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HEALTH INSURANCE TAX CREDITS: THE WRONG PRESCRIPTION FOR THE UNINSURED

Executive Summary

Despite a strong economy over the last decade, there are still millions of working adults who lack health insurance. High costs and difficulty in gaining access to care are the primary barriers to insurance coverage both for workers and for the unemployed. Many low-income workers are not offered insurance benefits through their employers. For them, the cost of private, non-group insurance plans can be prohibitively expensive. High costs also force some workers to decline employer-sponsored coverage because they cannot afford the employee share of the premiums. The unemployed face similar problems, and for them finding affordable health insurance coverage can be even more difficult.

Providing tax credits for health insurance is one approach that has been proposed as a means of reducing the ranks of the uninsured. The Bush Administration, for example, has proposed a refundable tax credit for uninsured individuals and families. But tax credits cannot fully address the problems of access and affordability for the vast majority of the uninsured in the United States.

The purpose of a tax credit is to lower the cost of health insurance premiums sufficiently to allow more people to buy coverage. Proponents argue that a health insurance tax credit would expand coverage by giving people money – either a fixed percentage of premium costs or a flat dollar amount – to use toward purchasing a plan in the private, non-group market.

To be effective, the credit must be large enough to allow the low-income uninsured to afford coverage and to give private insurers an incentive to provide that coverage. Under current tax credit proposals, however, health insurance would still be out of reach for most low-income Americans. Many very poor families would have to spend more than half of their annual income on health insurance to receive coverage under these plans. Tax credits alone would also do little to improve access to coverage, because providing coverage to people with health risks will not be profitable for insurers unless premiums are very high or better methods of pooling risks are developed. As a result, insurance providers may still turn away some uninsured because of age or health status, even if the applicants can afford to pay somewhat higher-than-normal premiums.

A more effective way to guarantee health coverage for the poor would be to extend coverage through existing public programs such as Medicaid and SCHIP. Most proposals would grant free coverage to the very poor and allow the near poor to buy into public programs at reduced rates. The advantage of these proposals is that they would virtually eliminate the problem of health insurance coverage for the poor, without spending public resources to subsidize those who can already afford and gain access to health insurance. In the longer run, offering tax advantages for health insurance for higher-income employees who are not covered by

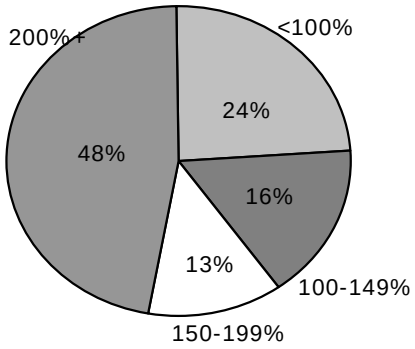
employer plans may even induce some employers to drop their plans, raising public costs for health insurance even further.

I. Why Do More Than 38 Million Americans Lack Health Insurance?

In 2000, more than 38 million Americans did not have health insurance at any point during the entire year, and many more lacked insurance for at least part of the year. Further, many of those who did have some insurance did not have enough coverage to allow them to pay for all their health care needs. These problems occurred in spite of record levels of employment, the most common source of health insurance. As the economy slows and unemployment increases, the number of uninsured will continue to rise.

Most of those without insurance are working adults under the age of 65. More than 75 percent of the uninsured – some 30 million Americans – are between the ages of 18 and 64. Most of them are working poor. The overwhelming majority (75.9 percent) worked either full or part-time during the year, yet more than half of the nonelderly uninsured have household incomes that are less than 200 percent of the federal poverty level (FPL), which in 2000 was about $17,500 for a family of four.

The Nonelderly Uninsured by Poverty Level, 2000.



Source: JEC Democratic Staff analysis of Congressional Research Service and U.S. Census Bureau data.

