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HEALTH INSURANCE

Proposals for Expanding Private and Public Coverage

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Health Insurance: Proposals for Expanding Private and Public Coverage

Mr. Chairman and Members of the Committee:

I am pleased to be here today as the Committee begins considering options to expand health insurance coverage for the 1 in 6 nonelderly Americans (under 65) who are uninsured. These 42 million people represent a heterogeneous population. As we noted in our testimony before your Committee earlier this week,[1] the majority of the uninsured are working, often for small businesses or in certain industries such as agriculture or construction that are less likely to offer health insurance, or are low-income persons who are ineligible for or not enrolled in public programs. A disproportionate share of young adults, Hispanics, and residents of southern or western states are uninsured. But the uninsured population also includes people employed by larger-sized firms and other industries as well as those of all income levels, ages, races and ethnicities, and geographic locations. Given the heterogeneity of this population, a variety of approaches have been proposed in the Congress and by proponents to increase private or public health insurance coverage in ways that may match the needs of different uninsured persons and maximize the potential impact for expanding coverage.

Several recent congressional efforts represent important steps toward increasing the availability of health insurance for workers and low-income families, including

- improving the availability of private health insurance for individuals changing jobs or with preexisting health conditions,
- increasing the percentage of health insurance premiums that self-employed individuals can deduct from their taxable income,
- giving additional flexibility to states to expand Medicaid eligibility to a larger group of low-income children and their parents, and
- establishing the new federal-state State Children's Health Insurance Program (SCHIP), which had already enrolled more than 3 million low-income children in 2000.

[1]See *Health Insurance: Characteristics and Trends in the Uninsured Population* (GAO-01-507T, Mar. 13, 2001).

These steps help millions of Americans, and the full effect of some of these actions likely has not yet been realized. Despite these efforts, however, millions of Americans remain uninsured.

To assist the Committee as it considers the variety of proposals offered to expand coverage to the uninsured, my remarks today will provide an overview of potential approaches for increasing private or public coverage and considerations that could impact their effectiveness in reaching significant numbers of the uninsured. Specifically, I will focus on

- proposed additional tax incentives, such as deductions or credits, to encourage individuals to purchase private health insurance or employers to offer coverage;
- proposed expansions to public programs, including expanding Medicaid and SCHIP to additional low-income children and adults, and allowing near-elderly individuals not yet 65 to "buy in" to Medicare; and
- the potential for unintended consequences of private and public coverage expansions on existing private health insurance coverage.

My comments are based on our prior and ongoing work on the uninsured population, private health insurance, Medicaid, and SCHIP, as well as other published research.[2] We reviewed key elements of major proposals that have been introduced in the 106th and 107th Congresses, as well as several put forth by various proponents.

In summary, the success of proposals to provide additional tax incentives to promote private health insurance—which already is the primary source of health coverage for most nonelderly Americans—will depend on whether they are large enough so that more uninsured individuals will purchase insurance or more employers will begin offering coverage or increase their contribution to premiums. Because most uninsured individuals either pay no taxes or are in the lowest marginal tax rate bracket, a refundable tax credit would provide a larger net reduction in premium costs for low-income uninsured individuals than would allowing a deduction from taxable income. Tax credits also will be more effective if available when low-income persons purchase coverage rather than in the next year when tax returns are filed. Most of the proposed tax credit amounts represent less than half of premiums for many individuals, which

[2]A list of related GAO products appears at the end of this statement.

some analysts conclude is not large enough to induce most low-income uninsured individuals to begin purchasing health insurance. Some proposed credits for small employers or those with many low-wage workers would be provided for a limited period of time, which may make affected employers hesitant to begin offering coverage or increasing their premium contribution if the continued availability of the credit is uncertain.

Other proposals would expand eligibility for existing public programs to more low-income children and adults. These include

- giving states the option of increasing income eligibility limits under Medicaid or SCHIP;
- expanding these public programs to persons who are not now eligible, such as most childless adults for the Medicaid program or the parents of children eligible for SCHIP; and
- allowing near-elderly individuals who are not yet Medicare-eligible to pay premiums and thereby buy in to Medicare.

The success of these efforts in reducing the number of uninsured is contingent upon (1) the willingness of states to pursue options to expand Medicaid and SCHIP eligibility and (2) the effectiveness of outreach to enroll eligible individuals, since at present many eligible individuals are not participating.

