Briefing Paper on Refundable/Transferable Health Insurance Tax Credits

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COLORADO
Coalition for the Medically Underserved

Statement of Values

The members of the Colorado Coalition for the Medically Underserved are united by a shared commitment to the following vision:

Nearly 700,000 Coloradans do not have health insurance coverage. A similar number of our citizens are estimated to be underinsured, exposing them to economic calamity if they experience a catastrophic illness or injury. Most of the uninsured and underinsured are employed. Most did not choose their uninsured status. Yet they face the very real prospect of not being able to obtain medical care when they need it. The result is that the uninsured get inadequate or insufficient health care and their health suffers as a result. The lack of health insurance, independent of income or social class, has become a predictor of ill health.

The Colorado Coalition for the Medically Underserved views this state of affairs as unacceptable. Colorado's resources and its community values make it possible to institute a better approach to meeting the health care needs of our citizens. The Coalition believes that all Coloradans can and should have access to quality health care and prevention programs. The Coalition believes that it is critical that Colorado achieves health insurance coverage for all of its citizens. We seek to make this vision become a reality.

Table of Contents

Executive Summary 5
Introduction 6
Background 7
CCMU and Tax Credits 7
Colorado Taxes 8
TABOR 9
Colorado Health Insurance Market 10
Tax Credit Program Issues 11
Other Tax Credit Experiences 14
Current Tax Credit Proposals 14
Conclusion 15
Bibliography 16
Appendix A 18
Appendix B 19

Executive Summary

The Colorado Coalition for the Medically Underserved (CCMU) has identified the use of refundable/transferable tax credits as a possible strategy to reduce the number of medically uninsured Coloradans by encouraging the purchase of private health insurance. The Coalition convened the Working Group on Refundable/Transferable Health Insurance Tax Credits in April of 2002 to explore a health care tax credit strategy in Colorado (see Appendix A for a complete list of members). This report briefly explores the issues surrounding a Colorado health care tax credit.

In exploring a Colorado health care tax credit the following issues need to be addressed:

1) Colorado's tax system and the impacts of TABOR
2) Who should be eligible for the tax credit?
3) Should there be an income level cap limiting who is eligible?
4) How much should the tax credit be? What parameters should be used to determine this?
5) How can one ensure that the credit is available when people need it?
6) How can one avoid people dropping their coverage in order to qualify for the credit?
7) Where should eligibles be allowed to use their credit?
8) What types of insurance plans should be eligible for the credit?
9) Should a minimum floor of benefits be required?

Tax credit strategies to increase health insurance coverage are not sufficient to address the many varied needs of Colorado's medically underserved population. They may be an effective component of a larger strategy to provide access to affordable, quality health insurance coverage for all Coloradans. Structuring and administering a simple, effective refundable/transferable health insurance tax credit program at the state level may prove to be difficult given Colorado's tax system, TABOR restrictions and the current budget shortfall. However, the development of a refundable/transferable health insurance tax credit program might be feasible with the participation of the federal government.

Introduction

The Colorado Coalition for the Medically Underserved (CCMU) is a coalition of more than 250 individuals and organizations. Members of the CCMU represent consumers, providers, government agencies, businesses, insurers, local health foundations and others. CCMU is committed to the following goals:

Goal 1: Achieve health insurance coverage for all Coloradans through a variety of public and private mechanisms by 2007.
Goal 2: Take interim steps to optimally meet the needs of Colorado's medically underserved and phase in affordable coverage solutions for those most in need.
Goal 3: Ensure that achieving these goals remains a public policy priority.

To reach these goals the Colorado Coalition for the Medially Underserved developed the Healthy Colorado Now: Quality Health Care for All initiative. The goal of this initiative is to uncover the best options and to build the will to provide access to affordable, quality health care and preventive programs for all Coloradans. After a series of over 90 community and organizational meetings held from 2000-2001, the CCMU developed a draft policy framework designed to meet the goals of the initiative. One important element of the first draft of the Healthy Colorado Plan revolved around the possible use of refundable/transferable tax credits for the purchase of health insurance for individuals and businesses.

