COUNCIL OF ECONOMIC ADVISERS
February 14, 2002

HEALTH INSURANCE CREDITS

SUMMARY

The President's proposal to introduce tax credits for the purchase of health insurance will enable millions of Americans to purchase private health insurance, improving the functioning of private markets, empowering patients to make informed decisions, and increasing utilization of high quality health care.

This proposal is part of a broader vision for promoting access to innovative, high-quality patient-centered health care for all Americans, by encouraging effective patient choice among competing health care coverage options. This vision is discussed in more detail in the *2002 Economic Report of the President*.

Program Description

- The health insurance credit is available to anyone under 65 without employer-sponsored or public insurance. Individuals would be eligible for a tax credit of up to $1,000, and families purchasing a family policy would be eligible for a tax credit of up to $3,000.

- The health insurance credit is "refundable," so that even those without tax liability can take advantage of it. It is "advanceable," so that people will have immediate access to the credit when they want to buy insurance, rather than having to wait until they file tax returns. The advance credit is based on income in the previous year, so people will not have to worry about having to return the credit if their incomes change over the course of the year.

- The maximum subsidy rate would both phase out at higher incomes, with a maximum subsidy rate of 90 percent. The phase-out, described below, would begin at $15,000 for single filers and $25,000 for others.

Policy Effects of the Health Insurance Credit

- *A significant number of currently uninsured people will take advantage of the tax credit.*

  Research suggests that the tax credit will allow **6 million** or more Americans who would otherwise be uninsured during a year to gain coverage. The credit covers a substantial portion of the premiums most people would face in the private individual insurance market, thus increasing participation in and enhancing the efficiency of the individual market for health insurance.

  Anyone without employer or public insurance, including people who would be ineligible for assistance through expansions of Medicaid or the State Children's Health Insurance Program

and dislocated workers who do not have COBRA coverage available to them, would be able to take advantage of this program.

- *The incentives created by the credit could improve the functioning of the individual private market and enable people to make informed decisions about their care.*

  Currently individual health insurance policies are expensive in part because many healthy people do not participate in the individual market. The health insurance credit encourages participation, especially among healthier individuals, and thus improves the "pooling" of health risks. Because people would have to pay at least some portion of their premiums, they would have an incentive to be well-informed and to seek out high value, high quality, informed care.

- *The credit makes the system of subsidies more equitable.*

  Employer-sponsored insurance (ESI) is already subsidized through the tax code, because employer contributions are untaxed, with the biggest tax benefits going to those with high earnings. People with the same income are also treated differently, based on the source of their insurance. The health insurance credit would make the system more equitable and more progressive, since it would be largest for those with lower incomes and would be available to those who do not receive subsidies through the current system.

- *The health insurance credit will complement the employer-sponsored group markets.*

  Because the health insurance credit is less generous than the tax subsidy on a typical employer plan for all but the lowest-income workers, the proposed credit would not substitute for the employer-sponsored group market. Any employee eligible for ESI who opted for the new credit would have to pay taxes on any additional wages earned in lieu of health insurance coverage, and would only be entitled to a capped credit. Employer decisions about offering health insurance, and the generosity of the insurance, depend on the value of the tax subsidy to average or typical employees and not just low-income employees. Most employers offering coverage would continue to do so, and low-income workers in these firms would continue to benefit from these generous contributions. Thus, the majority of those taking up the new health credit would be people who were either previously uninsured or previously covered in the non-employer market.

- *The health insurance credit does not distort labor markets.*

  The credit is available to anyone under 65 without employer-sponsored (or public) insurance, so it does not provide a disincentive for employment at the individual or firm level. Because the advance credit is based on the prior year's income, people can take new jobs without fear of having to repay it at the end of the year.

THE UNINSURED AND HEALTH INSURANCE MARKETS

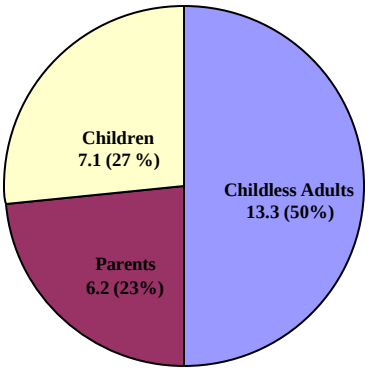
The goal of the health insurance credit is to increase participation in and improve the functioning of health insurance markets. To see the value of this improvement, it is important to understand the composition of the uninsured population and how those markets function.