Proposed approaches to expand insurance coverage may result in some individuals or employers dropping current coverage in order to take advantage of a new tax subsidy or public program that would reduce health insurance costs associated with individual or employment-based coverage. While some steps may be taken to reduce the potential for this phenomenon—known as "crowd-out"—some level of such displacement of existing private coverage may be an inevitable cost of efforts to decrease the number of uninsured Americans.

Background

Employers voluntarily offering private health insurance benefits are the predominant source of coverage for nonelderly Americans, and publicly sponsored programs also enroll many low-income people. Two-thirds of nonelderly Americans obtain private health insurance through employment. The federal tax code provides incentives for employers to subsidize health benefits by making their premium contributions tax

deductible as a business expense; this subsidy also is not considered taxable income for employees. In addition, tax benefits are available to individuals who purchase nongroup private insurance directly from insurers (referred to as "individual insurance") if the person is self-employed[3] or has premium and medical expenses combined that exceed 7.5 percent of his or her adjusted gross income.

However, private insurance is not accessible to everyone. Some workers, including those working for small firms or in certain industries such as agriculture or construction, are less likely to be offered employment-based health coverage. Health insurance may also be expensive and potentially unaffordable for those paying the entire premium individually rather than receiving employment-based coverage where employers typically contribute to some or all of the cost. In addition, while all members of a group plan typically pay the same premium for employment-based insurance regardless of age or health status, in most states individual insurance premiums are higher for older, sicker individuals than for young, healthy individuals, potentially making them unaffordable.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) provided several important protections to improve the availability of private health insurance, particularly for individuals changing jobs or with preexisting health conditions. HIPAA included guaranteed access to coverage for those leaving group coverage and for small employers; however, it did not address issues of affordability. In addition, many states have enacted reforms that guarantee access to health insurance for certain high-risk individuals and small groups and that sometimes limit the premiums these persons and groups pay. While these federal and state private insurance market reforms provide important protections for certain individuals and groups, recent research finds little, if any, effect from these reforms on overall private insurance coverage rates.

Public programs such as Medicaid and SCHIP cover certain low-income or disabled individuals. However, eligibility for these programs is often restricted to selected groups, such as children, parents of eligible children, pregnant women, or disabled individuals, and depends on the applicant's age, income, and other factors. For example, childless adults, unless disabled, are generally not eligible for Medicaid. States must set income thresholds to meet certain minimum federal standards but may opt for

[3]For 2001, self-employed individuals may deduct 60 percent of eligible health insurance expenses from taxable income; this share is scheduled to rise to 100 percent in 2003 and thereafter.

higher eligibility standards as long as they are within federal guidelines. SCHIP was established in 1997 to give states the choice of receiving enhanced federal funding to cover additional low-income children who do not qualify for Medicaid, generally those in families whose incomes are up to 200 percent of the federal poverty level. Unlike Medicaid, SCHIP is not an entitlement program, and states can halt enrollment once budgeted funds are exhausted.[4] As of September 2000, HCFA reported that 3.3 million children were enrolled in SCHIP. Although Medicare primarily insures most Americans 65 years or older, it also provides coverage for some nonelderly individuals who are disabled or have end-stage renal disease.

Impact of Proposed Tax Incentives Will Depend on Their Size and Timing

Additional tax incentives proposed to encourage people to purchase health insurance vary in terms of who would be eligible, whether the tax incentive is provided to individuals or employers, and whether the incentive is a deduction that reduces taxable income or a credit that reduces total tax liability. The proposals share challenges that will affect their success in covering newly insured individuals. These challenges include (1) making the reduction in premiums large enough to induce uninsured persons to purchase health insurance or to encourage employers to offer coverage or increase their contributions to premiums, and (2) timing a subsidy to be available for low-income individuals at the time they pay their premiums, rather than after the end of the tax year.

Tax Deductions

Some proposals would allow people who purchase individual, nongroup health insurance to deduct the cost of premiums from their taxable income, with the intention of both increasing coverage and making the tax treatment of individually purchased and employment-based insurance more uniform. These proposals vary as to whether tax filers would have to itemize deductions in order to receive the health insurance deduction or could make the deduction an "above-the-line" adjustment to gross income without itemization.[5] Some proposals would also allow employees' contributions to employment-based health insurance to be deducted from

[4]As an entitlement program, states must enroll all individuals who apply and meet state and federal Medicaid requirements.

[5]In 1998, nearly 31 percent of tax filers itemized their deductions.

their taxable income—potentially important if the employee must pay most or a large share (more than half) of the plan's premium, since these employees are more likely to turn down employment-based coverage.

