	\$207	\$337	\$423	\$573

### IMPACT ON WORKERS

Table 7 illustrates the net premiums for the 49 million workers and dependents without employer coverage using economical benefits, efficient administration, and equitable tax assistance.

**TABLE 7**  
**Annual Model Plan Premiums,  
after Tax Assistance (1998)**

<i>Adult</i>	<i>Adult/ Child</i>	<i>Couple</i>	<i>Family</i>
\$1,175	\$1,912	\$2,399	\$3,248

For adults and working couples, their premium costs would be less than 60¢ per hour. Lower-income adult/child and two-adult families who were eligible for the new child health insurance benefit, which can cover children in working families up to 200% of poverty, could find their family coverage costs to be much lower than the above premiums, e.g., by \$1,000 or more for a two-child family.

Some individuals and families would see greater savings, particularly workers whose premiums are higher than community rates. Individuals with health insurance that pays bills on the basis of undiscounted charges and uninsured individuals with large out-of-pocket expenses would benefit because health plans negotiate rates that are about 35% below such posted charges. Workers who elect coverage would gain the financial security of insurance coverage, and providers would have fewer bad debts.

Since the model plan would be offered by HMOs, Blue Cross/Blue Shield, and commercial insurers, it is also useful to illustrate how much lower their customers' costs could be with economical benefits, efficient administration, and equitable tax assistance (Table 8, page 8). The size of such savings—42% or more—plus consumer guarantees and protections could significantly expand the number of interested buyers in this market with 49 million potential enrollees.

### FEDERAL COSTS

The federal government's expenses for this model plan would consist of (a) the tax assistance provided and (b) start-up costs to establish large-group rating. Both these costs are influenced by the number of enrollees.

Because the model plan's premiums would be large-group-rated and it would offer other economies and desirable features, the product would be a good insurance value for most individuals in the target group. Its attractive features compared to most other products in the individual coverage market would include the lowest-cost product, workplace "default" sign-up and payroll withholding, guaranteed issuance and portability, predictable premiums (that would not rise if an individual or family member needed health care), and automatic transitional protection for those leaving group insurance or unemployed. It also would feature a well-recognized (Medicare) benefit and a government-overseen market.

**TABLE 8**  
**Illustrative Insurance Coverage Costs**  
**for Consumers, Family Policies, 1998**

	<i>HMO</i>	<i>Blue Cross/ Blue Shield</i>
Typical HMO-type benefits, current administrative loads, no tax assistance	\$5,631	\$5,678
Model Plan with economical benefits, FEHBP-type administration, tax assistance	3,248	3,248
Savings (\$)	2,383	2,430
Savings (%)	42%	43%

Based on the model plan's attractiveness to the major subgroups of the target population, illustrative estimates assume that approximately 10 million individuals, of 49 million eligibles, would elect enrollment in the plan. This would include about 5.7 million adults and 4.3 million children.

#### **Federal Tax Assistance**

The federal expenses involved for 10 million enrollees would be \$1.7 billion per year for tax assistance (15% of the enrollees' \$11.6 billion in premiums). If the entire eligible population elected coverage, tax assistance costs would be \$7.6 billion per year (15% of \$50.4 billion in premiums).

#### **Start-up Costs**

The need for start-up costs arises because, on average, workers who are currently using health services are more likely to join a voluntary insurance program than those who are not, especially given the availability of large-group-rated coverage.<sup>15</sup> A temporary subsidy of this adverse risk selection cost would be needed to keep premiums affordable. This temporary risk adjustment subsidy is necessary because of workers' past exclusion from coverage, and it is essential for setting up an individual coverage market that can offer open enrollment and large-group rates. As described earlier, a number of features, e.g., one-time open enrollment, would sharply reduce subsequent anti-selection problems. The need for subsidies would decline because most individuals who are initially high-cost (e.g., due to child birth or acute illness requiring hospitalization) could be expected to become more normal risks over time if the eligible population is a good risk group. Based on such consideration, actuarial analysis suggests that the initial start-up requirements would fall over time and would not increase costs significantly after the fifth year (Table 9).

**TABLE 9**  
**Estimated Start-up Costs for**  
**Large-Group Rating (in billions)**

<i>1998</i>	<i>1999</i>	<i>2000</i>	<i>2001</i>	<i>2002</i>
\$14.9	\$7.9	\$4.1	\$2.2	\$1.4

If the number of eligible persons who sign up is substantially greater, e.g., more than 35%, the larger number of good-risk enrollees would reduce subsidy costs. Thus, these costs would fall over time—and would be lower if many more people signed up. Indeed, with basic premium costs of only 60¢ per hour per worker, further assistance for lower-wage workers might produce many more enrollees and significantly reduce the start-up costs. If all 49 million eligible individuals were enrolled (which could be accomplished only

with mandatory coverage) there would be no need for subsidies at all to assure large-group-rated premiums.