The Uninsured

In 2000, approximately 39 million Americans, or 14 percent of the population, reported that they were uninsured for the entire year.[1] They may go without effective health care, or may rely on inefficient care at emergency rooms and clinics.[2] Expensive expansions of government run health care programs such as Medicaid and the State Children's Health Insurance Program (SCHIP) in the 1980s and 1990s did little to change the number of uninsured.

The uninsured population is not made up of just the poor or the unemployed. Over 80 percent of the uninsured population in 1999 were in families with at least one worker. Furthermore, while 36.4 percent of the uninsured had incomes below the poverty line, a large fraction, 28.7 percent, had incomes between 100 and 200 percent of poverty.[3] As shown in Figure 1, nearly three-quarters of the uninsured below 200 percent of poverty are adults, most of whom do not live in households with children. These childless adults would benefit from the health insurance credit, but would not be assisted by proposals to expand the SCHIP program to include parents. That said, many of the children who are currently uninsured are also eligible for Medicaid or SCHIP. Coupled with continuing outreach efforts to increase Medicaid and SCHIP enrollment, the availability of the credit provides another opportunity for low-income families to get coverage.

Figure 1: Distribution of Uninsured Below 200% Poverty Line (Total 26.6 Million)



Source: Commonwealth Fund Task Force on the Future of Health Insurance analysis of March 2000 Current Population Survey.

Insurance coverage differs significantly by race and ethnicity. In 2000, 32 percent of Hispanics were uninsured, compared to 20 percent of blacks and 19 percent of Asians. In contrast, just 10 percent of whites are uninsured.[4] Insurance coverage also differs across types of employment, with employer-sponsored insurance less likely to be available to part-time, seasonal, and short-term workers.

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[1] Estimates of the number of uninsured vary depending on the survey question and the length of time uninsured. This estimate is based on the March 2001 Current Population Survey. Data from other surveys such as the Survey of Income and Program Participation suggest that 55 to 60 million were uninsured for part of a year or more.

[2] Kaiser Family Foundation, *Uninsured in America: A Chartbook* (2000); Urban Institute, *Health Insurance Access and Use: United States*, (July 2000).

[3] Kaiser Family Foundation, *Uninsured in America: A Chartbook* (2000). Note that the Census Bureau does not report coverage for families with income between 100 and 200 percent of the federal poverty line.

[4] Census Bureau, *Health Insurance Coverage*, 1999.

The benefits of increasing participation in health insurance markets extend beyond those realized by the individuals themselves. First, even those without insurance receive publicly subsidized basic health care through emergency rooms – a very expensive way to provide care. Second, access to health care is important to control the spread of disease through immunizations or through early diagnosis and treatment. Third, greater participation in insurance markets allows broader pooling of health risks – the markets themselves work better.

Insurance Markets

One important goal of health insurance is to reduce the risk to individuals of high medical expenses, trading the certainty of a known premium for the uncertainty of very unpredictable health care costs. An important element of insurance is thus the "pooling" of risk – people sign up for insurance before they know how much they will spend on health care, and then the premiums of those who have low expenses help subsidize spending on those with high expenses.

Several things can interfere with the smooth functioning of this important insurance market. One is lack of choice and competition. Health insurance plans have little incentive to adapt to changes in medical care in order to compete for enrollees if the enrollees have no other options. Insurance markets with little or no competition are thus unlikely to keep up with innovations in health care, and without market discipline plans may encourage excessive care and inappropriate treatments. A second problem is "adverse selection": If individuals know their likely health insurance expenditures ahead of time, they can sign up for more generous insurance when they know their expenditures will be high, undermining the pooling of risk that is the key to insurance. Given a choice among plans, the healthiest people (with the lowest expected costs) can save money by pooling together in the least generous plan, or dropping insurance altogether, making the cost of the more generous plans rise as the expected costs increase.[5] Just as individuals with higher expenses want more insurance, insurance companies want customers with lower expenses, and may cater their plans to appeal to those with low risk.