A tax deduction may be limited in its ability to induce uninsured individuals to purchase private insurance because most uninsured individuals do not earn enough for a deduction to make any or a significant difference in their net health insurance costs. In 1999, about 40 percent of the uninsured either did not file income tax returns or were in the 0 percent marginal tax rate and would not benefit from the deduction if they purchased individual insurance. Nearly 50 percent of the uninsured were in the 15 percent marginal tax rate, which, if they purchased qualifying health insurance, would allow them a 15 percent net reduction in their insurance cost.[6] Analysts have generally agreed that this level of reduction would encourage few additional uninsured individuals to purchase health insurance. The remaining 10 percent of the uninsured, based on their marginal tax rates, would be eligible for a 28 to nearly 40 percent net reduction in the cost of their health insurance.[7] While this level of reduction in net premiums may induce some individuals in higher tax brackets to purchase health insurance, it is less than some analysts have concluded would be necessary to lead to a widespread increase in coverage. For example, the Congressional Budget Office (CBO) reported that tax subsidies "would have to be fairly large—approaching the full cost of the premium—to induce a large proportion of the uninsured population to buy insurance."[8]

Tax Credits

Other proposals would allow individuals purchasing health insurance to receive a tax credit. In contrast to a deduction, the amount of the credit depends not on the filer's marginal tax rate but how the credit is designed. Some proposals involve providing tax filers below a certain income threshold a flat credit if they purchase individual health insurance, such as up to $1,000 for single coverage or $2,000 for family coverage, while

[6]In 1999, the 15 percent tax bracket included single tax filers with taxable income of $25,750 or less, head-of-household tax filers with taxable income of $34,550 or less, and joint tax filers with taxable income of $43,050 or less.

[7]The 28 percent tax bracket included single tax filers with taxable income of $25,751 to $62,450, head-of-household tax filers with taxable income of $34,551 to $89,150, and joint tax filers with taxable income of $43,051 to $104,050. The 39.6 percent tax bracket included any tax filer with income over $283,150.

[8]CBO, *Options to Expand Federal Health, Retirement, and Education Activities* (Washington, D.C.: June 2000).

higher-income individuals could be eligible for a partial credit or no credit. Because more than half of uninsured individuals would not have had enough income tax liabilities in 1999 to receive the full credit amount, some proposals would make the credit refundable so that more low-income tax filers and a number of those who would not otherwise file could receive a larger portion or all of the amount.[9]

The number of individuals eligible for a tax credit would vary depending on the income thresholds specified in a proposal. For example, we estimate that in 1999 22 million uninsured Americans were in families that potentially would have been eligible for a tax credit available to single tax filers with $30,000 in taxable income and joint or head-of-household tax filers with $50,000 in taxable income. A recent study estimated that a tax credit of $1,000 for single coverage and $2,000 for family coverage with these taxable income thresholds could enable about 4.2 million—or nearly 20 percent of eligible individuals—to become newly insured.[10] If income eligibility levels were twice as high, we estimate that 3 million additional uninsured individuals would have been in families potentially eligible for the tax credit, and the study estimated that a credit at this higher income eligibility level would result in another 0.5 million newly insured.[11]

A fixed-dollar tax credit would represent a varying proportion of the health insurance cost, since health insurance premiums can vary widely with the locality, age, and health of the individual and the level of benefit and plan type. In 1999, we reported some examples of annual premiums in the individual health insurance market for single coverage, including

- a low premium of $744 for a healthy 30-year-old male in Arizona,
- a mid-level premium of $2,658 in a rural New York county, a state that has community rating and therefore does not allow variation by age or health status of the individual, and

[9]By being refundable, a tax credit allows tax filers whose income tax liability is less than the value of the credit to receive a refund in excess of their federal tax liability.

[10]Unpublished data from Jonathan Gruber based on Jonathan Gruber and Larry Levitt, "Tax Subsidies for Health Insurance: Costs and Benefits," *Health Affairs* (Jan/Feb 2000), pp. 72-85. The authors estimate that the number of uninsured that would be newly covered would be higher (about 6 million) if the credit was payable in advance but lower (about 2 million) if it excluded anyone with employer-based coverage.

[11]Gruber and Levitt, "Tax Subsidies for Health Insurance: Costs and Benefits."

- a high premium of $7,154 for a 60- to 64-year-old smoker in urban Illinois.[12]

Thus, in some states, a $1,000 tax credit could represent all or most of the premium for a young, healthy male or for someone purchasing a plan with a high deductible or limited benefits. On the other hand, a $1,000 credit could represent a small proportion of the premium for a comprehensive health plan for an older person or someone with existing health conditions. For many individuals, a $1,000 tax credit would likely represent less than half of a typical premium.

