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Financial Incentives to Individuals and Families to Purchase Insurance

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Executive Summary

Financial incentives to individuals and families are intended to overcome affordability barriers to the purchase of insurance and to encourage the uninsured to voluntarily purchase coverage. Policy options include:

- Premium assistance programs—subsidizing the employee's share of employer coverage
- Subsidies to purchase insurance in the form of tax credits, vouchers, or sliding-scale premiums
- Subsidizing the purchase of transitional coverage, such as COBRA

Such programs may also specify eligibility restrictions to target the incentives to certain populations, such as low-income people or those with high health risks.

Studies of decisions by individuals to purchase insurance suggest that subsidies must be quite large to encourage many new people to buy coverage. In addition, the larger the subsidy, the more likely it is that some who are currently insured will drop their current coverage to benefit from the subsidy, which will add to the cost of a subsidy program. Whether such "substitution" is viewed as good or bad depends on the priority placed on reducing the uninsured population and equity in program design versus other public policy goals, such as supporting the employer-based insurance system or keeping government programs as small as possible.

Subsidies to help pay the cost of employer coverage may not benefit low-income uninsured who frequently change jobs and, therefore, will not promote stable coverage for this population. Subsidies for transitional coverage will not benefit the long-term uninsured, who comprise the majority of those who are uninsured on any given day. However, many people do experience short spells during which they lack insurance, and subsidizing transitional coverage could help limit this problem.

This report is presented to the program staff of the Washington State Planning Grant on Access to Health Insurance. It represents the research findings and opinions of the consultant team.

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Problem Definition

Policymakers and analysts widely agree that many of the uninsured face premiums that are too high or have incomes that are too low to afford insurance. Thus, many proposals for reform include financial subsidies to individuals and families to reduce the affordability barrier and encourage them to purchase private coverage voluntarily (Meyer & Wicks, 2001).

Design of Policy Option

Subsidies can take many forms and be targeted to a variety of subgroups of the uninsured. The dimensions on which subsidy policy designs can vary are summarized in Figure 1 (see Appendix); some of these design choices are elaborated briefly below with illustrations of programs in other states or at the federal level.

What the Subsidy Can Be Used For

A number of states and communities have initiatives to promote employment-based insurance by subsidizing the required employee contribution. Some states, for example Iowa, Pennsylvania, and Texas, have a Health Insurance Premium Payment (HIPP) program, which is an authorized Medicaid program that permits states to subsidize employer-sponsored coverage for workers with Medicaid-eligible family members. Some states have received waiver authority to use State Children's Health Insurance Program (SCHIP) funds to subsidize employer-sponsored coverage for families with children targeted under SCHIP, including Massachusetts, Mississippi, and Wisconsin. Other states, such as Oregon, subsidize employee contributions for employer plans as part of state-financed subsidy programs. Washington's Basic Health (BH) also has a small program for employer-sponsored coverage. The use of subsidies to help the working uninsured obtain coverage is viewed as a way of leveraging private dollars to help solve the problem of uninsurance while building on current health insurance financing systems and structures.

In the wake of September 11 and in the face of an economic downturn, there is current interest in subsidies to help those who temporarily lose their employer coverage. COBRA (a provision of the 1985 federal Consolidated Omnibus Budget Reconciliation Act that allows former employees to purchase continued coverage through their former employer) coverage is an important option for many who become uninsured, since about two-thirds of uninsurance episodes begin with a

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loss of employer-sponsored coverage.* A number of proposals are under consideration at the federal level, many of which are for programs of limited duration (Lambrew, 2001). As part of its Medical Security Plan, Massachusetts has provided transitional subsidies to purchase COBRA coverage or individual insurance to unemployed persons since 1990. To be eligible, the individual must be receiving unemployment insurance and have a family income below 400 percent of the federal poverty level (FPL).

The lack of affordable coverage is a particular problem for those who do not have access to employer-sponsored insurance; health insurance purchased in the individual market is far more costly than insurance obtained in the group market (Pauly & Herring, 1999). At the federal level, there has been recent interest in assisting lower-income people to purchase in this market using tax credits (Kendall, 2000). Some subsidy for the purchase of individual coverage is currently available through the federal income tax system, especially for self-employed persons.†

Several states sponsor public programs, such as Washington's Basic Health, that enroll low-income persons in private plans at partially subsidized premiums. Typically, the number of plans available to participants in such state programs is limited, and the public program administrators negotiate premiums. Many states have established state-sponsored high-risk pools that provide health insurance coverage to high-risk individuals at prices below the premium they would face in the private market. Few states have implemented programs to subsidize the purchase of coverage in the broad individual market, but New Jersey's short-lived Health Access program is an example of such a state program. The New Jersey program provided subsidies that low-income families could use to purchase one of the standardized policies offered by carriers in the individual market (Swartz & Garnick, 2000).

Other Design Choices

In addition to what the subsidy can be used for, any subsidy scheme has several other important design parameters, listed in Figure 1. Eligibility criteria and the subsidy design entail decisions about the number of uninsured who will be reached versus target efficiency (that is, benefiting only the uninsured) versus cost. Programs with broad eligibility criteria will reach more of the uninsured, but are also likely to provide subsidies to many who would otherwise have purchased insurance. We provide information about the extent of such substitution in our review of the evidence, below.

To minimize substitution, most subsidy programs and proposals restrict eligibility to lower-income families who are less likely to be currently insured. Some programs, for example SCHIP waivers, require a prior period of uninsurance to minimize substitution. This latter strategy, however, leads to concerns about equity. Those who have chosen to purchase insurance previously are denied subsidies that are available to otherwise similar persons and families. Choices about the amount of the subsidy and the minimum benefits that it can be used to purchase also constitute tradeoffs between the reduction in the number of uninsured and the degree of substitution.

* Unpublished tabulations from the 1996 Survey of Income and Program Participation Panel.

† The self-employed are allowed to deduct the cost of health insurance, even if they do not itemize deductions; the allowed deduction is currently 50 percent of premiums, but will be phased into 100 percent by 2003. Others can deduct premiums for purchase of insurance only if they itemize deductions and have medical expenditures in excess of 7.5 percent of adjusted gross income.