This paper will briefly examine the scope and nature of the problems facing uninsured Coloradans. Spotlighting the current interest in tax credits, the paper will review Colorado's tax system and health insurance marketplace. It will present specific issues related to developing and maintaining a tax credit program, along with reporting on federal tax credit experiences and proposals.

Background

Lack of health insurance is a predictor of ill health (Institute of Medicine, 2002). Lack of health insurance also impacts the physical and economic health of individuals, the state and the nation by increasing costs to the health care system and decreasing productivity. Care for the uninsured is often more expensive and inefficient than the insured because of increased use of emergency rooms and decreased use of preventive services. Increased costs are shifted to insured individuals and businesses through higher premiums, increased taxes to fund public programs and hospitals, or they are absorbed by providers as uncompensated care (American College of Physicians-American Society of Internal Medicine, 2000; Denver Metro Chamber of Commerce, 2001).

In Colorado:

- Between12.7%-15.8% of Colorado's population is uninsured at any given time;
- Between 16.8-22.1% of Coloradans are uninsured for some period during the year;
- 26.9% of Coloradans have incomes under 200% of the Federal Poverty Level (FPL) (approximately $36,000 for a family of four), however, they account for 57.1% of state's uninsured;
- Three-quarters (74.1%) of Colorado's uninsured live in a family where there is at least one full-time worker; and
- Nearly 60% of uninsured, non-elderly adults work in Colorado firms with fewer than 100 employees. Employees in small firms account for 45% of uninsured working, non-elderly adults (Colorado Health Data Book, 2001).

Most people are uninsured because they cannot afford the cost of coverage. Many Colorado families are unable to pay $6,000-$7,000 per year in annual premiums for comprehensive coverage after paying for essential household expenditures such as housing, food and transportation (Glazner, 2000).

In addition, many Coloradans earn too much to qualify for public health insurance programs such as Medicaid and Child Health Plan Plus (CHP+). Because of stringent eligibility requirements, Colorado ranks 49th in the United States in terms of the number of low income, non-elderly covered by Medicaid (Hoffman and Pohl, 2000).

The number of uninsured Coloradans continues to grow. Health insurance premiums are climbing at double-digit rates, thereby decreasing the affordability of insurance for both businesses and individuals. Colorado is currently in a recession and unemployment is on the rise, leaving many more Coloradans without health insurance.

CCMU and Tax Credits

In 2000 the Colorado Coalition for the Medically Underserved (CCMU) launched an initiative called Healthy Colorado Now: Quality Health Care for All. The goal of this initiative is to uncover the best options and build the will to provide access to affordable, quality health care and preventive programs for all Coloradans by 2007.

The CCMU developed and refined a draft policy framework to ensure coverage for all Coloradans during a series of over 90 community and organizational meetings held around the state from 2000-

2001. Based on the feedback of those that attended meetings, over 30% favored the use of refundable tax credits as either their first or second choice out of five options to increase health insurance coverage in Colorado.[1] Some found refundable tax credits to be appealing because of the political viability of offering tax breaks to subsidize coverage versus authorizing direct subsidies through public programs. They noted the administrative infrastructure that already exists in the tax refund system. Some respondents favored this idea because they thought tax credits allow for more personal choice of health plans and personal responsibility for health decisions. Others believed that refundable tax credits could function as a starting point for a broader strategy to increase insurance coverage. Some were unconvinced that the use of tax credits is an effective strategy to significantly reduce the number of uninsured. Others were concerned about targeting and administering such a program so that it efficiently and cost effectively benefits those most in need, including those that do not owe any taxes. They cited the complexities involved in timing the delivery of the credit when premiums are due.

The CCMU convened the Working Group on Refundable/Transferable Health Insurance Tax Credits in April 2002 to conduct a refined technical analysis of the idea based upon the preferences and priorities expressed by Coloradans during the community meetings.

Colorado Taxes

The first step toward devising a new tax credit program is to determine how much tax Coloradans currently pay. Colorado taxes are directly tied to federal taxes. Coloradans pay 4.63% of federal taxable income to the state. Colorado ranks 47th when compared to other states in the amount of taxes collected per $1000 of personal income (Tax Foundation, 2002). Two out of the three states that ranked lower than Colorado had little or no individual income tax (Colorado Legislative Council, 2001). Table 1 shows relevant Colorado tax figures from the Colorado Department of Revenue.