A tax credit's ability to induce uninsured individuals to purchase coverage will also depend on the timing of the credit. Some low-income individuals who want to take advantage of a credit to purchase health insurance may find it difficult to do so if they must pay the premiums up front but cannot receive the credit until the following year after filing their tax return. To alleviate this problem, some proposals would allow advance funding of a credit, so that eligible individuals could receive the credit at the time they purchase the health insurance. There is limited experience with advance payments of tax credits for individuals, and establishing an effective mechanism could be administratively challenging. Procedures and resources to assess eligibility based on partial-year income information would need to be available nationwide. In addition, efficient and equitable procedures for end-of-year reconciliations and recovery of excess payments would be necessary.

The Earned Income Tax Credit (EITC), a refundable tax credit that offsets much of the impact of Social Security taxes paid by low-income workers in order to encourage them to seek work rather than welfare, does provide an option allowing recipients to receive 60 percent of the credit in advance. The share payable in advance is limited to 60 percent to reduce the risk to recipients of having to repay erroneous payments and to reduce the risk of overpayments. However, very few EITC recipients—about 1 percent—have received an advance payment for their EITC.[13] This low participation is in part because many EITC recipients are unaware of the advance payment option or prefer to receive the full credit at the end of the tax year. While the EITC experience suggests that it may be difficult to make an advance payment option work effectively for a health insurance tax credit, more low-income individuals may use this option for health

[12] *Private Health Insurance: Potential Tax Benefit of a Health Insurance Deduction Proposed in H.R. 2990* (GAO/HEHS-00-104R, Apr. 21, 2000).

[13] For more information on the EITC, see *Federal Taxes: Information on Payroll Taxes and Earned Income Tax Credit Noncompliance* (GAO-01-487T, Mar. 7, 2001).

insurance because they are required to spend money up-front to get the tax credit, whereas EITC is an addition to income, not a reimbursement for an expense.

Tax Incentives for Small Employers or Those With Many Low-Wage Workers

To encourage more employers to offer coverage, some proposals would provide a tax subsidy to small firms or those with low-wage workers that often do not offer health insurance to their employees. Although at least 96 percent of private establishments with 50 or more employees offered coverage in 1998, only 36 percent of private establishments with fewer than 10 workers and about 67 percent of private establishments with 10 to 25 workers offered coverage. Also in 1998, among private establishments in which half or more of the workers were low-wage, only 31 percent offered health insurance to their employees, while other private establishments were nearly twice as likely to offer health insurance.[14]

As with tax credits to individuals, if employer tax credits are to increase insurance coverage, they must be large enough to induce employers to begin offering coverage and to make the employee share affordable. Generally, credit amounts proposed to date for small employers would represent much less than half of the annual cost of coverage per employee, which is typically about $2,400 for single coverage and almost $6,400 for family coverage.[15] For example, one proposal would provide a temporary tax credit for employers with 2 to 50 employees that had not offered health insurance in the past 2 years and that began purchasing coverage through a qualified coalition. The credit would amount to 20 percent of employer contributions to the insurance, up to $400 per year for individual coverage and $1,000 per year for family coverage. Massachusetts and Kansas recently began offering a tax credit to small businesses, and Massachusetts also offers a tax credit to low-income employees. However, these policies are too new to fully assess their effects on coverage. Another proposal would provide a credit to employers to encourage them to pay a larger share of premiums for low-wage workers. This is intended to encourage more low-wage workers who are offered employment-based health insurance to accept it.[16] One study estimated

[14]Agency for Healthcare Research and Quality, Center for Cost and Financing Studies, 1998 Medical Expenditure Panel Survey, Insurance Component.

[15]The Kaiser Family Foundation and Health Research Educational Trust's *Employer Health Benefits: 2000 Annual Survey* reports that average premiums in 2000 were $2,426 for single coverage and $6,351 for family coverage.

[16]See Charles N. Kahn III and Ronald F. Pollack, "Building a Consensus for Expanding Health Coverage," *Health Affairs*, Vol. 20, No. 1 (Jan./Feb. 2001), pp. 40-48.

that in 1996 37 percent of workers earning less than $7 per hour were offered coverage but turned it down, while only 14 percent of workers earning $15 or more per hour turned down coverage.[17]

Many proposed or already available state-offered tax credits for employers provide only a temporary subsidy for the first few years an employer offers coverage. This may limit their potential for inducing employers to initiate and keep offering coverage. Experts we have consulted in our private insurance work told us that small employers are not likely to begin offering health insurance if they do not believe they will be able to do so permanently.