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Subsidies must be large enough to be attractive to the uninsured; but large subsidies will also create strong incentives for the currently insured to participate in the program. The lower the minimum benefit plan, the lower will be the cost of coverage. Assuming that more people will buy when the price is low, a given subsidy will lead to a greater expected reduction in the uninsured the lower the minimum benefits. However, the gains in access to health services for the newly insured will be lower with a package of fewer benefits than under a higher minimum benefit plan. The policy tradeoff is one of reduction in the number of uninsured versus improvement in access for a smaller number of persons. However, if people value only more comprehensive coverage, the price of the coverage they want may remain unaffordable even with public subsidies. Some education of the target population may be necessary regarding the purpose and value of insurance and the rationale for some consumer cost-sharing.

Administration and Financing

For some of the subsidy approaches, an administrative structure is already in place. For example, subsidies to individuals to purchase private coverage could be directed through Basic Health or Washington State Health Insurance Pool (WSHIP). Subsidies of employee contributions to employer-sponsored offerings can also be administered by the existing structure within Basic Health, with some modifications. Although employers already administer COBRA programs, they are not likely to want to administer a subsidy program that would involve eligibility determination based on family income. An alternative approach would be to have an existing premium assistance program (e.g., Basic Health) reimburse the premium payroll deductions of eligible individuals (Curtis, 1999). This approach would require significant changes for how Basic Health is operated today.

Another administrative issue is timing. Is eligibility for the public program treated as a qualifying event for enrollment in an employer plan or do employees have to wait until the established open enrollment period? Having to wait for an open enrollment period is cited in the literature as a factor holding down participation.

With regard to financing, maximizing federal matching funds must be balanced with the administrative costs of doing so. SCHIP requires a lot of administrative work in checking benefits, employer contribution rates, and otherwise conforming to the SCHIP regulations. Wisconsin estimates several months can be involved in verification. Other sources of funds include special taxes (e.g., the Health Services Account), general state funds, earmarked taxes on business, or taxes on insurers. Ideally, the source of funds would be relatively stable and broad to minimize the effects of cyclical events and to spread the financing burden across many groups.

Evidence

In this section, we review the quantitative and qualitative evidence on the likely effects of subsidy policies. We begin with a discussion of the size of the target population in Washington. Then we briefly review the literature on some of the behavioral responses that are important in evaluating a subsidy design. These factors include: the demand response to subsidies or price changes; the extent of substitution of private coverage that occurs when subsidized coverage is available; and labor market effects of subsidies. We conclude with a discussion of states' experiences with programs providing financial incentives to individuals and families.

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Potential Target Population

Almost two-thirds of Washington's uninsured population live in families with an income below 200 percent FPL, suggesting that low income is a barrier to coverage (see Figure 2, on page 5). 75 percent of Washington's adults with an income below 200 percent FPL do not have access to affordable coverage.* Financial incentive schemes can be designed to target all of the uninsured or specific subpopulations of the uninsured, depending on eligibility criteria and decisions about what the subsidy can be used for. Most state and federal proposals establish income limits for eligibility in order to minimize the substitution of existing private coverage for the subsidized coverage. As we show in the section "Substitution of Subsidized Coverage for Private Expenditure," this substitution can be substantial among higher-income populations.

Figure 2. Washington's uninsured population in 2000

	Percent of uninsured
All uninsured	
Family income < 200% FPL	64
Offered employer coverage (and dependents)	18
In transition--not working but held job within last two years (and dependents)	11
Uninsured with family income < 200% FPL	
Has access to employer coverage (and dependents)	13
In transition--not working but held job within last two years (and dependents)	13

Source: WSPS 2000

A waiting period for eligibility is another method to limit substitution. Because most of those who are uninsured at a point in time are in long spells of uninsurance, this restriction would have limited effect on the number of the uninsured eligible for the program at a point in time. For example, about three-fourths of the uninsured at any point in time have been uninsured for a year or longer.† However, waiting periods can have a much larger effect on the number experiencing *any* episode of uninsurance in a year. A much larger number of persons move in and out of uninsurance during a year than are uninsured on any given date. Although 9.2 percent of the population is uninsured at any given point in time, about 15.5 percent of the population has some spell of uninsurance during the course of a year.‡ Many of these spells are short; about 35 to 50 percent of new uninsured spells last six months or less.§ Waiting periods would deny benefits for those with short-term episodes, so waiting periods are a policy that best targets the long-term uninsured.

Other design choices may also affect whether policies are targeted to the long-term uninsured or the short-term uninsured. The short-term uninsured are more likely to be in the labor force and have higher family incomes. Thus, income eligibility and policies regarding the use of subsidies for employer-sponsored coverage may differentially target the long- versus short-term uninsured.

Some proposals for federal tax subsidies for the uninsured would limit eligibility to those who do not have access to employer-sponsored coverage. This limit is included to avoid undermining the

* Washington State Planning Grant Research Deliverable 3.1 *Targeting the Uninsured in Washington State*
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§ Unpublished analysis of the SIPP and MEPS for the nation's uninsured, 1996.

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existing employer-based system, which accounts for most private insurance. It is also viewed as an equitable way of adjusting for the current tax subsidies provided to workers, because employer-paid premiums are not treated as taxable income. Moreover, most of the uninsured work for firms that do not offer insurance, are unemployed, or are not in the labor force. In Washington, only 18 percent of the uninsured in 2000 had access to employer-sponsored coverage; among the low-income uninsured this figure was 13 percent (Figure 2).