Because continuing federal costs are limited to income tax assistance (\$1.7 billion annually) and enrollment after the initial open season is subject to actuarial approval or congressional legislation (and appropriations) for new enrollees, the on-going costs would be modest, predictable, and controllable.

### **Financing**

Among a number of financing options, an initial several years of tobacco suit settlement funds would be appropriate for financing the start-up costs, because the funds would be used to help pay costs of enrollees whose higher expenses were partly attributable to tobacco-related illnesses.

### **ISSUES FOR FURTHER ANALYSIS**

Consideration of this model plan and illustrative analyses suggest that there are several important areas for further research and analysis.

#### **Employer Response**

Policy officials have been concerned that, if there were comparable insurance arrangements and subsidies for all workers, employers would find it much easier to drop their health insurance benefits—resulting in an increase in the numbers of uninsured. Recent research indicates, however, that the rising numbers of uninsured workers have not been due to employers dropping coverage; in fact, more employers have been offering coverage, but fewer workers have been accepting their offer.<sup>16</sup> Nevertheless, these are legitimate concerns to be addressed, particularly if they restrain action on behalf of 49 million individuals without employer-based benefits. Some observations as starting points for further analysis include:

- Most employers that offer health insurance benefits, which they do as a way of competing in labor markets, would still find it beneficial to do so. The model plan's basic benefits are not as attractive as most employer-

based benefits. Employers that dropped health insurance and paid the premium amounts directly to workers would find that both employer and worker taxes would rise by the 7.65% (each) for the OASDHI tax. Workers in firms that dropped coverage would also be excluded from enrolling in the model plan, unless there were specific congressional legislation and appropriations to allow their enrollment and cover any additional subsidy costs.

- The model plan could expand employer benefits. If the federal government made the employer role as simple and easy as possible (e.g., employee payroll withholding with employers able to use, at their option, the remittance processes for income and OASDHI taxes), then employers might find it more attractive to contribute part of the premium. Such contributions would save both employers and employees 7.65% (the OASDHI tax) on the contribution amount, which, in today's economy, is the equivalent of 2 to 3 years of wage or price increases.<sup>17</sup> Large-group rating would also make it possible for smaller employers to begin sharing in premiums without the risk of sharp cost increases by an insurance company if an employee became sick.
- Employers most likely to drop coverage are very small employers (e.g., those with fewer than 5 workers) with higher-risk employees in states that allow wide variations in experience-rated premiums for these employers.

#### **State Roles and Options**

States vary in their regulation of the features of individual and small group markets, e.g., premium rate variations, portability arrangements, high-risk pools, and mandatory minimum health insurance benefits. All of these features could influence the worker and employer response to the model plan, enrollment, and costs. Other state policy factors that are important to consider include how the model plan would relate to Medicaid eligibility for pregnant women and children in lower-income

working families, to Medicaid “spend-down” eligibility, to state decisions on eligibility for the new child health insurance program and its implementation through Medicaid or private insurance, to welfare recipients transitioning into full-time work, and to other safety net provisions. Analysis of several prototype state policies may be useful. To assure coordination of all these elements, the model plan, like the new child health plan, might need to afford states with a major administrative role, discretion, and financial responsibility.

Some state reform experiences of the individual coverage and small-group (including self-employed) market may prove useful. As of 1996, for example, 9 states had community rating requirements for the individual coverage market, and an additional 8 states had rate band limits. Fourteen states had guaranteed issue for the individual coverage market, and 25 states limited pre-existing condition exclusions. In the small group market, 16 states have extended their small group reforms to self-employed individuals (group size of 1), a model for including individual workers with employer-organized groups for policy purposes.<sup>18</sup> These state initiatives suggest both political and practical feasibility for the broader national efforts to reform the individual coverage market discussed in this paper and likely provide learning opportunities.

### **Worker Enrollment**

Market research is needed to refine estimates about potential enrollment in the model plan. Indications for its effectiveness in reducing the numbers of uninsured, when coordinated with the new child health insurance initiative, would be desirable. Since the model is intended to test the limits of what may be accomplished with private health insurance markets, given the context of recent political agreements, it would be desirable to identify what the priority areas would be for modifying the model plan. It would be also be useful to assess the extent to which premium subsidies for lower-income workers would increase their enrollments.

### **Financing Sources**

Given that start-up financing (federal or federal-state) will be needed for the model plan, additional analysis would be desirable for funding sources. Among the candidates, noted earlier, would be tobacco suit settlement funds to help pay start-up (and perhaps ongoing) costs of enrollees with higher expenses due to tobacco-related illnesses. Other potential funding sources would include reforms of the tax expenditures for employer-based health insurance (income-relating, capping, converting to tax credit), risk adjustment levies and redistributions for the individual and small group market, joint federal-state financing, and state authority for social responsibility contributions from employers that do not offer health insurance. Additional subsidies for workers could be provided by excluding their premium payments from the 15.3% OASDHI tax—which would reduce per worker costs to about 50¢ per hour—and by allowing employers to make health insurance contributions in lieu of some future minimum wage increases.