Some proposed employer tax credits are linked to small employers obtaining health insurance through a purchasing cooperative. We reported last year that several existing cooperatives gave small employers the ability to offer a choice of plans, but typically at premiums similar to those available outside of the cooperative. We also reported that most current cooperatives represented a small share of their local small group market (5 percent or less) and several had recently been discontinued or faced declining insurer or employer participation.[18] Some analysts suggest that small employer purchasing cooperatives could be more effective in making coverage more affordable if they represented a larger share of the market. A significant employer tax credit linked to a small employer purchasing cooperative might stimulate participation and create larger market share, making them better able to secure lower-cost coverage for participants.

Success of Public Program Expansions Depends on State Responsiveness and Outreach

While expansions of Medicaid and the implementation of SCHIP in recent years have given states the ability to cover more low-income individuals, a significant number of this group remain uninsured. A variety of factors contribute to this situation. Some groups of low-income persons generally are ineligible, such as adults without children. Also, while some states have exercised options that allow them to increase existing limits on income eligibility thresholds for low-income children and parents, many states with high uninsured rates have not done so. Several proposals would further expand Medicaid and SCHIP to cover populations that are

[17]Philip F. Cooper and Barbara S. Schone, "More Offers, Fewer Takers for Employment-Based Health Insurance: 1987 and 1996," *Health Affairs*, Vol. 16, No. 6 (Nov./Dec. 1997), pp. 142-149.

[18]*Private Health Insurance: Cooperatives Offer Small Employers Plan Choice and Market Prices* (GAO/HEHS-00-49, Mar. 31, 2000).

not currently eligible (such as childless adults) or raise income and asset eligibility standards. Another proposal would allow some near-elderly persons to buy in to Medicare. But many low-income people who currently are eligible for these public programs have not enrolled. Therefore, state outreach efforts to low-income individuals are key to the success of current and proposed programs.

Medicaid and SCHIP Expansions

Despite mandatory and optional state Medicaid expansions and the implementation of SCHIP in recent years, millions of low-income children and adults remain uninsured. Nearly 3 million children in households below the federal poverty level were uninsured in 1999 even though they would typically have been eligible for Medicaid.[19] And although SCHIP now covers more than 3 million children, in 1999 there were nearly 6 million uninsured children in families with incomes below 200 percent of the federal poverty level (about $34,000 for a family of four)—the income threshold targeted by many SCHIP programs. Another 16.3 million adults with family incomes below 200 percent of the federal poverty level were uninsured, and nearly half of these had family incomes below the federal poverty level.

The federal statutes create some gaps in the ability of public programs to cover low income individuals (such as generally not allowing coverage for childless adults), but they also give states flexibility to cover children and parents at higher income levels. States vary considerably in the extent to which they have taken advantage of existing options for expanding eligibility for Medicaid or SCHIP. Some states have used Medicaid waivers and other authority to expand eligibility for their programs beyond traditional groups and income thresholds. For example, 12 states have obtained section 1115 research and demonstration waivers[20] from the Health Care Financing Administration for Medicaid to increase income thresholds for existing eligibility groups and in some cases to add new eligibility groups, such as childless adults. Recently, three states—New Jersey, Rhode Island, and Wisconsin—obtained section 1115 waivers to

[19]Section 6401 of the Omnibus Budget Reconciliation Act of 1989 (P.L. 101-239) required states to provide Medicaid coverage for pregnant women and children up to age 6 in families with income below 133 percent of the federal poverty level. Section 4601 of the Omnibus Budget Reconciliation Act of 1990 (P.L. 101-508) required, in effect, that states expand Medicaid coverage to older children living in families with incomes below the federal poverty level annually until October 2002, when children through the age of 18 will be eligible.

[20]Section 1115 refers to a section of the Social Security Act that allows the Health Care Financing Administration to exempt states from many title XIX and XXI requirements, thus allowing demonstration projects likely to assist in promoting program objectives.

use SCHIP funds to cover eligible children's parents—but few other states have sought to do so. Also, 30 states have expanded Medicaid eligibility under section 1931 of the Social Security Act to disregard portions of an applicant's income or assets when determining eligibility, which effectively increases the level of income and assets an eligible individual may have.