Nonetheless, policies that subsidize employee contributions to employer-sponsored insurance are attractive to some, who view this as an opportunity to leverage private dollars in covering the uninsured and to promote a connection to the workplace among the low-income population. In addition, subsidizing employee contributions could result in an increase in the share of employers that offer coverage—and most uninsured persons are workers or their dependents. Some studies have suggested that employers' failure to offer coverage stems at least in part from a lack of demand for insurance benefits in the compensation package on the part of employees (Marquis & Long, 2001; and Long & Marquis, 1993). Evidence that workers who do not value health insurance choose employers that do not offer insurance provides additional support for this hypothesis (Monheit & Vistnes, 1999). Subsidizing employee contributions, therefore, might increase employee demand for insurance benefits from their employers and lead to an increase in the proportion of employers that offer health insurance. Finally, many believe that the problems of substitution are minimized by policies that build on the existing employer-based system rather than replace it.*

Losing a job often results in a loss of health insurance coverage. In Washington State, about 25% of Washington's uninsured were unemployed in 2000. Half of these recently lost a job or are looking for work. Although many of these individuals have continued access to coverage at group rates as a result of the Federal COBRA legislation, they must pay the full cost (plus an administrative fee). Only about 20 percent of workers eligible for COBRA purchase it, primarily because of cost (Lambrew, 2001). Subsidies to help those who have lost employment-related coverage during their employment transitions is gaining popularity as we face an economic downturn and the prospect of increasing unemployment. Subsidizing COBRA coverage is a strategy intended to fill short-term gaps in coverage. As discussed above, such policies are unlikely to have a large effect on the number of uninsured *at a point in time*, because those in short-term spells are a small minority of the uninsured at any given time. We estimate that subsidizing COBRA coverage would target fewer than 11 percent of the insured and fewer than 13 percent of the low-income uninsured (see Figure 2).† However, transitional subsidies may reach a much larger number of persons with short, transitional uninsurance spells—as they were intended to. To better assess the role of this policy in reducing short-term gaps in Washington would require a longitudinal database.

* This does not mean substitution would be eliminated. Some families who otherwise pay their share of employee costs might participate in the subsidy program, unless measures are taken to prevent this. Employees might also reduce their contribution rates. But these actions probably result in smaller substitutions of public dollars for private dollars than would occur under programs that might encourage families to shift entirely to a public program. Incentives to employers to drop coverage are also minimized.

† These figures represent those who left a job within the last two years; but COBRA coverage is available only to those who left insured jobs with businesses with 20 or more workers. We are unable to measure how many of these previously had employer-sponsored coverage in such businesses.

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Demand Response to Subsidy

Figure 3, on page 7, summarizes the literature on the elasticity of demand for health insurance coverage in the individual market and the elasticity of take-up of employer-sponsored health insurance to variations in the employee contribution.

Estimates of the elasticity of demand for individual coverage range from about -.3 to -1.0 (see the first column of Figure 3), suggesting that a 25 percent subsidy would increase the number purchasing health insurance coverage by about 7 percent to about 25 percent.

We have used the estimates from the literature along with data about the insurance status of the Washington population in 2000 to estimate the effect different subsidy rates would have on the number of Washington's uninsured population (top panel of Figure 3). For example, starting from the current rate of 9.2 percent uninsured (see column 2 of Figure 3), an elasticity of -0.5 (first row of Figure 3) suggests than an additional 0.8 percent of the population would purchase coverage if the price is reduced by 25 percent, resulting in a new uninsured rate of 8.4 percent (column 3 of Figure 3). Columns 4 and 5 of the figure show the expected uninsured rate with a 50 percent subsidy and a 75 percent subsidy, respectively. Although the literature produces a wide range of responses, all clearly suggest that substantial subsidies would be needed to have much effect on the uninsured rate in Washington.

Figure 3. Elasticities of demand for insurance and estimated effect on Washington's uninsured rate

		Estimated uninsured rate in Washington			
I. Elasticities of demand for individual coverage and effects of subsidies to purchase price.					
	Elasticity	**Base rate**	**25% subsidy**	**50% subsidy**	**75% subsidy**
Marquis and Buchanan, 1992	-0.5	9.2	8.4	7.6	6.8
Marquis and Long, 1995	-0.3 to -0.6	9.2	8.3 to 8.7	7.3 to 8.3	6.3 to 7.8
Gruber and Proterba, 1994 (a)	-0.3 to -1.0	9.2	7.6 to 8.3	6.1 to 8.3	4.4 to 7.8
Pauly and Herring, 2001 (b)	-.7 to -1.12	9.2	8.0	4.5	1.5
II. Elasticities of demand for individual coverage and effects of COBRA subsidies (c)					
Literature cited above	-.3 to -1.0	9.2	8.9 to 9.1	8.6 to 9.0	8.3 to 8.9
III. Elasticities of take-up of employer coverage and effects of transitional subsidies					
Long and Marquis, 2001	-.01 to -.13	9.2	7.6 to 9.0	7.6 to 8.9	7.6 to 8.7
Chernew, Frick, and McLauglin, 1997	-.03 to -.09	9.2	7.7 to 8.7	7.6 to 8.2	7.6 to 7.7
Blumberg, Nichols and Banthin, 2001	-0.04(d)	9.2	8.5	7.9	7.6

(a) Based on overall estimates for the self-employed population; estimates for single persons were higher.
(b) Elasticity of demand for individual insurance among those without group or public insurance, elasticity computed from reported effect of subsidy on uninsured and Washington data on the uninsured and individually insured
(c) Upper-bound estimate based on those who left a job within two years; does not account for restrictions to those leaving insured job, size of employer, and other possible restrictions on transitional subsidies.
(d) Estimated response for families; they found no effect of out-of-pocket premiums on single coverage

Our estimates of the effect of large subsidies are subject to a great deal of uncertainty. Most of the estimates from the literature are based on observed variation in prices, and this variation is

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over a fairly limited range. Therefore, extrapolating these results to large subsidies is quite risky; as we have little information about how behavior actually responds to large price changes. The estimate we derive from Pauly and Herring's study of tax credits is based on observed take-up in the group market. However, a purchaser in the individual market faces many other barriers and costs—including search costs—that are reduced for those in the group market. Hence, it is uncertain that we can assume that take-up rates in the group market would generalize to the individual market.

We also use the range of estimates from the literature to estimate the effect on the number of uninsured of transitional subsidies for those who have lost their jobs. Policies aimed at filling short-term gaps would have limited effect on the uninsured rate, because most persons uninsured at any point in time are in long spells of uninsurance, even though most uninsurance spells are quite short.

The bottom panel of Figure 3 draws on literature estimating how take-up of employer coverage varies as the amount of the employee contribution to that coverage varies in order to estimate the effect of premium assistance programs for employer-sponsored coverage. Note that here a 25 percent subsidy is a subsidy of the employee contribution, not of the total purchase price. This type of program is predicted to have a limited effect on the overall number of the uninsured, because only about 20 percent of the uninsured have access to employer sponsored coverage.