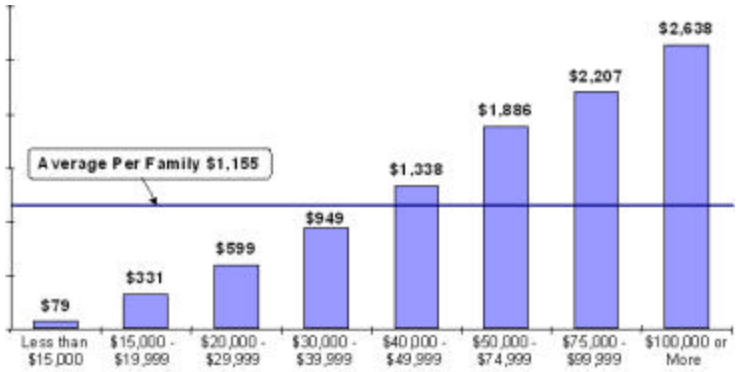
Both of these incentive problems can lead to premiums that are higher than they need to be, lower value care because efficient services are not offered, and increases in uninsurance because people conclude that the coverage is simply not worth the cost. The result of non-optimal coverage is inefficient health care use, with worse health outcomes and avoidable costs due to disease complications that could have been prevented with better coverage. The health insurance credit can improve the functioning of health insurance markets by addressing these problems.

The vast majority of private health insurance in the U.S. is purchased through employers. An important reason is that these purchases are subsidized through the tax code: Employer contributions are not taxed, which provided an estimated $126 billion subsidy in 2000 (including $85 billion through the exclusion of employer contributions from income taxation and another $32 billion through their exclusion from Social Security and Medicare HI taxes). This tax

[5] This can again induce the healthiest remaining in the more generous plan to leave that plan. In extreme cases, this drives the most generous plans or those with the sickest members out of the market altogether.

benefit is larger for those with higher incomes, since they face a higher marginal tax rate (see Figure 2).[6]

Figure 2
Tax Benefits for the Purchase of
Employer-Sponsored Insurance



The current tax subsidy encourages provision of health insurance through employers. In addition, provision through employment forms a basis for risk pooling that is largely independent of health status, at least in most large firms.

This is one of the main reasons that the health insurance available through individual (non-group) markets is often more expensive than comparable coverage through an employer: the people who choose to obtain such coverage are those who think they are likely to have higher health expenditures, raising premiums and making the insurance even less appealing to those with lower expected costs. Furthermore, the administrative costs associated with these non-group plans are often much higher. (These problems also afflict the market for small employers.) State measures to reduce the cost or increase the availability of insurance in the non-group market are discussed in more detail below. Unfortunately, some of the regulatory approaches intended to improve the availability of affordable coverage have often done more harm than good, in effect discouraging participation in insurance markets.

In contrast, the health insurance credit will increase participation in these individual markets, increasing risk pooling and improving market functioning overall. An important question is the degree to which it would interfere with the functioning of employer-sponsored group markets by inducing some employers to stop offering insurance and some employees to stop taking the employer-sponsored insurance (ESI) they are offered. In practice, the health insurance credit has been structured to complement employer-sponsored insurance markets.

[6] Estimates include the likelihood of receiving employer-provided health benefits and the value of the tax benefit of employer-provided health insurance. Source: John Sheils, Paul Hogan, and Randall Haught, "Health Insurance and Taxes: The Impact of Proposed Changes in Current Federal Policy," October 1999, The Lewin Group, Inc.

LIKELY EFFECTS ON INSURANCE PURCHASES

The Administration's health insurance credit would be available to people under 65 purchasing private health insurance coverage outside of plans offered by their employer or a spouse's employer. That is, both working and unemployed people who do not already have tax-subsidized, employer-provided insurance (or insurance through public programs such as Medicare or Medicaid) would be eligible.[7] Workers who are laid off and lose their insurance would be able to take advantage of the credit regardless of whether or not COBRA continuation coverage was available to them.

Individual Participation Decisions

Evidence suggests that the decision to purchase health insurance is quite sensitive to its cost. The President's proposal provides a refundable tax-credit of up to $1,000 for a single person and up to $3,000 for a family with two or more children, with the credit phasing out between $15,000 and $30,000 for single filers and between $25,000 and $60,000 for other filers purchasing policies for more than one person (or $25,000 to $40,000 if purchasing a policy for one person only). The effect of the credits on participation in individual insurance markets depends critically on the cost of the available insurance.

Some reports have placed the "mid-range" cost of family health insurance at approximately $7,000 per year, large relative to a $3,000 tax credit.[8] This estimate is likely overstated: it reflects the average cost of plans offered, not the best offer available. In addition, many of these plans often provide near first-dollar coverage — that is, all expenses, even predictable periodic and routine expenses, are covered, and there are almost no copayments, coinsurance, or deductibles.