States' willingness and ability to use additional federal flexibility will be key to efforts to expand public coverage. States with high uninsured rates typically have lower income eligibility thresholds for Medicaid than those with low uninsured rates. For example, the average Medicaid eligibility level for parents in the 13 states with high uninsured rates is 54 percent of the federal poverty level, compared with an average of 99 percent of the federal poverty level for the 29 states with low uninsured rates. Furthermore, states with low uninsured rates have been more likely to use available authority to expand coverage than states with high uninsured rates. Whereas 10 of the 29 states with uninsured rates significantly lower than the U.S. average have used section 1115 waivers to expand Medicaid eligibility, only 1 of the 13 states with uninsured rates significantly higher than the U.S. average has done so. Appendix I summarizes selected eligibility requirements and options that states have adopted for Medicaid and SCHIP.

States' financial capacity may be a factor in what states have done to expand Medicaid and SCHIP to cover additional low-income individuals. States with high uninsured rates tend to be poorer and already cover a larger share of their population in Medicaid. On average, 16 percent of the nonelderly populations in the 13 states with high uninsured rates are in poverty compared with 10 percent in the 29 states with low uninsured rates. These high uninsured states also cover a higher proportion of their nonelderly residents through Medicaid (9 percent) than do states with low uninsured rates (7 percent).

Medicare Buy-In

Another proposed public program expansion known as a Medicare "buy-in" would allow some near-elderly individuals to pay premiums to enroll in Medicare. This proposal targets the more than 3 million uninsured near-elderly individuals between ages 55 and 64. This population is of particular concern because near-elderly individuals approaching retirement now are less likely to have employment-based retiree coverage available than in the past. As we reported in 1998, fewer employers

sponsored retiree health benefits in 1997 than in 1991.[21] Recent employer surveys indicate that this decline has not reversed since 1997.[22] Further, with the aging of the baby boom generation, over the next decade the number of near-elderly individuals not yet eligible for Medicare will grow, which likely will increase the number of uninsured persons in this age group.

CBO estimates that few individuals would be able to afford the full premium that would be necessary to buy-in to Medicare—$300 to more than $400 per month initially.[23] High-cost individuals who would face higher than average premiums in the individual insurance market would be most likely to opt for a Medicare buy-in, which would likely lead to premium increases over time. Subsidies to low-income individuals would encourage more lower-cost near-elderly individuals to buy in to Medicare.

Outreach Is a Key to Success of Public Program Expansions

Many low-income individuals who are eligible for Medicaid and SCHIP do not enroll. Some may be unaware that they or their children may be eligible, while the administrative complexity of enrolling and other reasons may discourage other eligible individuals from participating. Thus, outreach to low-income individuals to enroll in existing or expanded public programs is key to the success of the programs. We reported in 1996 that 3.4 million Medicaid-eligible children—23 percent of those eligible under federal standards—were uninsured.[24] Another study found that in 1998 16 percent of children under 200 percent of the federal poverty level were eligible for Medicaid or SCHIP but were uninsured.[25]

Lessons from the Medicare program also illustrate the importance of effective outreach for low-income beneficiaries. We reported that about 43 percent of low-income Medicare beneficiaries that were eligible in 1996

[21]See *Private Health Insurance: Declining Employer Coverage May Affect Access for 55- to 64-Year-Olds* (GAO/HEHS-98-133, June 1, 1998). A forthcoming GAO report will update trends in retiree health coverage for early and Medicare-eligible retirees.

[22]See Mercer/Foster Higgins, *National Survey of Employer-Sponsored Health Plans 2000* and Kaiser Family Foundation and Health Research and Educational Trust, *Employer Health Benefits: 2000 Annual Survey*.

[23]CBO, "Medicare Projections and the President's Medicare Proposals" (Apr. 1999).

[24]*Medicaid: Demographics of Nonenrolled Children Suggest State Outreach Strategies* (GAO/HEHS-98-93, Mar. 20, 1998).

[25]Kaiser Family Foundation, based on Urban Institute simulations of 1997 Current Population Survey March Supplement, projected to 1998.

for federal-state assistance for paying Medicare premiums and/or other out-of-pocket expenses not covered by Medicare were not enrolled.[26] Recognizing the low participation by these individuals eligible for the Qualified and Specified Low-Income Medicare Beneficiary programs, last year the Congress enacted requirements that the Social Security Administration identify and notify potentially eligible individuals, and that the Department of Health and Human Services develop and distribute to states a simplified uniform enrollment application.[27]

Proposals Could Unintentionally Lead to Crowd-Out Among Those Already Privately Insured

Efforts to expand private or public coverage to those currently uninsured can also provide new incentives to those already having private health insurance. Some currently insured individuals may drop employment-based coverage to get tax-subsidized individual insurance or enroll in Medicaid or SCHIP. While there was disagreement among analysts about the extent of crowd-out of private health insurance resulting from the Medicaid expansions in the late 1980s and early 1990s,[28] concern led the Congress to include a requirement in SCHIP that states devise methods to avoid such crowd-out. While several approaches may offset the extent of crowd-out, some degree of crowd-out may be an unavoidable cost of expanding private or public coverage to insure those that are currently uninsured. For example, CBO analysts suggested that some displacement of private insurance is inevitable, particularly since some low-income families move in and out of private insurance coverage and public programs can allow these low-income families to achieve more stable insurance coverage.