The estimates in Figure 3 are all estimates of how changes in the price for coverage in the private market affect demand for coverage. Few studies exist of how demand for coverage in public programs varies with the price that participants must pay to participate. However, a few studies of the role of price in decisions' of low-income persons in Washington to participate in BH suggest elasticities similar to those found in the purchase of private insurance. Long and Marquis report a price elasticity of demand for BH of -.3 to -.7 (Long and Marquis, 2002). This finding is consistent with earlier studies from the demonstration phase of Basic Health (Madden et al, 1995).

Substitution of Subsidized Coverage for Private Expenditure

Without eligibility restrictions, a subsidy program might enroll a large number of persons who currently purchase insurance, as well as the target population of uninsured people. The extent to which this occurs is of concern to policy makers, if they want to avoid substituting public dollars for private dollars and to minimize the cost of a new program. The existing literature about the extent of this substitution is summarized in Figure 4. The extent of substitution is measured as the decrease in private coverage as a percent of the increase in public coverage. Thus, a substitution effect of 15 percent suggests that 15 percent of those enrolled in the public program would have held private insurance in the absence of the program.

Most of the estimates come from estimating the substitution of public for private coverage that occurred with the Medicaid eligibility expansions for pregnant women and children (column 2 in Figure 4 lists the population that is covered by the public program under study). It is unclear whether estimates of the substitution that occurs in programs for special populations can be generalized to the degree of substitution that would occur in broader-based programs. Nonetheless, these estimates, along with the few estimates of general subsidy programs, suggest some important conclusions. First, substitution increases as income eligibility increases. For this reason, most subsidy programs limit eligibility based on income.

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Figure 4. Estimates of the substitution of public coverage for private coverage from public subsidy programs

Study	Population	Extent of substitution (change in private coverage/ change in public coverage)
I. Medicaid eligibility expansions for children and pregnant women		
Cutler and Gruber, 1996, 1997	Children and pregnant women	15 to 60%
Dubay and Kenney, 1996, 1997	Children	17%
	Children above poverty	21%
Dubay and Kenney, 1996, 1997	Pregnant women	14%
	Pregnant women above poverty	45%
Shore-Sheppard, 1997	Children	15 to 30%
Blumberg, Dubay, and Norton, 2000	Children	5 to 23%
Thorpe and Florence, 1998	Children	16%
Yazici and Kaestner, 1998	Children	5 to 24%
II. COBRA subsidies		
Klerman, 1995	Eligible for COBRA and receiving unemployment insurance	60%
Baumgardner, 1998	Eligible for COBRA and receiving unemployment insurance	50%
III. Other public subsidy programs		
Gilmer, 2001	Those with income below poverty	0%
	Persons 100-200% poverty	33%
	Persons above 200% poverty	60%
Marquis and Long, 2001	Adults and children	50-75%

Second, substitution may be considerable. As many as half or even more of participants may be persons who would otherwise purchase insurance. For this reason, some programs require some waiting period between the end of participation in an insurance plan and eligibility for the subsidized program to discourage persons from dropping insurance. Examples of state subsidy programs that have waiting periods to discourage substitution include Minnesota's MinnesotaCare and Tennessee's TennCare (Chollet, Birnbaum, & Sherman, 1997). States applying for waiver authority to make premium assistance payments to employers under SCHIP are required to impose waiting periods. However, many argue that such waiting periods are inequitable and create unintended victims. They are considered inequitable, because premium assistance is denied to those who have previously engaged in the desired behavior—that is, purchasing insurance—but provided to otherwise similar individuals who have not purchased insurance. Moreover, the waiting period punishes those who lose insurance through no fault of their own as well as deterring those who are trying to work the system by dropping insurance.

As well as individuals dropping private insurance to obtain a subsidy, many are concerned that subsidies to the purchase of individual coverage might induce employers with a large number of workers eligible for the subsidy to drop insurance as a benefit. Although few studies have looked at the effect of subsidy programs on employers' decisions about offering coverage, they have generally suggested that employer offer decisions are not altered, but that substitution occurs because of lower employee take-up (Cutler & Gruber, 1996; Shore-Sheppard, Buchmueller, &

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Jensen, 2000; Marquis & Long, 2001). A related concern is that employers with a large number of workers eligible for subsidized employee contributions will reduce their contribution share. No evidence exists on the existence or magnitude of this substitution, but states using SCHIP waivers to subsidize employee contributions impose a minimum employer contribution for eligibility in order to limit this potential behavior.

Adverse Selection

Adverse selection is a potential concern with subsidy programs. A subsidy applied to the purchase of insurance in an existing pool (e.g., the individual insurance market) could attract sicker-than-average people to that pool. If such adverse selection occurs, it could result in premium increases for the pool and drive out healthier persons who participate in that pool, further increasing premium prices. Subsidy programs are generally structured so that the lowest-income individuals face the lowest premiums. To the extent that low income and poor health status are related, subsidy programs may tend to encourage greater participation in insurance by those in the poorest health (Swartz & Garnick, 2000). If the number of new participants in the pool is small relative to the size of the existing pool, however, the consequences of adverse selection are likely to be small.

Evidence from state-sponsored subsidy programs, including BH, have consistently found that adverse selection does not occur in publicly funded programs (Kilbreth, et al., 1998; Diehr, Madden, & Martin, 1993). Moreover, a recent evaluation of New Jersey's subsidy program for the purchase of insurance in the individual market indicated no adverse selection stemming from that program (Swartz & Garnick, 2000).

Labor Market Effects

A number of investigators have found that employer-sponsored insurance induces job immobility or job lock (Gruber, 1999). That is, employees with health insurance will be reluctant to leave that job, if it means giving up coverage. Figure 5, on page 10, summarizes several studies that have investigated the extent to which the availability of an alternative to employer coverage affects labor market decisions. A large number of studies have found that the availability of alternative coverage leads to an increase in early retirement. Several studies have also shown that the availability of alternatives increases job turnover.