Barriers to Coverage: Access and Affordability

There are two primary barriers to coverage for the low-income uninsured – access and affordability. The cost of a comprehensive health insurance plan can be a significant share of a low-income family's monthly budget. After paying rent and buying food, many simply cannot afford to pay insurance premiums.

Access to coverage is also a serious problem. Many people are uninsured because they do not meet the eligibility requirements for group plans or for public programs such as Medicaid. Those who have past or present health problems may be unable to find an insurer willing to cover them in a private, non-group plan, and these plans often exclude existing medical problems and are very expensive when they do exist.

The problems of affordability and access plague all three markets for health insurance – employer-sponsored group insurance, public programs, and private non-group plans.

Employer-sponsored group insurance

Most Americans with health insurance are covered by a plan offered by their employer. However, many of the uninsured do not have access to an employer-based plan. The majority (80 percent) of those who are working but uninsured are not offered or are not eligible for an insurance plan at work.[1] Smaller firms, which tend to employ more low-wage workers, are much less likely than large firms or those with a higher proportion of high-wage employees to offer health insurance benefits. Even if an employer offers health benefits, many part-time and temporary employees are not eligible to participate. While employer contributions and tax advantages make employer-sponsored plans generally more affordable than non-group plans, the cost of the employee share of the premiums may still put insurance out of reach for low-income workers. In 2001, workers paid an average monthly premium of $150 for a family health insurance plan.[2] A worker making minimum wage would earn $716 a month after deducting social security payroll taxes; therefore, such health insurance premiums would cost about 20 percent of the worker's monthly take-home pay.[3]

Public coverage

Medicaid offers an insurance safety net for some very low-income families, but not all. Federal law established a stringent set of eligibility guidelines for the program. Very few adults without children can qualify, regardless of how poor they may be. More than 80 percent of uninsured adults with incomes below 200 percent of poverty do not qualify for Medicaid coverage.[4] Many of these adults are disabled, but even their poor health does not necessarily qualify them for coverage. In most states, non-working individuals with a chronic disability are not eligible for Medicaid unless their incomes are below 74 percent of the poverty line (about $6,800 for a single adult). A disabled adult being supported by a spouse or parent making the minimum wage, for example, would not qualify for Medicaid. The disabled cannot get Medicare coverage until they have been receiving Social Security disability benefits for two years. So while public insurance programs have been very effective in expanding coverage to the elderly and poor children, a large portion of the low-income population remains uninsured.

Private non-group insurance

The only avenue left for people without access to employer-sponsored coverage and who do not qualify for public programs is private, non-group insurance. But securing coverage in the private market is very difficult. Insurers in most states have the right to refuse coverage based on health risk and age. This means that people who have had a heart attack or who suffer from chronic health problems may not be able to find an insurer willing to cover them. One-third of insurance applications from people with mild to severe health problems are rejected.[5] Even those who are accepted may not be able to get insurance that covers their pre-existing health problems.

Even if someone is able to get coverage, the cost of a plan with adequate benefits can be prohibitive. Insurers in most states can charge higher premiums based on a person's age or health status. The high costs put this type of insurance out of reach for many people. In the group market, on the other hand, insurers can pool their risk and keep premiums lower. Low-cost insurance plans do exist, but the benefits are very limited – some do not even cover basic maternity care – and the deductibles can be as high as $5,000 per year.

A Growing and Persistent Problem

As unemployment continues to rise and health care costs increase, the number of uninsured people is expected to grow in 2002. More than 60 percent of Americans get their coverage through an employer-sponsored plan.[6] When people lose their jobs, they are at greater risk of becoming uninsured. One estimate suggests that the number of people without health insurance could increase by 2.4 million this year.[7]

What is COBRA?

The Consolidated Budget Reconciliation Act of 1985 (COBRA) requires employers with 20 or more employees to offer the option of continuing group health insurance coverage if an employee is fired, has his or her hours reduced, retires, dies, or gets divorced or separated. Workers who are fired or have their hours reduced can continue coverage for 18 months, otherwise they can carry it for 36 months. Employers do not pay any share of the premiums. The individual must pay the full cost of the health insurance premium as well as a 2 percent administrative fee.