Expanding tax preferences are also not immune from potential crowd-out. Tax deductions or credits to subsidize uninsured individuals to purchase individual health insurance would also provide a tax subsidy to the approximately 13 million nonelderly individuals who purchased individual health insurance in 1999. While this tax expenditure to those already insured would make more equitable the tax treatment of individually-purchased and employment-based health insurance, it also increases the

[26] *Low-Income Medicare Beneficiaries: Further Outreach and Administrative Simplification Could Increase Enrollment* (GAO/HEHS-99-61, Apr. 9, 1999).

[27] These requirements were enacted under sections 709 and 911 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 that was incorporated by reference in P.L. 106-554.

[28] See, for example, Lisa Dubay and Genevieve Kenney, "Did Medicaid Expansions for Pregnant Women Crowd Out Private Coverage?" *Health Affairs*, Vol. 16, No. 1 (Jan./Feb. 1997), pp. 185-193, and David M. Cutler and Jonathan Gruber, "Medicaid and Private Insurance: Evidence and Implications," *Health Affairs*, Vol. 16, No. 1 (Jan./Feb. 1997), pp. 194-200.

federal cost per newly insured person since much of the subsidy goes to those already covered. Moreover, some employers currently offering health insurance to their employees may discontinue offering coverage if their employees have tax preferences available for individually-purchased insurance.[29] Similarly, even if employers continued sponsoring coverage, some employees—especially those who are young and healthy—may be able to purchase lower-cost insurance in the individual market, which could over the long-term increase the costs for some remaining in the group employment-based market. One study estimated that, among people electing a tax credit, nearly half would already be purchasing individual insurance, about one-quarter would shift from employment-based coverage, and another one-quarter would have previously been uninsured. Of those shifting from employment-based coverage, about one-fourth would be because the firm dropped coverage.[30]

Similarly, when eligibility for public programs is expanded, employers with many low-income individuals eligible for public coverage may decide to discontinue coverage or individuals offered employment-based coverage may shift to public programs where they have lower or no premiums or other out-of-pocket costs. The absence of measures to reduce crowd-out can be significant. For example, a recent report indicated that one state that extended Medicaid coverage to parents with eligible children without a waiting period found that nearly one-third of those that became newly enrolled had previously had private health insurance.[31]

Several approaches have been tried or proposed to minimize crowd-out, but none may completely eliminate it. For example, some tax subsidies or public program expansions would exclude anyone offered employer-subsidized health insurance or where the employer contributes to most of the cost of coverage. Requiring a waiting period between the time the individual had employment-based coverage and when they are eligible for a tax subsidy or public program could also reduce crowd-out. For example, some states in accord with the federal requirement to establish mechanisms to reduce crowd-out behavior, have established waiting

[29]Employers that decide to no longer offer health insurance may increase their employees' compensation a comparable amount in wages or other benefits. The net cost to the federal budget from providing a tax deduction or credit to those dropping employment-based coverage for tax-subsidized individual insurance would be largely offset if employees' wages were increased and subject to income taxes.

[30]Gruber and Levitt, "Tax Subsidies for Health Insurance: Costs and Benefits."

[31]Academy for Health Services Research and Health Policy, *State of the States*, produced for the Robert Wood Johnson Foundation's State Coverage Initiatives (Jan. 2001).

periods requiring individuals not to have had employment-based coverage for a certain time before becoming eligible for SCHIP. Other states have established cost sharing requirements (premiums or copayments) for SCHIP, thereby providing less of a financial incentive for low-income workers to switch from an employment-based plan where cost sharing requirements are common.

Concluding Observations

A variety of approaches have been proposed to increase private and public coverage among uninsured individuals. The success of these proposals in doing so for these diverse populations will depend on several key factors. The impact of tax subsidies on promoting private health insurance will depend on whether the subsidies reduce premiums enough to induce uninsured low-income individuals to purchase health insurance and on whether these subsidies can be made available at the time the person needs to pay premiums. The effectiveness of public program expansions will depend on states' ability and willingness to utilize any new flexibility to cover uninsured residents as well as develop effective outreach to enroll the targeted populations. While crowd-out is a concern with any of the approaches, private or public, some degree of public funds going to those currently with private health insurance may be inevitable to provide stable health coverage for some of the currently 42 million uninsured.