Figure 5. Insurance and effects on labor market

I. Availability of alternatives to own employer insurance and retirement		
	Probability of early retirement	**Age at retirement**
Madrian, 1994	6 to 15 % increase	5-18 mo. decrease
Karoly and Rogowski, 1994	.8 %increase	
Gustman and Steinmeier		4 mo. decrease
Headen, Clark, and Ghent, 1997	6 % increase	
Gruber and Madrian, 1996	1 % decrease	
Rogowski and Karoly, 2000	4 % decrease	
II. Availability of alternatives to own employer insurance and employment		

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	Probability of unemployment/ not in labor force	Duration of unemployment
Gruber and Madrian, 1997	12-15% increase	none
Wellington and Cobb-Clark, 2000	4-10% increase (men)	

These labor market responses are especially important for transitional subsidies, which are expressly intended to help people purchase insurance during labor market transitions, but subsidies that make non-group insurance a more affordable option may also induce labor market changes. These labor market changes can have substantial implications for market productivity. Early retirement decisions reduce the time individuals spend in productive market activity. However, job mobility is essential to the efficient functioning of the labor market. Gruber and Madrian found an increase of about 12 to 15 percent in job mobility stemming from the availability of transitional coverage (see Figure 5), but concluded that this was largely an increase in opportunities to move to more productive employment. Nonetheless, in designing transitional subsidies, policymakers should be aware that the policy itself may lead to an increase in the expected number of people who are eligible for the program.

State Experiences

Subsidized state-sponsored plans

A number of states have subsidized programs to help low-income people obtain coverage. Washington's Basic Health was the first such program in the nation and has served as a model to other states. Some of these state programs are operated under Medicaid or SCHIP waiver authority and receive some federal financing (such as Minnesota's MinnesotaCare program); others are financed solely by state funds (such as Basic Health). These programs have made some limited progress in expanding insurance coverage to the uninsured. Analysis by the Urban Institute suggests that states with the more generous state programs do have a somewhat lower uninsured rate than states with less generous programs (Holahan, Wiener, & Wallin, 1998). On the other hand, Lipson and Schodel reviewed the experience of 16 state subsidy programs and found that overall these programs reached about 25 percent of their target population but only about 5 percent of the uninsured (Lipson & Schrodel, 1996). Washington's experience with BH supports these conclusions. The uninsured rate has declined steadily in the state since 1993 and is mirrored by an increase in participation in public programs.[*] On the other hand, about 20 percent of the target population of people below 200 percent FPL remains uninsured, and they account for almost two-thirds of the uninsured, or 308,000 people under age 65 in the state.[†]

Because these state-only programs are not entitlements, many use a variety of mechanisms to limit enrollment, such as enrollment caps, and this may be a factor in their limited reach. For example, the Oregon Family Health Insurance Assistance Program reports that it has an enrollment of 5,000 and a waiting list of 12,000 to 14,000 (AHSRHP, 2001a). The budget allocation for Basic Health has required limits on enrollment since its inception; Basic Health enrollment will still be capped even with the new funds made available through passage of I-773. The program experienced a demand surge in 1993 when it shifted from a pilot project in a few counties to a statewide program that, when maximum enrollment was attained, resulted in a long

[*] Washington State Planning Grant Research Deliverable 3.1 *Targeting the Uninsured in Washington State*
[†] Washington State Planning Grant Research Deliverable 3.1 *Targeting the Uninsured in Washington State*

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waiting list. Basic Health enrollment currently approximates the limit of 130,000—as of September 2001, enrollment was 130,055*.

Affordability—the size of subsidies and the number of subsidized "slots" available—is the primary factor in how many people are covered in these public programs. However, state experience suggests that factors in addition to affordability must also be considered in the design of subsidy programs. For example, not all workers take up employer-sponsored coverage, even though it is heavily subsidized, and some people who are eligible for public insurance at no premium cost fail to participate (Blumberg & Nichols, 2001). Many hypotheses have been offered to explain lack of participation, including the availability of the safety net, stigma of public programs, lack of knowledge, and administrative barriers. Marketing and the enrollment processes have been suggested as other factors that affect participation (Lipson & Schrodel, 1996). However, little is known about the relative importance of these non-financial barriers. (Blumberg & Nichols, 2001). Such information is essential for policy makers to design subsidy programs that will attract the uninsured.

High-risk pools

Thirty states operate high-risk pools that offer health insurance benefits to individuals who have expected medical costs that preclude them from obtaining coverage at affordable prices in the private market. Premiums for coverage are typically capped at some percentage of the average individual market rate, and funding for the subsidy is through assessments on insurers or through government revenues. The evidence suggests that most of these pools cover only a small share of the target population of uninsurable people—about 5 to 25 percent (Laudicina, 1988 and Sterns, Slifkin, & Mroz, 1997). Despite fairly substantial premium subsidies for high-risk pools, premiums may still pose a larger barrier for this population. Enrollments across pools vary inversely with the premium levels, and analysis of disenrollments suggests that price is a factor in participation and disenrollment (Stearns & Mroz, 1995). Thus, affordability may remain a barrier.

Subsidies for employee contributions

Iowa operates the nation's oldest Health Insurance Premium Payment (HIPP) program. HIPP programs subsidize enrollment in employer-sponsored private health insurance for Medicaid-eligible people and their families who have access to employer coverage. Two other states have HIPP programs that are considered by CMS to be aggressive, Pennsylvania and Texas (GAO, 1997). HIPP beneficiaries represent a small share of the total Medicaid population, primarily because most Medicaid beneficiaries do not have access to employer-sponsored coverage. In 1999, only about 3 percent of the Medicaid population participated in HIPP (Sexton, 2000).

Several states have implemented employer buy-in programs to subsidize employee contributions under SCHIP. Massachusetts has an 1115 waiver to subsidize employer-sponsored coverage using Medicaid dollars and a waiver to use SCHIP funds for employer-sponsored coverage. In 2000, about 7,000 people received assistance with their contribution to employee-sponsored coverage. Most of these individuals were subsidized by Medicaid funds, because the administrative complexity of using SCHIP dollars is greater (Polzer, 2000). Wisconsin's BadgerCare also subsidizes employer-sponsored coverage under a HIPP program and SCHIP waiver authority. However, the programs cover few families, because few have access to

*Washington State Health Care Authority, *BH Enrollment History*, 2001.

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employer coverage and because stringent federal guidelines for buy-in make it difficult to qualify. The state also reports that the administrative requirements for verification are very time consuming and labor intensive (Alberga, 2001). Washington also has a small program that allows employers to pay their employees' BH premiums (if 75 percent of their employees are eligible).