Expensive "first dollar" coverage may not make good economic sense. First, minimal copayments lead to a disconnect between cost and value in health care decisions, contributing to rising health care costs (and patient frustration with managed care plans meant to control costs). As health care costs rise rapidly, such policies will be even less sustainable. Second, reliance on minimal copayments in both private managed care and government health insurance plans has led to significant regulatory intrusions and price controls, all of which adversely affect doctor-patient decision-making. However well-intentioned as an approach to limiting cost increases, such intrusions may make it more difficult for patients to get both appropriate treatment and protection from very high medical expenses. Third, patients will be much more likely to take an active interest in the value of the care they receive when they face at least a portion of the cost.

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[7] There are other restrictions: The credit cannot be applied to the purchase of ESI, and people may not contribute to Archer MSAs in the same year that they claim the credit. Plans must meet minimum benefit standards. Those participating in ESI or public programs may not use the tax credits, although in some circumstances states may provide an additional contribution to individuals who purchase private insurance through Medicaid or SCHIP purchasing groups. Those over 65 (and thus eligible for Medicare) or anyone eligible for public insurance cannot claim the credit.

[8] See, for example, Center on Budget and Policy Priorities, "Unemployed Workers Need Help with Health Insurance," October 2001; General Accounting Office Report HEHS-00-104R.

Analysis by the Council of Economic Advisers finds that Preferred Provider Organization (PPO) policies with significantly lower premiums are almost always available. These plans, which are not "first-dollar" plans but which provide effective health insurance assistance, are described in more detail in the Appendix. They typically cover all major types of medical services and treatment, have per person deductibles of $1,000 ($2,000 per family) while also covering preventive and emergency care, they generally provide significant discounts on all prescriptions and in-network services, and they support a full range of provider choices. The average premium for a plan of this type was less than $3,000, and was less than $1,000 for young individuals. For lower-income Americans, the proposed health insurance credit thus generally covers more than half of the premium the purchaser would face, and almost always covers more than a third.[9] Moreover, these prices are representative of actual coverage in the population, not the premiums available to just a few very healthy people. A recent study by the health insurance distributor eHealthInsurance found that three-quarters of premiums for individual health insurance plans that it sold were less than $2,000 and three-quarters of family premiums were less than $5,000.[10] Similarly, another study found that people with all but the most serious chronic illnesses were able to get affordable individual market insurance offers in every market examined.[11]

The type of plans that those using the health insurance credit are likely to purchase have distinct economic advantages. The growth of PPO and similar plans in the private sector reflects patients' desires for more choice, and the health insurance credit would allow individual purchasers to have the same choices. These policies function well as true insurance, providing excellent protection against large unanticipated expenses caused by a severe illness or needed surgery, and assistance with access to the full range of modern health care treatments. Patients who prefer lower copayments could choose a Health Maintenance Organization-style plan that used more restrictive networks and tighter control of care to keep the premium down. The presence of the credit may encourage insurers to offer even more plans catering to new insurance market purchasers, such as plans with good catastrophic coverage but deductibles high enough to keep premiums in line with the size of the credit. These plans would not only encourage the use of the credits, but would encourage responsible and informed use of health resources.

The analysis also documented substantial differences across geographic areas in the price of similar policies. This variation indicates that national averages can hide substantial heterogeneity in cost and may provide a poor representation of the market facing most families. One cause of this variation may be differences in the cost of care at the local level. (Another important source of variation is different state regulatory environments discussed below.) Having more involved

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[9] Low cost policies are substantially less common in states with community rating than in states without such regulation.

[10] eHealthInsurance is a leading national health insurance distributor of individual and small group plans, and in 2001 analyzed 20,000 recently purchased policies. More than 80% of the policies sold had comprehensive coverage. 75% were PPO plans, and 71% of those PPO plans had deductibles of $1,000 or less. http://www.ehealthinsurance.com/ehealthinsurance/eHealth2.pdf.

[11] Pollitz, Sorian, and Thomas, *How Accessible is Individual Health Insurance for Consuers in Less-than-perfect Health*, Kaiser Family Foundation, June 2001; and eHealthInsurance Services, Inc. The original Kaiser study investigated whether the mock applicants with different preexisting health conditions were rejected by any insurer, not whether they actually received offers, and reported average offers, not the best offer, which is more indicative of the cost that they would actually incur. All of the mock applicants received offers in every market tested, with the exception of an HIV positive applicant. The best offer was often not much more expensive than the offer for healthy mock applicants.

and informed consumers of health care and greater individual participation may help reduce geographic disparities.