Mr. Chairman, this concludes my statement. I would be happy to answer any questions that you or Members of the Committee may have.

GAO Contacts and Staff Acknowledgments

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Appendix I: Selected Medicaid and SCHIP Eligibility Standards Among States

State	Uninsured as percentage of nonelderly population, 1998-99	Medicaid upper income eligibility standard for parents, as of March 2000 (percentage of federal poverty level)[a]	SCHIP upper income eligibility standard, as of September 30, 2000 (percentage of federal poverty level)
Uninsured rate significantly above U.S. average			
New Mexico	26.6	60	235
Texas	26.3	31	200
Arizona[b]	25.5	50	200
California	23.4	108	250
Louisiana	23.2	22	150
Nevada	23.2	78	200
Florida	22.0	68	200
Montana	21.5	71	150
Mississippi	20.9	39	200
Oklahoma	20.8	50	185
West Virginia	20.7	29	150
Idaho	20.6	34	150
New York	19.1	56	192
Average	**22.9**	**54**	**189**
Uninsured rate not significantly different from U.S. average			
Arkansas[b]	19.3	22	100
Alaska	18.9	104	200
South Carolina	18.7	56	150
Georgia	18.6	44	200
District of Columbia	18.4	200	200
Wyoming	18.3	67	133
U.S. average	**17.9**	**82**	**202**
Alabama	17.8	21	200
Colorado	17.4	43	185
North Carolina	17.2	54	200
Average	**18.1**	**68**	**174**
Uninsured rate significantly below U.S. average			
New Jersey[c]	16.5	45	350
Illinois	16.2	40	185
Kentucky	16.2	52	200
Maryland	16.2	44	200
Oregon[b]	16.2	100	170
Virginia	15.8	32	185
Washington	15.4	200	250

State	Uninsured as percentage of nonelderly population, 1998-99	Medicaid upper income eligibility standard for parents, as of March 2000 (percentage of federal poverty level)[a]	SCHIP upper income eligibility standard, as of September 30, 2000 (percentage of federal poverty level)
North Dakota	15.2	81	140
Utah	15.2	57	200
South Dakota	15.0	67	200
Delaware[b]	14.9	108	200
Indiana	14.2	30	200
Maine	13.9	104	185
Michigan	13.6	46	200
Tennessee[b]	13.5	75	100
Kansas	13.0	42	200
Connecticut	12.8	193	300
Wisconsin[b,c]	12.7	193	185
Vermont[b]	12.3	185	300
Ohio	12.1	108	200
New Hampshire	11.9	61	300
Hawaii[b]	11.8	100	200
Massachusetts[b]	11.7	133	200
Pennsylvania	11.5	71	200
Nebraska	11.2	42	185
Missouri[b]	10.8	108	300
Iowa	10.2	90	200
Rhode Island[b,c]	9.8	193	250
Minnesota[b]	9.6	275	280
Average	**13.6**	**99**	**216**

Note: States are categorized as higher than, similar to, or lower than the U.S. average based on whether the state-level estimate statistically is significantly different from the U.S. average. Because smaller states have smaller sample sizes in the Current Population Survey, the potential sampling error is larger in these states than in larger states. Thus, a specific uninsured rate may be significantly different from the U.S. average for one state but not for another with a smaller population and sample size. For this reason, New York's uninsured rate of 19.1 percent is significantly higher than the U.S. average, even though it is slightly lower than Arkansas' estimated rate of 19.3 percent, which is not significantly different from the U.S. average.

[a]Income eligibility level for parents assumes a family of three with one wage-earner, that all income is from earnings, and that only earned income disregards are taken.

[b]State has received a section 1115 waiver implemented to expand Medicaid eligibility (as of Jan. 26, 2001).

[c]State has received a section 1115 waiver implemented to expand SCHIP eligibility (as of Jan. 18, 2001).

Source: Uninsured rates from 1999 and 2000 Current Population Supplements, which were combined to improve the precision of the state estimates. Medicaid eligibility standards for parents from Families USA "Disparities in Eligibility for Public Health Insurance Between Children and Adults, 2000" (Mar. 2000), based on Center for Budget and Policy Priorities analysis of state Medicaid eligibility levels; SCHIP eligibility standards from Health Care Financing Administration.

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