The low participation in most state programs to subsidize employer-sponsored coverage is disappointing. However, experience in Oregon suggests that subsidizing employee contributions can play a bigger role in subsidy programs than is seen in other states. About 17 percent of those in the Oregon subsidy program are enrolled in employer-sponsored plans (AHSRHP, 2001b).

The Oregon program is funded entirely with state funds and so is not subject to the stringent federal guidelines under which most of the other programs operate, which may be a factor in its greater success.

Wisconsin's experience also highlights the fact that employment is not static, but is a critical factor in designing programs to use the employment system to expand health insurance coverage. Linking coverage to the workplace will not promote a stable source of insurance for those with frequent employment turnover, which raises the question of when and for whom policy goals are consistent with the expansion of the employment-based insurance system. For example, in Wisconsin employers, responding to program inquiries about families applying for the program, indicate that they no longer employed one-fourth of the applicants.[*]

Subsidies for Transitional Coverage

Massachusetts is the only state that we are aware of that has a program to subsidize transitional coverage (IHPS, 2001). Started in 1990, the Medical Security Plan provides premium assistance for those who are eligible to purchase COBRA, if they are receiving unemployment benefits and have family income between 200 and 400 percent FPL.[†] As of September 2001, the plan provides an 80 percent subsidy to a maximum of $234 per individual or $532 per family. About 2,000 persons are enrolled in this premium assistance program.

In order to receive the subsidy, claimants send the plan administrator a copy of their COBRA letter showing the amount of the premium and a copy of the cancelled check showing that the premium has been paid. This latter requirement poses a cash flow problem for some recipients.

Washington State Context and History

Washington has a number of programs that offer subsidies to individuals for insurance coverage, including Medicaid, Basic Health, WSHIP, and others. Taken together, these programs facilitate coverage for nearly 900,000 individuals, or about one of every six state residents.

Washington is one of a few states that have a state-funded insurance program for low-income residents. Washington's Basic Health was started in 1987 as a demonstration program and extended to the entire state in 1993. In its demonstration phase, BH was administered by a separate agency and paid for with general fund revenue. When it was expanded statewide, its

[*] From "EVIC Statistics" (Wisconsin program data) as of June 30,2001, Wisconsin Division of Health Care Financing.

[†] It provides direct coverage for those with incomes below 200 percent FPL.

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administration was shifted to the Health Care Authority. Basic Health's primary funding source is now the Health Services Account, which comprises various "sin" taxes.

Several components of Basic Health are relevant to this option. The dominant program has offered subsidies to individuals with incomes up to 200 percent FPL. The Health Insurance Reform Act of 2000 authorized enrollment of individuals up to 250 percent FPL, but funds were not made available to fully implement this extension of eligibility. However, state voters passed Initiative 773 in November 2001, which increased tobacco taxes and is projected to expand the number of subsidized BH slots by 20,000 by 2004**.** [*]The premium subsidy varies by income. Below 65 percent FPL, individuals contribute $10 per month; at 65 percent to 100 percent FPL, they contribute $14. Above the federal poverty level, premiums are subsidized on a sliding scale that phases out above 200 percent FPL. The program also has copayments and preexisting-conditions restrictions. Benefits are offered through managed care plans with which the state contracts. As noted earlier, Basic Health as had enrollment caps since its inception, which limits participation.

Basic Health Plus (BH Plus) began in 1994 as a vehicle to cover children below 200 percent FPL with comprehensive Medicaid coverage. BH Plus coordinates with Medicaid to maximize federal matching funds. Basic Health also has a non-subsidized program for individuals whose incomes exceed the eligibility threshold (now essentially closed to new enrollment), and a very small program that allows employers to pay their employees' BH premiums. In the latter, employers must enroll at least 75 percent of their eligible employees within a classification of employee; those who are not eligible or who waive coverage are not counted when determining 75 percent participation.

Washington also has a high-risk pool, the Washington State Health Insurance Pool (WSHIP), for individuals who are medically uninsurable. Created in 1988, WSHIP was designed for individuals who were denied private health insurance for medical reasons. Pursuant to passage of health care reform legislation in 1993, the Insurance Commissioner mandated an open enrollment in the individual market that allowed most people on WSHIP to obtain private health coverage. In 1999, WSHP was altered during the individual insurance market crisis to allow in those who lived in counties in which no individual insurance market existed. Premiums in the pool are limited to 125 percent of the individual market average for managed care plans or 150 percent for fee-for-service options. Those who are below 300 percent of the federal poverty level and between ages 55 and 65 are eligible for a subsidy for WSHIP coverage.[†]

In early 2000, Washington became one of the last states to receive federal government approval for its State Children's Health Insurance Program (SCHIP). Children between the ages of 0 and 19 with family incomes between 200 and 250 percent FPL are eligible for benefits comparable to Medicaid benefits. Premiums are $10 per child up to $30 maximum per family, with copayments of $5 per visit.

Implications

- Subsidies will have to be quite large to have much effect.

[*] Personal communication, Office of Financial Management.
[†] www.insurance.wa.gov

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- Participation rates in public programs and subsidy demonstration programs suggest that affordability is the primary but not only barrier; other barriers that impede participation need to be addressed for policies to be successful.
- The potential for substitution of public for private funds is considerable; to the extent policy makers want to minimize this effect, income limits for eligibility would be necessary.
- Programs designed to fill short-term gaps will not have much effect on the uninsured rate, because most uninsured individuals on a given date are in long-term spells of uninsurance. Nonetheless, such programs might affect a large number of people who have short spells of uninsurance. We cannot adequately evaluate the role of such programs in Washington without a longitudinal database.
- Subsidies for employer-sponsored coverage will have limited benefits for low-wage earners, because they experience frequent employment transitions.
- Administrative complexities of employer buy-in requirements of HIPP plans or SCHIP waivers limit the role of buy-in programs that are financed and regulated by the federal government.

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References

(AHSRHP) Academy for Health Services Research and Health Policy. *Employer buy-in programs, how four states subsidize employer-sponsored coverage.* (2001b). Washington, DC.

(AHSRHP) Academy for Health Services Research and Health Policy*. State of the states*. (2001a). Washington, D.C.

Alberga, J. (2001). Wisconsin's BadgerCare program offers innovative approach for family coverage, State coverage initiatives case study. *Academy for Health Services Research and Health Policy*.