The Consolidated Budget Reconciliation Act of 1985 (COBRA) (see box) allows many people who have insurance coverage through their jobs to continue it after they are laid off. The vast majority of laid-off workers either cannot or choose not to take advantage of this opportunity, however. Over 40 percent of workers and their adult

dependents, often those in the lower-income brackets, fail to meet COBRA's eligibility standards. Small firms, for example, are not obligated to offer COBRA coverage to workers. High costs prohibit many of the remaining 50 to 60 percent of unemployed workers from participating. Under COBRA, employees must shoulder the entire burden of the premium costs plus an additional 2 percent administrative fee.

The increase in the cost of health insurance for the individual losing a job can be substantial because, on average, employers pay almost three-quarters of the cost of the health insurance they provide as a fringe benefit for their employees.[8] Few continue to pay a share of health insurance premiums when workers become unemployed, however. In 2001, the average monthly premium (including both employee and employer shares) for an employer-sponsored plan was $221 for an individual and $588 for a family[9]. This means that average workers with family coverage would see their share of premiums rise from $150 a month when they were employed to $588 a month when they were unemployed and using COBRA.

Even those workers who are employed may find health insurance more difficult to get in tough economic times. As the job market gets tighter, employers have less incentive to offer health insurance benefits to lure new employees. They may stop offering insurance or shift a greater share of the premium cost to employees.

II. Can a Health Insurance Tax Credit Help the Uninsured?

Tax credits have been proposed as one option to help reduce the ranks of the uninsured. A health insurance tax credit would give people money – either a fixed percentage of premium costs or a flat dollar amount – to use toward the purchase of a health insurance plan in the private, non-group market. (Some proposals would also allow the credit to be used toward COBRA coverage or the employee share of premiums in an employer-sponsored plan.) Refundable credits would allow any eligible individual to get the credit, even if he or she does not have any income tax liability.

Proponents argue that health insurance tax credits can help expand coverage by giving people the resources to purchase coverage and allowing them the freedom to choose among the options in the private market. However, tax credits are an inefficient and relatively high cost tool to expand health insurance coverage, particularly for low-income people. Tax credits do not address some of the fundamental problems with access and affordability of coverage in the private, non-group market.

What is a Tax Credit?

A *tax credit* is used to reduce an individual's tax liability. The recipient generally must complete an income tax return to get the credit. If the credit is refundable, amounts in excess of a worker's tax liability are paid to the worker. As opposed to a *tax deduction*, which reduces an individual's taxable income, the value of a tax credit is the same for everyone and does not increase for those in higher tax brackets.

Affordability of Insurance with Tax Credits

The tax credits proposed to date are too small – relative to the cost of premiums in the private, non-group market – to allow many of the low-income uninsured to buy adequate coverage. Even with the additional funds, insurance premiums can be a significant share of income for poor individuals and families. For some young and healthy individuals who can find inexpensive coverage fairly easily, a tax credit could make coverage more affordable. But premiums for non-group coverage can be significantly more expensive for and less healthy people.

Timing of payments is also a crucial part of making insurance affordable. People need the money on a monthly basis to pay their premiums. Tax credits are typically paid out as annual, lump-sum payments.

- ·**Health insurance premiums can be a significant share of income for poor families, even with the added funds from a tax credit.** Very poor families – even with the benefit of a tax credit – would likely have to spend half or more of their annual income in order to purchase a health insurance plan. According to the Employer Health Benefits Survey 2001, the cost of an employer-provided family plan was about $7,000 in 2001. The Administration's tax credit proposal would give a $1,000 per adult and $500 per child for a maximum of $3,000 for a family. It is important to note that these estimates are based on the cost of premiums for *group* policies offered through an employer. A *non-group* plan that included the same type of benefits could be twice as expensive and would consume an even greater share of family income.