In order to infer the effect of health insurance credits on the purchase of individual insurance policies, we need to know not only what insurance policies are available, but how sensitive individuals' decisions are to the price of the insurance that they face. Estimates of this price sensitivity are difficult to obtain, but some studies suggest that individuals are quite sensitive to large subsidies, and are thus much more likely to buy insurance when they receive a 50 to 90 percent subsidy. [12]

Several different studies have examined the likely effects of the health insurance credit on insurance purchases. Pauly, *et al.* (2001) find that a $1000 refundable tax credit would likely increase the participation rate among the uninsured by 21 to 85 percent.[13] Gruber (2000) finds smaller effects, closer to 10 percent, but analyzes plans with premiums that are much more expensive than those described above. Other studies focus on average premiums, not the best offers available. Even with the most conservative assumptions, the health insurance credit would substantially increase participation in health insurance markets. If even 15 percent of those uninsured for a full year (or 10 percent of those uninsured for part of a year or more) take advantage of the health insurance credit, 6 million people would be newly covered. In addition, the credits would encourage those already purchasing non-employer coverage to purchase more comprehensive policies.

LIKELY EFFECTS ON MARKETS

The health insurance credit would likely significantly increase participation in non-employer health insurance markets and increase the generosity of coverage selected. This increased, more generous participation would both increase the pooling of risk and reduce administrative costs.

Individual Health Insurance Markets

The health insurance credit could increase the participation in individual markets of a wide cross-section of Americans. As shown in the Appendix, it would cover a substantial portion of premiums for younger, healthier people, heavily subsidizing their purchase of insurance. The credit would cover a lower percentage of the premium for individuals over 50 and those with chronic illnesses, for whom rates in the individual market are higher. While there is little evidence on this point, older and sicker people are likely less sensitive to the price of insurance and would value the credit more highly, so even though their premiums might exceed the maximum credit by more, they may increase participation in individual markets just as much as their younger, healthier counterparts. This broad increase in participation, especially of younger and healthier people, would improve the pooling of risk in the individual market (since insurers cannot perfectly underwrite individuals' health risks).

[12] Marquis and Long, *Worker demand for health insurance in the non-group market,* Journal of Health Economics, v. 14 (1995).
[13] Note that their hypothetical credit had a somewhat different structure.

There are several other regulatory reforms that affect the efficiency and availability of insurance through individual markets. In an effort to subsidize the insurance purchase of those with high expected medical expenses, some states have implemented regulations that limit or prohibit the extent to which insurers can vary prices based on expected expenses. Some of these regulations have the perverse effect of driving people out of individual insurance markets.

States have several regulatory devices at their disposal, including restrictions on the variation in premiums (rating bands), requirements on the fraction of premium receipts that must be paid out in benefits (loss ratio restrictions), mandated benefits, restrictions against the exclusion of preexisting conditions, community rating and guaranteed issue. In community rated states, insurers must offer all purchasers in the same "community" the same rate.[14] By prohibiting insurers from charging higher premiums to those in high-risk categories and in effect averaging costs of the high risk people with the lower risk people, this regulation is intended to hold down the premiums for those who are expensive to insure. States with guaranteed issue regulations require that insurers write policies for all comers. When coupled with community rating (such as in Maine, New Jersey, New York, and Vermont), this policy means that even those with very high expected health care costs will face the same price as healthy people. The drawback of these policies and many other forms of regulation is that the premiums facing most purchasers may be higher than they would be in the absence of regulation, since the premium collected must be sufficient to cover the expected expenses of the group. Given higher premiums, the healthiest individuals (those with low expected costs) may chose not to buy policies. Regulation thus provides another cause for adverse selection, and a spiraling upward of premiums.

As an alternative to policies such as community rating, states can establish high-risk pools.[15] These pools are often subsidized with general revenues or through taxes on insurance companies. Broadly funded high-risk pools can subsidize the insurance purchase of people with consistently high medical expenses, without making health insurance unappealing for others. Today, 29 states have adopted high-risk pools (including some states, such as Kentucky and Washington, that used to have guaranteed issue but found that it severely undermined their individual insurance markets).[16] States with adequate, broad-based funding for their risk pools are providing good insurance at affordable rates for people who would otherwise face high premiums in the individual market, and are doing so without driving up rates and reducing coverage.[17]

Finally, lower-income people can also use Administration's health insurance credit in non-employer purchasing groups, including private affinity groups and state-sponsored purchasing

[14] A community can be defined broadly, such as all individuals in the state, or more narrowly, with some differences permitted by age and/or geographical location, for example. Premiums in community rated states cannot vary with factors such as occupation or health status. Some states have modified community rating, allowing some, but only limited variation based on health factors.