Baumgardner, J.R. (1998). Providing health insurance to the short-term unemployed. *Inquiry*, Vol. 35, p. 266-279.

Blumberg, L.J. &, Nichols, L.M. (2001). Why are so many Americans uninsured? Paper presented at Research Agenda Setting Conference, Research Initiative on Health Insurance, University of Michigan, July 8-10.

Blumberg, L.J., Dubay, L., Norton, S.A. (2000). Did the Medicaid expansions for children displace private insurance? An analysis using the SIPP *Journal of Health Economics, Vol. 19*, p. 33-60.

Blumberg, L.J., Nichols, L.M., Banthin, J. (2002). Worker decisions to purchase health insurance. *International Journal of Health Finance and Economics, Vol.1,3*, p. 305-326.

Chernew, M., Frick, K. & McLaughlin, C.G. (1997). The demand for health insurance coverage by low-income workers can reduced premiums achieve full coverage? *Health Services Research, Vol. 32*, p. 453-470.

Chollet, D.J., Birnbaum, M.L., & Sherman, M.J. (1997). *Deterring crowd-out in public insurance programs: State policies and experience*. Washington, DC: Alpha Center.

Curtis, R. (1999). *Subsidy payment structure alternatives*. Washington, DC: Institute for Health Policy Solutions.

Cutler, D. & Gruber, J. (1997). Medicaid and private insurance: Evidence and implications. *Health Affairs, Vol. 16,* p.194-200.

Cutler, D., & Gruber, J. (1996). Does public insurance crowd out private insurance. *Quarterly Journal of Economics*, Vol. 111, p. 391-430.

Diehr, P., Madden, C.W., Martin, D.P., et al. (1993) Who enrolled in a state program for the uninsured: Was there adverse selection? *Medical Care. Vol. 31 (12),* p. 1093-1105.

Dubay, L. & Kenney, G. (1996). The effects of Medicaid expansions on insurance coverage of children. *The Future of Children, Vol. 6,* p. 152-161.

Dubay, L. & Kenney, G. (1997). Did Medicaid expansions for pregnant women crowd out private coverage. *Health Affairs, Vol. 16*, p. 185-194.

GAO (General Accounting Office). (1997) *Three states' experiences in buying employer-based health insurance*. GAO/HEHS-97-159.. Washington, DC. Gilmer, T. (Jan 30, 2001). Testimony before a joint hearing of the California senate health and human services and insurance committees and budget and Fiscal Review Subcommittee.

Gruber, J. & Proterba, J. (1994). Tax incentives and the decision to purchase health insurance, evidence from the self employed. *Quarterly Journal of Economics, Vol. 193*, p. 701-773.

Gruber, J. (2000). Health insurance and the labor market. In J.P. Newhouse & A.J. Culyer, (Eds.) *Handbook of Health Economics* (pp. 646-706) Amsterdam, North Holland: Elsevier.

Funded by the U.S. Department of Health and Human Services, Health Resources and Services Administration
Grant #1 P09 OA00002-01.

Gruber, J., & Madrian, B.C. (1996). Health insurance and early retirement: Evidence from the availability of continuation coverage. In D.A. Wise (Ed.), *Advances in the Economics of Aging* (pp. 115-143). Chicago, IL: Univ. of Chicago Press.

Gruber, J., & Madrian, B.C. (1997). Employment separation and health insurance coverage. *Journal of Public Economics, Vol. 663*, p. 349-382.

Gustman, A.L. & Steinmeier, T.L. (1994). Employer-provided health insurance and retirement behavior. *Industrial and Labor Relations Review, Vol. 48*, p. 124-140.

Holahan, J., Wiener, J., & Wallin, S. (1998). Health policy for the low-income population: Major findings from the assessing the new federalism case studies. Occasional Paper, No. 18. Washington, D.C.: *Urban Institute*.

IHPS (Institute for Health Policy Solutions). (2001). *Coverage of Displaced Workers' Children, Roundtable Discussion*. Washington, DC.

Karoly, L.A. & Rogowski, J.A. (1994). The effect of access to post-retirement health insurance on the decision to retire early. *Industrial and Labor Relations Review, Vol. 48*, p. 103-123.

Kendall, D.B. (2000). A *Health Insurance Tax Credit: Backgrounder*. Washington, DC: Progressive Policy Institute.

Kilbreth, E.H., Coburn, A.F., McGuire, C et. al. (1998). State-sponsored programs for the uninsured: Is there adverse selection? *Inquiry, Vol. 35 (3),* p. 250-265.

Klerman, J.A. (1995). Evaluating *proposal to extend health insurance among the unemployed*. PML-459-DOL. Santa Monica, CA: RAND.

Lambrew, J.M. (2001). *How the Slowing U.S. Economy Threatens Employer-Based Insurance*. New York, NY: Commonwealth Fund.

Laudicina, S. (1988). State health risk pools: Insuring the uninsurable. *Health Affairs, Vol. 7*, p. 97-104.

Lipson, D.J., & Schrodel, S.P. (1996). *State subsidized insurance programs for low-income people.* Washington, DC: Alpha Center.

Long, S.H. & Marquis, M.S. (2001). Low-wage workers and health insurance coverage: Can policymakers target them through their employers? *Inquiry, Vol. 38,* p. 331-337.

Long, S.H. & Marquis, M.S. (2002). Participation in a public insurance program: subsidies, crowd-out, and adverse selection, RAND.

Long, S.H., & Marquis, M.S. (1993). Gaps in employer coverage: Lack of supply or lack of demand? *Health Affairs, Vol. 12 (Supplement)*, p. 282-293.

Madden, C.W., Cheadle, A., Diehr, P. et al., (1995). Voluntary public health insurance for low-income families: The decision to enroll. *Journal of Health Politics, Policy, and Law, 20 (No 4),* 955-972.

Madrian, B.C. (1994). The effect of health insurance on retirement. *Brookings Papers on Economic Activity*, p. 181-232.

Marquis, M.S., & Buchanan, J.L. (1992). Subsidies and national health care reform: The effect on workers demand for health insurance coverage. In *Health Benefits and the Workforce*. Washington, DC: U.S. Dept. of Labor.

Marquis, M.S., & Long, S.H. (1995). Worker demand for health insurance in the non-group market. *Journal of Health Economics, Vol. 14*, p. 47-63.