Colorado employers can deduct 100% of their contribution to employee health benefits as an operating expense. As of 2003, self-employed persons will also be able to deduct all health care expenses. Individuals can deduct insurance costs if the total medical expenses exceed 7.5% of their adjusted gross income.

In Colorado the minimum income to file a tax return is:

- Single: $7,450
- Household head: $9,550
- Married filing jointly: $13, 400

It is noteworthy that 45% of the uninsured do not file income taxes (Gruber and Levitt, 2000). Refundable tax credits may provide options for those that do not file taxes. A refundable tax credit is a type of tax credit whereby if the value of the credit exceeds a person's tax liability then he/she can apply for a refund from the government for the difference. Taking this idea one step further, refundable/transferable tax credits could be used issued in the form of vouchers that could be transferred to insurance companies in exchange for coverage.

[1] Percent of respondents who ranked options as their first or second choice is as follows: 1) 66.6% single payer, but not necessary single delivery, system; 2) 59.9% expand existing programs; 3) 32.1% refundable tax credits; 4) 21.9% employer pay or play; 5) 22.7% proof of coverage and safety net plan. Felix, Burdine & Associates, 2001.

Table 1 **2000-2001 Colorado Tax Facts**
• Average individual taxes paid, $1,653.82
• Average corporate taxes paid $5,776.68
• Individual taxes accounted for 47% of collected state revenues
• Nearly 2.3 million individual income tax returns processed
• Nearly 2 million income tax refunds issued
• Net income taxes after refunds for individuals, $3.8 billion
• Net income taxes after refunds for corporations, $340 million
• Average tax refund for individuals, $612
• Total individual tax refunds, $1.21 billion–of that total, $904.5 million was refunded under TABOR as a sales tax refund
• Average tax refund for corporations, $19,832
• Total corporate tax refunds, $82.8 million
• Total state tax credits claimed by individuals, $162.7 million
• Total state tax credits claimed by corporations, $49.4 million

A substantial tax credit for health insurance would be the largest tax credit in Colorado. For example, if 316,000 individuals (equivalent to approximately 50% of the uninsured) took a tax credit of $1,500 per person per year (which would cover about 50% of the cost of coverage for a young, single individual with standard HMO coverage, see Table 2), then the total costs would equal $474 million. It's important to note that for 2001, the total amount of individual tax credit issued for *all* programs in Colorado was $162 million (Colorado Department of Revenue, 2001). Many of the uninsured will still not be able to afford the rest of the premiums and additional out-of-pocket expenses. Moreover, a flat tax credit of $1,500 may not be sufficient for all uninsured residents, especially if they are older and/or are in poor health. Federal participation in a tax credit program is necessary.

TABOR

The Taxpayer's Bill of Rights (TABOR) constitutional amendment affects Colorado's ability to raise and spend revenues. TABOR limits the annual increase in revenue collections to household consumer prices plus population growth. Revenue in excess of the population plus inflation limit must be returned to the taxpayers. Annual General Fund Appropriations are limited to 6% over the prior year's appropriations. The percentage increase is calculated from actual expenditures so that any unspent revenues from the previous year decrease the appropriations for the following year. The TABOR amendment contains two other major provisions: 1) voter approval is required to increase or institute new taxes, 2) TABOR places limitations on the kinds of taxes that can be implemented. (The Bell Policy Center, 2002)

In the late 1990's Colorado experienced revenue growth spurred by a booming economy. The state began generating a TABOR surplus in 1997. Initially, the excess revenues were returned through a sales tax refund. Since then the legislature has created additional mechanisms through which to fund the excess. In addition to the sales tax refund, the excess revenues were returned to taxpayers through several tax cuts, temporary tax credits and refunds. Because of a number of

factors including an economic downturn, the state currently faces a budget deficit due to declining revenues. Budget cuts have been necessary to make up for the shortfall. The Office of State Planning and Budgeting estimates that revenues were more than $1 billion below the TABOR limit for fiscal year 2001-2002. Taxpayers will not receive TABOR refunds in fiscal year 2002-2003 because there are no excess revenues.