Cost of Group Health Insurance As a Percentage of Family Income Credit = $1,000 per adult, $500 per child			
With a $2,000 tax credit one adult, two children		**With a $3,000 tax credit** two adults, two children	
Family Income (2001$)	**Percentage of Income**	**Family Income** (2001$)	**Percentage of Income**
$7,100 approximately 50% of poverty	70%	**$9,000** approximately 50% of poverty	45%
$14,300 approximately at poverty level	35%	**$18,000** approximately at poverty level	22%
$21,400 approximately 150% of poverty	23%	**$25,000** approximately 140% of poverty	16%

Source: JEC Democratic Staff calculations.

A tax credit would do little toward making insurance affordable for these individuals and families. An alternative approach that would do more to make insurance affordable would be to cap the cost of premiums paid by poor people. For example, federal law caps the cost of premiums for low-income families enrolled in the State Children's Health Insurance Program (SCHIP) to 5 percent of family income. This approach would help to target federal subsidies for health insurance toward those who need them most.

- **Premiums in the non-group market are generally more expensive than comparable employer-provided or public insurance plans.** Insurers can and do increase the cost of a plan based on a person's health status. In one study, almost half of all accepted applications had premiums above the standard rate because of a pre-existing health problem. The added costs are not just for people in very poor health. Common afflictions such as hay fever and sports-related knee injuries can also raise the price of insurance in the non-group market.[10] Premiums also increase with age. In some cases, a healthy 55 year-old can be charged twice as much as a 25 year-old for the same type of coverage.[11]

Recent Tax Credit Proposals

Examples of recent health insurance tax credit proposals include:

In its FY 2003 budget, the Bush Administration has proposed a refundable income tax credit for the purchase of health insurance in the private, non-group market for people under age 65.

- The maximum value of the credit would be $1,000 per individual, $500 per child, maximum credit would be $3,000 for a family.
- The credit would be targeted to low-income people. It would begin to phase out for individuals without dependents with an adjusted gross income (AGI) of $15,000 and for families with two or more children and an AGI of $25,000.
- Starting in July 2003, recipients could receive the credits in advance.
- Eligibility for the credit would be based on the prior year's income.
- The IRS would not seek to reconcile advance payments with actual earned income at the end of the year.
- The credit could not be used to pay premiums for employer-sponsored or public health insurance plans.
- Starting in 2004, states could allow certain individuals to use the credit to purchase private insurance through a state-sponsored purchasing pool.

The economic stimulus package passed by the House of Representatives in December 2001 included a temporary, refundable health insurance tax credit for unemployed workers that would pay up to 60 percent of health insurance premiums for a plan under COBRA or one purchased in the private, non-group market.

- Only workers who were laid off after March 15, 2001 and eligible for unemployment compensation or are certified by a state as eligible for benefits but are beyond their benefit year or have exhausted their maximum benefit levels. would be eligible for the credit.
- There is no income eligibility requirement.
- The credit would only be available for 12 months.
- Eligible individuals would file for a health insurance credit eligibility certificate as part of the process for applying for unemployment compensation. Individuals would pay 40 percent of their premium to their insurance company, and the federal government would directly reimburse the provider for the balance.

- **People need the money on a monthly basis.** Insurance payments are due every month, but most tax credits are single, lump-sum payments. Without a monthly flow of funds, health insurance will not be affordable for many low-income households. To best help low-income households that face tight monthly cash constraints, financial assistance for health insurance needs to be spread throughout the year. The current tax system is not structured to meet this demand. Changes would have to be made – new procedures, new tax laws, new tax forms – to an already complicated tax code in order to get the health insurance tax credit funds out on a monthly basis.

- **The availability of low-cost plans is limited and the benefits are poor.** Given the high cost of comprehensive insurance plans, one option for the uninsured would be to purchase a plan equal to the size of the tax credit. While there are some low-cost insurance plans ($1,000 or less annual premium for an individual) available in the private, non-group market, recent surveys suggest that these plans are not abundant, they are not always available nationwide and they are generally poor in quality of coverage.