Marquis, M.S., & Long, S.H. (2001). *Public insurance expansion and crowd out of private coverage*. Arlington, VA: RAND.

Marquis, M.S., & Long, S.H. (2001). To offer or not to offer: The role of price in employers' health insurance decision. *Health Services Research, Vol. 36 (No. 5),* p. 935-958.

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Grant #1 P09 OA00002-01.

Meyer, J.A. & Wicks, E.K. (Eds.). (2001). *Covering America, Real Remedies for the Uninsured*. Washington, DC: Economic and Social Research Institute.

Monheit, A.C. & Vistnes, J.P. (1999). Health insurance availability at the workplace: How important are worker preferences? *Journal of Human Resources, Vol 34 (No. 4).*

Pauly, M. & Herring, B. (2001). Expanding coverage via tax credits: Trade-offs and outcomes. *Health Affairs, Vol. 20,* p. 9-26.

Pauly, M., & Herring, B. (1999). *Pooling health insurance risks.* Washington DC: AEI Press.

Polzer, K. (2000). *Using SCHIP to subsidize employer-based coverage: How far can this strategy go?* Washington, DC: National Health Policy Forum.

Rogowski, J.A. & Karoly, L.A. (2000). Health insurance and retirement behavior: Evidence from the health and retirement survey. *Journal of Health Economics, Vol. 19*, p. 529-39.

Sexton, J. (2000). *Overview of the Iowa health insurance premium payment program.* Washington, DC: Institute for Health Policy Solutions.

Shore-Sheppard, L. (1997). *Stemming the tide? The effect of expanding Medicaid eligibility on health insurance coverage.* Working Paper. Pittsburgh, PA: University of Pittsburgh.

Shore-Sheppard, L., Buchmueller, T.C., & Jensen, G.A. (2000). Medicaid and crowding out of private insurance: A re-examination using firm level data. *J*ournal of *H*ealth *E*conomics, *Vol. 19*, p. 61-91.

Stearns, S.C. & Mroz, T.A. (1995). Premium increases and disenrollment from state risk pools. *Inquiry, Vol. 32,* p. 392-406.

Sterns, S.C., Slifkin, R.T. & Mroz, T.A. (1997). The structure and experience of state risk pools: 1988-1994 *Medical Care Research and Review, Vol54*, p. 223-238.

Swartz, K., & Garnick, D.W. (2000). Adverse Selection and Price Sensitivity When Low-Income People Have Subsidies to Purchase Health Insurance in the Private Market. *Inquiry, Vol. 37 (No 1),* p. 45-60.

Thorpe, K.E. & Florence, C.S. (1998). Health insurance among children: The role of expanded Medicaid coverage. *Inquiry, Vol. 35,* p. 369-379.

Washington State Health Care Authority. (2001) *BH Enrollment History*. Olympia, Washington.

Wellington, A.J., & Cobb-Clark, D.A. (2000). The labor supply effects of universal health coverage: What can we lean from individuals with spousal coverage? In S.W. Placheck (Ed.), *Worker Well Being: Research in Labor Economics*. Amsterdam: Elsevier Science.

Yazici, E.Y. & Kaestner, R. (1998). Medicaid expansions and the crowding out of private health insurance among children. *Inquiry, Vol. 35,* p. 369-379.

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Appendix

Figure 1. Financial subsidies to individuals to purchase private insurance: design choices

Design Choice	Options and Issues
What the subsidy can be used for.	**Employee contributions to employer-sponsored coverage**
	Advantages: Leverage private dollars; builds on current system; large number of uninsured are workers or dependents; promotes work force attachment.
	Disadvantages: Employment turnover reduces continuity
	COBRA continuation coverage
	Advantages: Uninsurance episodes are often transitional episodes between jobs; may enhance productivity by reducing job lock.
	Disadvantages: COBRA not available to all workers who lose an insured job; may have unwanted labor market effects; effect on cost of group plan might lead some employers to drop or alter benefits.
	Individual insurance (including high risk pools, BH)
	Advantages: Reaches uninsured who do not have access to employer sponsored coverage; increased choice may improve match between consumer preferences and purchases.
	Disadvantages: Behavioral response might undermine existing employment-based system; ensuring access to coverage for high risk persons
Who is eligible	**Income cap:**
	Advantages: Most uninsured are low income; minimize substitution effects.
	Disadvantages: Many moderate income families do not have access to affordable coverage
	Required period of uninsurance:
	Advantages: Target the uninsured; minimize substitution
	Disadvantages: Unequal treatment of equals; enforcement costs; may increase number of transitory periods of uninsurance.
	Labor force restrictions for transition coverage:
	Advantages: Restricting COBRA to unemployed persons or those receiving UI benefits may minimize unwanted labor market effects
	Disadvantages: Enforcement costs; not available to many who lose employer-sponsored coverage.
	Special populations: E.g., the uninsurable
The subsidy design	**Amount**
	Substantial subsidy necessary for participation vs. encourage substitution
	Fixed amount vs. variable amount
	Sliding scale with income avoids eligibility cliffs vs. complexity of administration
	Minimum benefit that can be purchased
	Effects on take-up vs. improvements in care access

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Figure 1 (continued). Financial subsidies to individuals to purchase private insurance: design choices

Design Choice	Options and Issues
How subsidy is distributed	**Voucher**
	Advantages: Avoids liquidity (cash flow) problems ensures use for intended purpose.
	Direct payment to individual or insurer
	Advantages: Avoids liquidity problems
	Disadvantages: Ensuring used for intended purpose
	Tax credit
	Advantages: Builds on existing administrative tax structures
	Disadvantages: Liquidity problems; no state income tax
Financing	**Extending Federal Programs**
	Advantages: Leverages state funds
	Disadvantages: Must comply with federal rules
	Special taxes (e.g. sin taxes)
	Advantages: Targeted source of funds
	Disadvantages: May not be a stable source of revenue
	Taxes on providers and/or plans
	Advantages: Targets those who share benefits
	Disadvantages: Heavily opposed by targeted groups
Administration	**Integrate with existing programs**
	Advantages: Builds on existing administrative structures
	Disadvantages: Possible stigma of association with existing programs
	New administrative structure
	Advantages: Clear focus on new program; no "baggage"
	Disadvantages: Additional administrative burden/cost

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