Because of TABOR, a state health insurance tax credit would have to be funded trough excess revenues. The Office of State Planning and Budgeting estimates that TABOR revenue surpluses are not expected until fiscal year 2006-2007.

Colorado Health Insurance Market

Sixty-three percent of Coloradans receive their health insurance from their employer, while 5.2% have other private coverage. Another 16% of the population have public coverage through Medicare, Medicaid or other government programs (Colorado Health Data Book, 2001).

The following tables show sample premiums for Colorado for employer sponsored and individual health insurance.

Table 2
Typical Monthly Premium – Summer 2002
Small Employer Group PPO & HMO
Denver Metropolitan Area

	PPO				HMO	
	$500 Deductible 90/70 - $20 office visit Rx $10/$30/$50		$1,000 Deductible 90/70 - $20 office visit Rx $10/$30/$50		$20 office visit Rx $15/$30/$45	
	Single	Family	Single	Family	Single	Family
Age 30	$215	$712	$193	$625	$248	$768
Age 50	$376	$1,033	$333	$883	$405	$1,078

Table 2
Typical Monthly Premium – Summer 2002
Individual Major Medical- PPO Plan
Denver Metropolitan Area
Evidence of Good Health Required

	$500 Deductible 80/50 PPO Rx 50%		$1,000 Deductible 80/50 PPO Rx 50%	
	Single	Family	Single	Family
Age 30	$107	$356	$94	$342
Age 50	$227	$576	$191	$486

Source: Sandbak and Company

The cost of care and the cost of health insurance premiums are increasing in Colorado. While the reasons for these increases are beyond the scope of this paper, it is important to note that this rise is not unique to the state. The rest of the nation faces similar circumstances. According to the Center for Studying Health System Change, health insurance premiums rose 11% in 2001 and are

expected to rise 13% nationally this year. Milliman USA estimated that HMO premiums will increase by 17% nationally and 19% in mountain states in 2003. In 2000, 13.2% of the nation's gross domestic product was devoted to health care. That rate is expected to rise to 16% or higher over the next five year (American Association of Health Plans, 2002).

Rising costs directly impact the number of uninsured, the viability of the current system, the state's economy and the health of its citizens. Given the preponderance of private, employer-sponsored insurance in the state, Colorado employers are facing some grim realities. As the Denver Chamber of Commerce recently reported, "Employers faced with rising health care costs now must either find the money to pay for the premium increases, pass some or all of the cost on to employees, or decrease the level of benefits covered" (Denver Chamber of Commerce, 2001). A preliminary analysis of current trends suggests that employers are shifting more costs to employees by moving to plans with higher co-pays and deductibles and requiring more employee contributions for premiums (Kaiser Family Foundation, 2002; Austin, Denver Post, July 2, 2002).

Tax Credit Program Issues

Structuring an efficient and effective refundable tax credit program requires certain administrative mechanisms. Tradeoffs between maintaining simple, streamlined administration and targeting specific populations shape the design of those processes.

Eligible Population

There are several different ways to determine who would be eligible for a tax credit to purchase health insurance. Strategies include using income level, insurance status, limiting eligibility to those that do not have employer-sponsored insurance, tying eligibility to the Earned Income Tax Credit, or a combination of the above.

Eligibility for tax credits can be structured for populations with certain income levels. Income restrictions can effectively target certain populations that ostensibly are in most need of assistance. However, income restrictions add administrative complexity because income levels must be verified. Tax credits without income restrictions allow for broader eligibility and ease of administration, but the benefit may be applied toward less needy groups. Less stringent income eligibility creates a larger scope for the program and in turn is more expensive.

Eligibility for tax credits can also be determined by requiring eligibles to be uninsured. In order to deter crowd-out of other coverage, this idea can be taken a step further to require individuals and/or families to be uninsured for a certain period of time. The more requirements that are added, like look back periods to determine the number of months a person has been uninsured, the more administratively complex the system becomes. Caution must be used in requiring periods of uninsurance in order to avoid making it too easy to drop existing coverage or making the waiting period too long, which decreases the effectiveness of the program.