[15] The National Association of Health Underwriters found premiums for a 53 year old male in 14 states with high risk pools. The average premium in these 14 states was $5086. The average premium in our data for the 55 year old single male was $2597. The high risk policies sought had $500 deductibles and generally had more comprehensive coverage.

[16] Communicating for Agriculture, *What is a Risk Pool?*, 2002, www.cainc.org/riskpools/commonwealth.html.

[17] Communicating for Agriculture, op cit; Communicating for Agriculture/National Association of State Comprehensive Health Insurance Plans, *Comprehensive Health Insurance for High-Risk Individuals*, 1999.

pools. Many states have already established purchasing pools that allow individuals enrolled in their Medicaid or SCHIP programs to choose from competing private plans. All states have competitive purchasing pools for their state enrollees. Thus, states generally have an infrastructure in place to provide a group coverage option, giving people using the credit another option for obtaining affordable health insurance choices.

Employer-sponsored Insurance Markets

The generosity of the credit would also influence the cost of the expansion of coverage. A very generous credit would induce more people to obtain coverage but, depending on its design, might also draw more workers away from current employer coverage, either by leading them to opt out of taking up coverage that their employers offer or by inducing employers to stop offering coverage. The result would be a relatively expensive incentive with relatively less net effect on coverage.

Employees who are eligible for ESI may forgo employer insurance and voluntarily enter the non-group market if doing so allows them to select a policy that better meets their specific needs. Single, healthy individuals may wish to use their credit to purchase less generous coverage than the coverage offered by their employer. Employers may choose not to offer health insurance at all if many of their employees can take advantage of the credit and purchase insurance individually, and receive taxable wages in lieu of employer health insurance contributions. Insurance in the non-group market carries higher administrative costs, which implies that such an outcome would not be efficient in the short run. In the long run, as discussed above, increased participation in individual insurance markets may improve their functioning such that they have similar risk pooling and administrative costs as group markets.

Such arguments suggest that a tax credit that is too large may disrupt the ESI market. In this case, the phase-out of the proposed health insurance credit and the cap on the maximum amount are important features to ensure that there are minimal disruptions to the ESI market. Those low-income Americans who are eligible for the largest credit are less likely to have employer-sponsored health insurance. About 80 percent of uninsured workers are not offered health insurance by their employers.[18] Only 36 percent of people under age 65 with income below 200 percent of the federal poverty line have ESI, while 77 percent of those above do.[19] Furthermore, employers make the decision to offer health insurance based on all of their employees, so they are unlikely to stop offering insurance simply because a minority of their employees become eligible for the health insurance credit. Most employees would be significantly better off with the uncapped, untaxed payments for their health insurance, and with the administrative savings of group plans, than with the capped credit and some additional taxable wages. Moreover, even if this minority of employees dropped employer coverage because they could get more affordable non-employer insurance, there would not be a large effect on overall employer health insurance costs. Consequently, the impact of the proposed credit on employer health insurance coverage would be minimal, and the majority of individuals taking up the proposed health credit

[18] Garrett and Nichols, *Workers without health insurance: who are they and how can policy reach them*, Urban Institute, 2001, cited in Blumberg, *Health insurance tax credits: potential for expanding coverage,* Urban Institute, August 2001.

[19] Department of Health and Human Services tabulation of the March 2001 CPS, which includes data from 2000.

would be those who were either previously uninsured or previously covered in the non-employer insurance market.

By comparison, research indicates that 50 percent or more of those who became eligible for Medicaid in the expansions of the late 1980s and early 1990s lost private coverage, suggesting that providing near first-dollar coverage (even in a government insurance plan) requires much more substantial government funding to achieve comparable reductions in uninsured rates.[20]

Some health policy experts and members of Congress have proposed a broader-based refundable tax credit—one that would also provide significant new subsidies to all workers with employer-provided coverage. Because so many workers have employer coverage already, however, a tax credit for employer coverage would have a far greater budgetary impact, and a much larger share of its costs would go toward existing rather than new health insurance coverage. To limit the additional budgetary costs, many experts have proposed a gradual transition from the current tax exemption to a system of tax subsidies for employer coverage that relies more on credits. Although such a transition would probably encourage lower cost employer coverage and increase the takeup of employer coverage by lower income workers, it could have a significant impact on current employer plans, union negotiations, and other issues affecting worker compensation. Thus, it seems less likely to be effective as an incremental, immediate step to improve insurance coverage significantly.