### **Improving the Safety Net**

Since the model plan is based on voluntary choice and limited subsidies, it will still fall short of universal coverage. This means that a number of uninsured workers would still have the misfortune of illness or injury that involves significant (perhaps catastrophic) health care expenses. Useful work might be done on improving the safety net for those who still cannot afford (or do not choose) coverage, in a way that would mesh with the model plan initiative. Among such initiatives could be a national “charity care” policy that limited how much workers who decline basic health insurance would need to pay, as a percent of income, for health care; redesign of disproportionate share hospital payments to support such arrangements; and uniform “spend-down” eligibility for Medicaid benefits.

The authors thank Gordon Trapnell, F.S.A., M.A.A.A., and Monica Van Doren for their assistance.

---

## ENDNOTES

1. Blue Cross and Blue Shield Association, *State Legislative Health Care and Insurance Issues*, December 1996.
2. Non-working adults also merit health insurance coverage, but their low incomes probably require coverage through public programs rather than private health insurance.
3. For HIPAA-eligible workers (18-month continuous coverage, exhausted COBRA, age 18 or over) who leave group coverage, states are allowed to meet guaranteed issue requirements by buy-in only to a state "high-risk" pool; typically, the premiums charged by such pools (and other features) are such that few people apply. Approximately two-thirds of states have elected this high-risk pool option.
4. The three components of savings are interactive, rather than additive. The 11% administrative savings applies to the 25.2% lower benefits; the 15% tax savings applies to the final premium, after the benefit and administrative savings.
5. About 50% of the uninsured are without coverage for 6 months or less, e.g., because of unemployment. Robert Bennefield, "Who Loses Coverage and for How Long?" *Current Population Reports*, U.S. Bureau of Census, P70-54, May 1996.
6. Even in the period of 50% SMI premium subsidy (it is now 75%), more than 95% of eligible persons accepted enrollment with automatic premium deductions from Social Security checks.
7. For a policy with a loss ratio of 56%, benefits would be \$56 for each \$100 of premiums. Administrative costs and load factors would be \$44. The ratio of administrative costs and load factors (\$44) to benefits (\$56) would be \$44/\$56, or 78.5%.
8. A cost estimate for commercial insurers is not shown in Table 4 or Table 8, since their current administrative practices and expenses differ so much from the model plan that it would be difficult to make a fair comparison.
9. Health Insurance Association of America, *Source Book of Health Insurance Data, 1996*, Washington, D.C., 1997. Market share statistics are provided in Deborah Chollet et al., *Mapping Insurance Markets: The Group and Individual Health Insurance Markets in*

26 States, Alpha Center, Washington, D.C., October 1997.

10. *Analytical Perspectives, Budget of the United States Government, Fiscal Year 1998* (Washington, D.C.: Government Printing Office, 1997), 74. Estimates are not available for federal tax expenditures from the payroll tax. State governments also incur revenue losses (provide subsidies) if their taxable income base also reflects the federal exclusions.
11. Although some employers pay all premiums, the average employer share is 80%. The exclusion of employer-paid premiums from both income and Social Security taxes may offer (on average) a rough equivalency to 100% exclusion for self-employed workers from the income tax alone.
12. The federal tax code inequities are even greater for retirement benefits. Self-employed individuals and high-income managers with employer-based pensions can invest up to \$30,000 annually in tax favored plans; workers without employer-based pensions are limited to \$2,000 IRA contributions.
13. Employer-paid premiums are also excluded from the 15.3% OASDHI tax (7.65% each from workers and employers). Self-employed persons, however, are only allowed to exclude premium payments from the income taxes, so income tax-only exclusion is the equity comparison used in these analyses.
14. Full tax equity for self-employed and self-paid workers, compared to employer-paid premiums, could also exclude their payments from the combined 15.3% OASDHI tax. This would more than double the tax subsidies shown in the table, e.g., to \$1,146 for family coverage.
15. The model plan's benefit package has some disadvantages for higher-risk enrollees, including lack of outpatient prescription drug coverage, substantial copayments, and no limit on out-of-pocket expenses; thus some eligible higher-risk individuals with pre-existing insurance would not be likely to switch into the model plan.
16. Philip Cooper and Barbara Schone, "More Offers, Fewer Takers for Employment-Based Health Insurance: 1987 and 1996," *Health Affairs*, November/December 1997, 142-149.
17. For example, if an employer that did not now offer health insurance benefits shifted \$1,000 from wages into a health insurance contribution, the employer's and employee's payroll taxes would each decline by \$76.50, a total of \$153.
18. Blue Cross and Blue Shield Association, December 1996, op. cit.