Limiting eligibility to those that do not have access to employer-sponsored insurance is another option. About 70% of the uninsured lack access to employer-sponsored insurance (Feder, et al, 2001). This approach requires eligibles to verify that they do not have employer-sponsored coverage, adding to administrative complexity.

Eligibility tied to the Earned Income Tax Credit (EITC) is another approach. EITC eligibles would receive health care tax credits in addition to the EITC credit. Individuals under the age of 25 are not eligible for the EITC. A provision would have to be made to reach uninsured individuals under 25 years old. For more on EITC see page 12.

Combinations of the above strategies can also be effective. For example, the tax credit can be structured so that only low-income persons that are uninsured and do not have access to employer-sponsored insurance are eligible. It's important to reiterate that if the eligibility determination process is more targeted, then ease of use for the consumer decreases and administration of the program becomes more elaborate.

Amount of Tax Credit

Studies show that substantial tax credits for the purchase of health insurance are necessary in order to incent proper participation by the uninsured. A majority of small businesses favor the use of tax credits to help employers purchase private insurance for their employees. However, the size of that subsidy directly affects participation rates among those that currently do not offer insurance. Almost 70% of small employers that currently do not offer coverage would participate in a tax credit program as long as the government paid 75% of the cost (Kaiser Family Foundation, 2002). Other studies and experience suggest similarly high subsidies (50%-60+%) would be necessary in order to encourage individuals to purchase health insurance using tax credits (Kaiser Family Foundation, 2000; Center for Studying Health System Change, 2002; Marquis and Long, 1995; Glazner, 2000).

Actual credit amounts due to eligibles can be based upon fixed rates, sliding scales, pegged as a certain percentage of the premiums that individuals or families pay for insurance, and basing the credit on age, health status and geography.

Families and individuals that qualify for the tax credit could receive a fixed, flat amount. For example individuals might receive a tax credit of $1000 and families might receive $1000 for each adult and $500 for each child. This application allows for predictable, simple assistance.

Alternatively, the amount of the tax credit can be determined on a sliding scale. Lower income families would be eligible for the highest amount of the tax credit. As income levels increase the amount of the tax credit decreases. Eventually the tax credit would taper off. This method of structuring a tax credit allows for a higher benefit for those that need it the most. However, it adds to the administrative complexity because the amount of the credit changes depending on income levels.

The amount of a tax credit can be determined by calculating it as a percentage of the individual or family's health insurance premiums. For example, if a young family is eligible for a tax credit worth 60% of their $9228 annual HMO premium (see Table 3), then the credit amount would be $5,537. Using a percentage of the premiums paid is equally beneficial to all recipients regardless of how much they pay in premiums. Documentation of the amount of premiums paid would be required, in addition to meeting at least a minimum level of benefits. Projecting overall budget costs for such a program may be difficult because the size of premium and therefore the credit would fluctuate.

Finally, the amount of a tax credit can be determined by considering age, health status and geography. For example, young and healthy eligibles that live in urban areas with high concentrations of health care providers and insurance carriers would receive smaller credits than elderly, unhealthy eligibles living in rural areas. This method attempts to level the playing field in terms of ability to pay and actual buying power of the premium (Kaiser Family Foundation, 2000). Verifying age, health status and geography would add documentation requirements.

Timing of the Tax Credit

In order to reduce the number of uninsured, a tax credit needs to be available to families at the time when their premiums are due instead of at tax filing time. Tax withholding strategies at the place of work may be effective for some families and individuals. However, low-income uninsured persons typically have very little disposable income and may not be able to float the cost of health

insurance premiums until they file their taxes, if they do at all, and receive their refunds (Glazner, 2000). Advance payment of tax credits during the year could help uninsured individual and families purchase health insurance. A system and a mechanism for advanced distribution would need to be created. Advanced payment of a tax credit would also require a mechanism to reconcile advance payments with the actual end of the year credit (Kaiser Family Foundation, 2000). Some eligibles may be hesitant to accept advance payment for fear of owing more money at the end of the year.

Vouchers

In order to ensure that recipients use health insurance tax credits for the purchase of health insurance, a voucher system would need to be created. Recipients of the tax credit could receive a voucher, instead of an actual credit, that could be sent or transferred to an insurance company along with their portion of the premium for coverage. The insurance company would then turn the voucher into the government for reimbursement. Many argue that vouchers allow for greater choice of plans and providers.