Labor Markets

Because this credit is available to all low-income uninsured Americans, it will provide both increased options for workers and an improved safety net for the unemployed. It can help ease transitions between employment, dislocation, and reemployment without distorting labor markets. Unlike employment-based insurance, part-time and seasonal workers will be able to keep the coverage they purchase with the health insurance credit even if their jobs change.

CONCLUSION

The Administration's health insurance credit will allow millions of Americans to purchase good insurance through private markets. It will improve the functioning of individual insurance markets, and will encourage high-value, high-quality care.

[20] Cutler and Gruber, *Does Public Insurance Crowd Out Private Insurance?*, Quarterly Journal of Economics, 111(2), May 1996, 391-430.

APPENDIX: THE COST OF HEALTH INSURANCE IN INDIVIDUAL MARKETS

The Council of Economic Advisers performed quantitative analysis to document the likely effects of the health insurance credit on the purchase of health insurance. A key component of this is the cost of the insurance plans available through non-group markets.

Data Description

To analyze the purchasing power of the proposed health insurance tax cut, we compiled a data set of sample premiums. Using the web site www.ehealthinsurance.com we collected data on premiums for low-cost traditional indemnity (i.e., Fee-for-Service or FFS) plans and low cost Preferred Provider Organization (PPO) policies, in which patients can see physicians outside their network, but with higher copayments. We obtained observations for one large and one small city in each state. In each case we priced policies for six hypothetical purchasers.[21] Our total number of observations is 1020 (2 plans x 6 families x 50 states x 2 cities, less missing values for cases in which we were unable to find policies that satisfied our criteria).[22] Although the sample is small, it provides a starting point for an investigation of the affordability of insurance in the individual market. The purchaser and plan types included in the sample were:

Purchasers:	**Plan Characteristics:**
• 55-year-old single male	• $1000 per person deductible
• 25-year-old single male	• $2000-$3000 family deductible
• 25-year-old couple	• covers office visits
• 55-year-old couple	• covers emergency room care
• 25-year-old mother and daughter	• 20% coinsurance or $30 copayment
• 25-year-old couple with two children	

We attempted to obtain quotes for plans with characteristics as close as possible to those listed above. While all the plans we sampled cover emergency room care and all but 12 (those in New York City) cover office visits, the deductibles and coinsurance/copayments are occasionally higher or lower than our specifications. Overall, 92 percent of our single policies have deductibles of $1,000; 5 percent have higher and 3 percent have lower deductibles. Eighty-one percent of our family policies have deductibles of $2,000 or $3,000, with 8 percent lower and 11 percent higher. All of the plans have coinsurance of 20 percent, except for the plans in New York City, which have no coinsurance, and the plans in Boston and Brockton, Massachusetts, which have 10 percent coinsurance. We also assumed that the individuals were in good health, with no preexisting conditions, and were not smokers.

[21] Plan premiums typically vary by age. We choose one "young age" and one "old age." Premiums for family policies vary by the age of the adults.

[22] We were unable to obtain information on regulations in the District of Columbia. We found no individual policies available in Hawaii and no PPO plans in Maine, New Hampshire, or New Jersey.

Premiums and the Credit

This section provides summary information on the types of policies available.[23] The discussion highlights not only national averages, but also the distribution of premiums relative to the proposed health insurance credit.

Premiums vary substantially across states and across types of purchasers. Table 1 has summary statistics for PPO premiums by family type and appendix table A1 shows PPO premiums for the two cities in each state by type of purchaser.[24] For a family of four, annual premiums vary from $1,272 for Bloomington, Illinois to $9,675 in Boston, Massachusetts (the Boston policy has relatively generous benefits).[25] The average price for a family of four is $3,287.[26] Premiums for young single males are substantially lower, averaging just $975, or $25 *below* the proposed health insurance credit.[27] Premiums for individuals in their 50s are much higher. The average premium for a 55-year-old male is $2,749.