A study by Families USA found that six of twenty-five states surveyed did not have any $1,000 plans available for a healthy 25 year-old woman. Eighteen states did not have $1,000 plans for a healthy 55 year-old woman. Because insurance coverage for families and people in less-than-good health is more expensive, it is likely that people in those circumstances will have even fewer options. And even when low-cost insurance plans are available, there is no guarantee that insurance providers will approve specific applicants for coverage.

The low-cost plans that do exist have limited coverage and are of little use to the low-income uninsured. Almost no existing insurance plans with annual premiums of $1,000 or less cover maternity care and many do not cover emergency care, mental health services or prescription drugs. The deductibles are very high – often ranging from $500 to $15,000 for a family plan. After the deductible is met, many plans also have a co-insurance fee that would require the insured to pay a certain percentage of the costs of any medical services they used. Some argue that deductibles, co-insurance fees and co-payments help limit the "moral hazard" problem in health insurance by creating an incentive for people to limit unnecessary treatment. However, the extremely high cost of some deductibles and coinsurance rates can put health care completely out of reach for many low-income people.

Supporters of tax credits suggest that families could set aside funds in tax-advantaged flexible savings accounts (FSAs) to cover the cost of deductibles. While this may be a good option for some people with access to an FSA and sufficient disposable income, it would not help most of the low-income uninsured. First, workers can only access an FSA through their employer. Part-time workers and workers in small firms are less likely to have or be eligible for an employer-sponsored FSA. Second, workers must have sufficient disposable income to contribute to the account. Low-income workers on tight budgets would be less likely to be able to afford regular contributions. They would also get less of a tax break on their savings than higher-income workers. Even if FSAs are modified to allow workers to rollover contributions from year to year (currently, a worker must forfeit any unused funds at the end of the

year), it could still take a long time for a low-income worker to accumulate sufficient funds to make a $5,000 or higher deductible affordable.

Insurance companies have little incentive to offer low-cost insurance plans because they are not likely to be very profitable. The market for these plans is limited because their coverage is poor and most people without known health problems would get little benefit from them, so insurers do not have a large pool over which to spread their risks. If a significant number of people with low-cost plans incur high medical costs, the insurers could lose money.

Access to Insurance with Tax Credits

Money is not the only barrier to coverage for the uninsured. There is no guarantee of coverage in the private, non-group insurance market. Insurers in most states have the right to deny or limit coverage based on age and health condition.[12] Even with funds from a tax credit, some of the uninsured may simply not be able to find a private insurance firm willing to offer them adequate coverage. A tax credit does nothing to address this problem.

The problem of access also extends to the tax credit itself. If eligibility for the credit is based on prior-year earnings, as has been suggested, people in need of health insurance assistance this year may not qualify for the credit.

- **More than a third of applications for non-group coverage may be denied due to mild or serious health conditions, according to a recent study.[13]** Further, more than 60 percent of the accepted applications imposed some kind of restriction based on pre-existing health conditions. Even minor problems can cause difficulties. In one case, some insurance carriers rejected a woman with hay fever and more than 80 percent of her acceptances came with coverage exclusions. A coverage exclusion means that the insurance plan will not cover costs relating to a specific illness or a part of the body. So while money is an important part of the equation for expanding health insurance coverage, it will not help people who are effectively shut out of the market as a result of their age or health status.

In initial descriptions of its tax credit policy, the Administration suggests that the uninsured could get access to insurance through state-sponsored insurance purchasing and high-risk pools. However, in their current form, high-risk pools would not be much better than the private market. Not all states have a high-risk pool, and those that do have them usually limit the number of enrollees. Only about 110,000 people nationwide are insured through these pools. While people may be able to get an offer of coverage, the premiums are often very high – an average of $3,083 for an individual plan in 1999 – and the deductibles and coinsurance rates are also high. In addition, many pools have a six to twelve month waiting period before an applicant can get coverage.[14]

Crowding Out

If the government offers a tax credit for health insurance, there is a risk that some people will drop their employer-sponsored coverage in order to collect the money and purchase a private plan. This is called *crowding out*. This raises the possibility that, over time, employers will be less likely to offer insurance so that their employees can take advantage of the tax credit. Without the option of affordable, group insurance that mandates coverage, more people may become uninsured.