Purchasing Health Insurance

There are several different mechanisms that can be used for purchasing health insurance with a tax credit.

Individuals or families can use a tax credit to purchase insurance on the individual market. This allows eligibles the greatest choice in determining their benefits and insurance plan. Studies show that individual market coverage may be unaffordable depending on age and health status (Families USA, 2001).

Alternatively, individuals or families can be required to purchase their health insurance through their employer if it is offered. This allows eligibles to work from a system that is already in place, while simultaneously shoring up the private system. The down side is that many low-income, uninsured work for companies that do not offer health insurance.

Eligible persons could use their tax credit to buy into a public program such as Medicaid or Child Health Plan Plus. Certain precautions would have to be made in order to protect against destabilization of the private market. Or eligibles could be required to purchase their health insurance through a purchasing pool. This method may maximize risk sharing.

Combinations of the strategies above are also possible. For example, individuals and families could be required to purchase their health insurance through their employer. Eligibles that are not offered health insurance at the work place could then be required to purchase their health insurance through a purchasing pool.

Qualified Health Insurance Plans

A minimum set of benefits would have to be identified in order to protect consumers. Therefore, both the source and kind of coverage would have to be determined. Health insurance companies could be required to meet certain standards in order to participate (Kaiser Family Foundation, 2000). Selecting and monitoring health plans could prove to be a large administrative task. Additionally, monitoring plan selection by eligibles could be complicated.

Other Tax Credit Experiences

Earned Income Tax Credit (EITC)
In 1975 the Federal EITC was implemented to offset low-income, working families income tax liability. The EITC can be a tax refund if the taxpayer does not owe taxes. The amount of the credit is based on the size of the family and the level of adjusted gross income.

The Colorado EITC was implemented in 1999. The Colorado EITC is equal to 10% of the federal EITC. The state funds the EITC through excess revenues under TABOR. The Colorado EITC has an excess revenue threshold that must be reached in order for the credit to be implemented.

Table 4 shows examples of the 2001 Federal and State EITC at various income levels.

Table 4
2001 Federal and State EITC at Various Incomes

	Federal Credit			**State Credit (10%)**		
Income	No Children	1 Child	1+ Children	No Children	1 Child	1+ Children
$ 9,000	$ 131	$ 2,428	$ 3,600	$ 13	$ 243	$ 360
$ 18,000	$ 0	$ 1,633	$ 2,963	$ 0	$ 163	$ 296
$ 27,000	$ 0	$ 173	$ 1,043	$ 0	$ 17	$ 104

Source: Colorado Fiscal Policy Institute

In 2000 Colorado processed 196,302 EITC claims for an average of $153.90 per claim. Almost 216,000 Coloradans filed for the federal EITC in 2000 resulting in an average claim of $1,490.98.

Colorado State Income Tax Credit for Health Benefit Plans
The Colorado Legislature passed an income tax credit for health insurance in 2000 (HB 00-1104). This income tax credit is for health benefit plans not paid by an employer or deducted from federal adjusted gross income. The credit is capped at $500, with qualifying income capped at $25,000 for individuals without dependents, $30,000 for joint filers without dependents, and $35,000 for individuals or joint filers with dependents. The credit is not refundable and is limited to one per household. Any amount that exceeds the taxpayer's liability may not be carried forward or refunded (Office of State Planning and Budgeting, 2002; Colorado Department of Revenue, 2000). The Income Tax Credit for the Cost of Health Benefits ranks number 21 out of 22 tax credits currently on the books and requires a state surplus of $443.2 million before it can be activated. This tax credit has not yet been granted due to the excess revenue threshold.

Current Tax Credit Proposals

Using the tax system to insure more people is appealing for several reasons. The tax system is already in place and is structured to measure and redistribute income. Politically, tax credits may be easier to gain support than new subsidized programs that would require new appropriations and entitlements. Also, tax credits do not carry the stigma that many public subsidized programs do (Kaiser Family Foundation, 2000). Many organizations have developed national health insurance tax credit proposals or have taken positions on tax credits for the purchase of health insurance.