Table 1: Mean Annual Premium for PPO Plans

Characteristic	Average	Median	Minimum	Maximum
Younger Male	$975	$772	$504	$4094
Older Male	$2749	$2464	$1524	$6722
Younger Couple	$2142	$1729	$1032	$7370
Older Couple	$5145	$4613	$2904	$12099
Mother and Child	$1931	$1518	$852	$7224
Family of four	$3287	$2683	$1272	$9675

[23] In the following, we focus on PPO premiums because they are lower and thus more likely to be selected by those helped by the tax credit. Also, PPOs are the most commonly offered type of plan by employers. In 2000, 75 percent of large employers offering health insurance coverage offered a PPO plan, compared to 25 percent for a traditional indemnity plan and 51 percent for an HMO (Mercer/ Foster Higgins Mercer/ Foster Higgins, National Survey of Employer-Sponsored Plans, 2000). Premiums for FFS plans follow the same pattern, but are higher.

[24] These premiums are similar to premiums that were actually purchased. In the 1996 Medical Expenditure Panel Survey, the average premium paid by single policy holders for plans purchased in the non-group market was $1573; half of the individual premiums were between $600 and $1,992. The average family policy was $2,651; half of the premiums were between $600 and $3650. (Accounting for the potential accidental reporting of supplemental plans by eliminating the lowest 5 percent of premiums raises the average single plan cost for 18 to 39 year olds by only $150.) There was substantial variation both by age and by specific plan. The average individual premium in the MEPS ranged from $1230 for those less than 40 years old to $1976 for those 55-64 years old. (Statistics provided by Jessica Banthin at the Agency for Healthcare Research and Quality.)

[25] The average premium in 2001 for employer-provided health insurance was $2,652 for single plans and $7,056 for family plans (Kaiser Family Foundation, 2001Kaiser/Health Research and Educational Trust Survey). The average yearly contributions for employees for whom some contribution was required was $840 for a single coverage and $2868 for a family plan. Fifty percent of employees paid no contribution for single coverage but only 18 percent for family coverage (Mercer/Foster Higgins, National Survey of Employer-Sponsored Plans, 2000).

[26] Because deductibles are measured on a per person basis with annual family caps of $2000-$3000 it is possible for a family with these policies to have substantial out of pocket expenses. They are, however, protected against large expenses that might be incurred with a hospitalization, chronic condition, or serious illness.

[27] Although we did not conduct as thorough an analysis, premiums for young women appear to be only slightly higher on average (approximately $50 to $100 higher) and identical in some states (these policies typically do not include maternity coverage).

The differences in the prices faced by older and younger Americans are substantial: the average premium for an older couple is over $5,000 compared to $2142 for a younger couple. These premiums are for a couple aged 55; older couples (not yet eligible for Medicare) would face higher prices.[28] However, there is also evidence suggesting that older Americans may value health insurance more than younger Americans and may therefore be more willing to devote a larger fraction of their income to health insurance premiums, so that a $1,000-$2,000 tax credit would be sufficient to stimulate purchases.

Prices vary substantially across cities and states. We examine the distribution of premiums with respect to the credit to which the purchaser would be entitled. Nearly three quarters of the PPO plans for young single men had premiums less than the proposed $1000 health insurance credit and over 90 percent cost less than $2000. Thus the health insurance credit would provide young men substantial assistance in purchasing a policy. In contrast, the subsidy covers much less of the policy premium for older single men: only 1 percent of plans have premiums below $1000 and just 17 percent of plans were less than $2000. Younger families fare much better than older Americans. A $3000 subsidy would cover half the PPO premium for a family of four in more than 90 percent of the plans. If children in a low-income family are eligible for SCHIP or Medicaid, then a $2000 credit would cover all of the cost for the mother and father in more than 70 percent of the plans.

These premiums are for plans that do not provide first-dollar coverage, yet as noted earlier, provide comprehensive coverage for large expenses. Plans with lower annual deductibles will be more expensive. To investigate the difference, we priced health insurance policies with a $500 deductible but coverage similar to our sample in other dimensions.[29] We collected this information for families in 10 states, and premiums were approximately 20 percent higher. The premium data presented assume that the individuals are in good health and are non-smokers. Just as premiums increase with age because expected medical expenses increase, plan availability and premiums also change with the underlying health of the beneficiary. There is also substantial variation in price across insurers as well as variation in the quality of service provided. For example, in Kansas City, Kansas, premiums for family policies that fit our criteria range from $182.50 to $434. Consumers need to shop carefully for plans, comparing prices and coverage to find the plan that best suits their needs.

[28] The fraction of employers providing retiree coverage has fallen sharply in recent years (Employee Benefits Research Institute, *Health Benefits Data Book*, Washington, DC, 1999).

[29] The median deductible for in-network individual coverage for employer sponsored policies was $250 in 2000 (Mercer/ Foster Higgins, National Survey of Employer-Sponsored Plans, 2000).