- **People who need financial assistance the most may not be able to access the tax credit.** Most recent tax credit proposals have addressed the problem of eligibility for very low-income individuals by making the credits refundable—allowing people to get the credit even if they have no tax liability from which to deduct it. Most tax credits can only be used to offset taxes owed, but a refundable credit can be paid directlyto people even if they do not have taxable incomes. However, even refundable credits are not generally available until tax returns are filed, which maybe a year or more after a worker has become uninsured. This would do little to help those who need health care coverage now.

  Some tax credit proposals would deal with this problem by paying insurance subsidies to those with low incomes as soon as they become unemployed or lose insurance, without requiring reconciliation at the end of the year. This means that people could get the credit without having to go back at the end of the year and verify that their incomes for the year as a whole remained below the eligibility guidelines. Having to do so would be a major adminis trative headache and could expose some workers to large, unexpected tax liabilities. But such a system has great potential to be abused if no income verification is ever required.

  To allow the credit to be prepaid – without requiring those who turn out to be ineligible to pay it back – proposals gener ally base eligibility on the prior year's earnings. This means that people who lose their job or suffer a significant financial setback this year would likely not be able to claim the credit if they had good incomes last year. At the same time, those who have good incomes now but did not last year could qualify for the credit based on last year's tax return.

III. Implementation Problems with a Health Insurance Tax Credit

There are inherent problems in using the tax system to get money to the people who need it the most, when they need it the most. The tax system is based onan annual accounting of income and annual payments of refunds and credits. But an individual's income and expenses, particularly for low-income households, can vary greatly on a monthly basis. In order for a health insurance tax credit to be effective, people need to get the money every month to pay their premiums. Making a health insurance tax credit "advanceable" – delivering subsidies on a monthly basis – poses serious hurdles to effective implementation.

Making the Tax Credit Advanceable

Current tax credit proposals do not fully address all aspects of the process they would use to advance money on a monthly basis. Most tax credit proposals acknowledge the need to make the credit advanceable so that people will have the money on a monthly basis. However, there is not an existing process by which to do this and most proposals offer only a limited description of how they will implement their idea. For example, the Bush Administration proposes that the credit would be paiddirectly to health insurance providers. Individuals would pay their monthly share of the premium and, using a tax credit identification number, providers would be directly reimbursed by the Treasury Department.

Implementation Questions

What process would be used to determine income?

As noted above, there are problems in using the prior year's income to determine eligibility for a tax credit because some people who need the money now may not qualify if they had good earnings last year. If the income tax return

is used to determine income eligibility for the tax credit, it would create two problems. First, people who were not required to file an income tax return last year, but otherwise would be eligible for the tax credit, would not be able to get it. Second, people would need to apply for the tax credit throughout the year – not just in April when they file their return.

What process would be used to distribute checks on a monthly basis?

If a tax credit were to be paid directly to the insurance provider, it raises the question of how the government would determine what constitutes an eligible provider. In order to guard against fraud, a process would have to be developed to make sure that insurance providers are legitimate. This could certainly delay the process of implementation.

What incentive would health insurance providers have to participate?

It is unclear whether health insurance providers would have sufficient incentive to participate. While they would get new business under this scenario, they would have to weigh that benefit against the costs of devoting time and resources to accounting for a new stream of funds. If the government does not issue the monthly premium checks in a timely manner, the insurance company could be forced to carry the cost of unpaid premiums. In addition, insurers would have to be held harmless for any fraudulent use of health insurance tax numbers by individuals.