The Bush Administration has forwarded a health insurance tax credit plan. Under this proposal individuals earning less then $15,000 would be eligible for a maximum credit of $1000. Eligibility for the individual credit would phase out at $30,000. Families earning less $25,000 would be eligible for a $3,000 credit, with eligibility phasing out at $60,000. The tax credit would be limited to those who do not have access to employer-sponsored coverage and are not eligible for Medicaid.

Criticism of this and similar proposals focuses on the affordability and accessibility of coverage for individual health insurance. Some argue that $1,000 does not cover the cost of insurance for even healthy individuals. Some plans that are priced at about $1,000 exclude certain services and require hefty co-pays and deductibles (Families USA, 2002).

Studies by the Commonwealth Fund report that flat tax credits alone are not enough to make health insurance affordable to the low income, uninsured. The Commonwealth Fund suggests that health insurance tax credits be adjusted by age, sex, health or geographic location. Reforms in the individual market would also be necessary including requiring plans that offer state employees coverage to offer group rates to individuals or opening up the Federal Employees Health Benefit plan to individuals (Commonwealth, 2002).

The Heritage Foundation has developed a proposal that would make refundable tax credits available to working families. It would replace the current tax deductibility of health insurance for employees and would require employers to assume certain "clearinghouse" functions like adjusting withholdings, setting up deductions and creating enrollment mechanisms. Employees would receive credits, based on income and household health costs, for the purchase of health insurance. They would have to choose the plan offered by their employer or they would automatically be enrolled in a default state plan (Butler, 2001). The American Medical Association has put forth a similar proposal.

Conclusion

The Colorado Coalition for the Medically Underserved has identified refundable/transferable tax credits as a possible strategy for increasing insurance coverage based upon the preferences and advice of Coloradans heard at community meetings held around the state. The CCMU Refundable/Transferable Tax Credit Work Group explored the issues surrounding feasibility of implementing a refundable/transferable tax credit for the purchase of health insurance in Colorado. The work group found the following issues to be of importance in determining a tax credit proposal for Colorado:

- Colorado's tax system and the impacts of TABOR
- Who should be eligible for the tax credit?
- Should there be an income level cap limiting who is eligible?
- How much should the tax credit be? What parameters should be used to determine this?
- How can one ensure that the credit is available when people need it?
- How can one avoid people dropping their coverage in order to qualify for the credit?
- Where should eligibles be allowed to use their credit?
- What types of insurance plans should be eligible for the credit?
- Should a minimum floor of benefits be required?

This paper shows the difficulties involved in administering a simple, effective, substantial refundable/transferable tax credit at the state level. It also highlights the funding challenges that would have to be surmounted should Colorado choose to pursue such a strategy to increase health insurance coverage. Tax strategies to increase insurance coverage are not sufficient to address all of the problems facing the medically underserved. If they are funded, targeted, structured and administered correctly, then refundable/transferable health insurance tax credits may be an effective component of a larger policy framework to increase health insurance coverage.

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Appendix A

Members of the Colorado Coalition for the Medically Underserved Working Group on Refundable/Transferable Health Insurance Tax Credits.

Rita Avalos – Southwest Healthcare Systems
Mary Boland – Catholic Charities
Peg Brown – Colorado Association of Health Plans
Adela Flores – Colorado Fiscal Policy Institute
Kim Hacker – Hot Issues in Health Care
Jeremy Lazarus, MD – Colorado Medical Society
Steve Medema – University of Colorado
Lorez Meinhold – Colorado Consumer Health Initiative
Ralph Pollock – Business Council for Healthcare Competition
Peggy Sandbak – Sandbak & Company
Gary VanderArk, MD
Barbara Yondorf – Yondorf & Associates

Appendix B

2001 Colorado Collected Revenues		
Source	**Amount**	**Percentage**
Sales, Use & Excise	$ 2,708,780,347	33.03%
Individual Taxes	$ 3,859,355,758	47.06%
Corporate Taxes	$ 340, 113, 575	4.15%
Local Taxes	$ 832,520,687	10.15%
Motor Vehicle	$ 203,799,702	2.49%
Misc.	$ 256,153,406	3.12%
Total	$ 8,200,723,475	100%

Source: Colorado Dept. of Revenue