Advancing the Tax Credit through Payroll Deductions

Another option for getting the money into people's hands on a monthly basis is to lower the withholding in their paychecks. This would require the cooperation of employers. Almost all of the people who would be claiming this credit would be working in firms that did not offer health insurance. It is unlikely that these employers would want to take on the added burden of paperwork and adjusting withholding. Of course, individuals who do not work would not beable to claim the credit with this method.

The Earned Income Tax Credit (EITC) offers an example. Data show that almost all recipients opt to take the credit as a lump-sum payment as part of their tax return. As few as one percent of recipients opt to submit the necessary paperwork to their employer in order to receive the credit throughout the year in their paycheck. Economic theory would suggest that low-income individuals on tight budgets would prefer to receive the money over the course of the year to help meet basic expenses. While there is no evidence about why most EITC recipients opt for the lump sum, it raises the possibility that the added paperwork burden and the involvement of employers may discourage some people.

Access to State-Sponsored Pools

As noted earlier, the Administration has recommended state-sponsored purchasing and high-risk pools as one avenue for the uninsured to get access to coverage. This raises some implementation questions:

How will the federal government encourage the formation of state-sponsored pools?

Only 29 states currently have high-risk insurance pools and many of these limit the number of people who can join. According to a recent report by The Commonwealth Fund, all of the existing high-risk pools operate at a financial loss. While some limited funds are contributed by insurance companies, state budgets are left to make up the bulk of the shortfall. The initial descriptions of the Administration's tax credit proposal do not include any funding or reimbursements to states to encourage them to establish or expand a state-purchasing pool. As states face tighter budget constraints, many states will not have the necessary resources to cover the pools.

How will the government pool risk?

Uninsured individuals will likely turn to state-sponsored purchasing pools after they have been rejected by insurers in the private market. This means that the vast majority of people in these pools will have past or present health problems that make them a poor risk in the eyes of the insurance provider. The insurance coverage options available to such a high-risk pool will be limited and carry high premiums.

IV. Conclusion

Despite dramatic increases in wealth and prosperity during the 1990's, the lack of health insurance – particularly among low-income individuals – remains a persistent problem. While health insurance tax credits may help some healthy people with good incomes to buy coverage, millions of Americans will not be helped by this approach.

Tax credits do little to address the fundamental reasons why so many low-income people are not able to get adequate health insurance in this country. The size of proposed tax credits would not make health insurance more affordable for many of the uninsured. Premiums for adequate health insurance would consume a significant share of income for poor households – even with the boost from a tax credit. Low-cost insurance plans are not widely available and their benefits are quite limited. And tax credits do nothing to address the serious problem of access to insurance coverage. Even with the necessary funds, many of the uninsured could be turned awayfrom insurance providers because of their age or health status.

Expanding public insurance programs avoids some of the inherent problems with tax credits. Most current proposals would grant coverage free to the very poor and allow the near poor to buy into public programs at reduced rates. Expanding a public program to everyone below a certain income level, regardless of age and health status, would have a dramatic effect on the ability of the low-income uninsured to access coverage. The clear advantage of these proposals is that they would virtually eliminate the problem of health insurance coverage for the very poor.

In order to solve the persistent problem of the uninsured, the nation will need to make a significant investment. Over the long-term, the cost of having millions of people without health insurance and thus without access to basic care will put pressure on public health services and reduce earnings among people who can least afford it.

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Endnotes

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[8] *Employer Health Benefits Annual Survey 2001*. In 2001, employers paid 73% on average for a family health insurance plan.

[9] *Employer Health Benefits Annual Survey 2001*.
[10] Pollitz et al.
[11] *A 10-Foot Rope for a 40-Foot Hole: Tax Credits for the Uninsured*. Families USA Foundation, September 2001.
[12] Fifteen states require insurers to guarantee coverage for all participants in non-group plans. However, half of these states only require insurers to offer a basic plan. Even with a guarantee of coverage, insurers in almost all states can charge higher premiums based on health status and age.
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