



Five Approaches
to
Achieving
Health
Insurance
Coverage *for*
All Coloradans

Statement of Values:

The Coalition's Vision for Colorado

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

Nearly 600,000 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.

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by Barbara Yondorf

July 2000

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Table of Contents

Introduction.....	4
Table 1: Brief Descriptions of Five Approaches to Achieving Health Insurance Coverage for All Coloradans.....	6
The Context for Considering Options.....	7
Option 1: Expand Existing Programs	9
Option 2: Require “Proof of Coverage” and Use a Safety Net Plan	15
Option 3: Employer Mandate.....	20
Option 4: Refundable Tax Credit	25
Option 5: Single Payer System	31
Appendix: Summary of Major Features of Five Approaches to Achieving Health Insurance Coverage for All Coloradans.....	37
References	42
Glossary	45

Introduction

The Options

This paper presents information on five general options identified by the Colorado Coalition for the Medically Underserved to ensure that all Coloradans have health insurance coverage. The Coalition developed the options to help it determine how best to pursue its goal of “achieving health insurance coverage for all Coloradans through a variety of public and private mechanisms by 2007” (*A Plan for Colorado, 1998*). The options for achieving this goal, which are briefly described in Table 1, include:

1. Expand government-sponsored health insurance programs
2. Require “proof of coverage” and use a Safety Net Plan
3. Enact an employer mandate
4. Provide refundable tax credits for the purchase of health insurance
5. Establish a single payer system

Each of these options is defined broadly and encompasses an array of possibilities. For example, the single payer system approach allows for setting up the program along several different lines. This includes using as a model the Federal Employees Health Benefit Plan, Medicare, or the Canadian health system.

Analysis of the Options and Purpose

With respect to each of the options, the paper addresses several questions. How would the program work? How would it be financed? What has been the experience with each of the options? What are significant implementation issues? What are major pros and cons? With respect to the last question, the paper does not address the issue of whether or not a particular option is politically feasible. Assessments of political feasibility are largely subjective and dependent on political will and the political climate, and thus are left to the individual reader to make.

The paper does not present a detailed analysis of each option. Rather, it is intended as a basic primer for people interested in ways to make sure everyone has health insurance. (For people new to the topic, a glossary of health care terms is included at the end of the paper.) The presentation of each option has intentionally been held to approximately five pages. The primary purpose is to stimulate public discussion. Readers are encouraged to think about each of the options and expand on the points presented in the paper.

A table summarizing the significant implementation issues associated with, and the major pros and cons of, each option is presented in the appendix.

Combining Options

It should be noted that the options are not mutually exclusive. Hybrids are certainly possible. For example, some have suggested that children, but not necessarily everyone, should be covered under a single payer system similar to the Medicare program for seniors. Others have recommended that everyone below 100% of the federal poverty level (FPL) should be covered by Medicaid; uninsured persons between 100% and 200% FPL should be given vouchers to purchase individual coverage; and tax incentives and subsidies should be used to encourage employers to offer coverage to their employees. Still others have endorsed universal, progressive employee tax credits for middle and upper income families, and vouchers for low-income families to allow individuals to purchase their own private coverage. Other combinations are also possible.

Conclusion

The overview of options presented in this paper suggests there is no approach that is clearly superior. Each option has elements to recommend it but also has drawbacks. The experience with different options suggests that some may work better than others in certain parts of the state or with certain populations (e.g., low-income families, people with jobs, the unemployed, etc.). What is heartening is that, as this paper shows, states that are committed to expanding access and reducing the numbers of uninsured can and have mounted successful programs. In addition, there are important lessons to be learned from initiatives at the federal level, in related fields, and from other countries.

Table 1

Brief Descriptions of Five Approaches to Achieving Health Insurance Coverage for All Coloradans

1. Expand Existing Programs

- Existing programs for low-income uninsured persons (e.g., Medicaid, Child Health Plan Plus, etc.) would be expanded. The income thresholds for these programs would be raised, perhaps to 250% of the federal poverty level, and the asset test would be loosened or abolished.
- A premium subsidy program would be offered to low-income workers so they could afford coverage offered at the workplace.

2. Require “Proof of Coverage” and Use a Safety Net Plan

- Everyone would be required to show they have health insurance coverage. Coverage could be provided by one’s employer, purchased individually, or, for eligible persons, obtained through Medicaid, Medicare, or CHP+. Families with low incomes would be eligible for premium subsidies on a sliding scale basis.
- Those who could not provide proof of insurance would be automatically enrolled in a government-sponsored Safety Net Plan and would be billed for their coverage (perhaps through the income tax system) on a sliding fee scale.

3. Employer Mandate

- All employers would be required to contribute to the cost of coverage for their employees in one of two ways. Employers could directly offer coverage at the workplace (“play”), or they could pay a fee to the government instead (“pay”).
- Employees whose employer selected the “pay” option would be offered a choice of plans through a privately run purchasing cooperative funded with the “pay” fees. Alternatively, they could be issued vouchers to purchase coverage.
- Low-income, unemployed persons would get government subsidized coverage either through the purchasing cooperative or by expanding existing government programs, such as Medicaid.

4. Refundable Tax Credit

- Uninsured workers and their families would be eligible for a refundable tax credit to cover a portion of their cost of purchasing health insurance.
- The tax credit would be refundable to benefit the roughly one-third of uninsured persons who have no tax liability. The credit could be adjusted to provide a greater benefit for lower income families.

5. Single Payer System

- The current system of financing care would be replaced by a wholly government-financed system.
- Everyone would be automatically covered by the system.
- The program could operate in one of two ways. Using a model based on the Federal Employees Health Benefit Plan or Medicare, the government would offer several different, comprehensive, private health insurance plans. Using a Canadian approach, the government would cover every person with the same package of benefits.

The Context for Considering Options

In order to evaluate options to ensure health insurance coverage for all, one needs to know who already has coverage, the types of coverage they have, and how their coverage is paid for. One also needs to know who is uninsured and why. Some salient facts about the present system are presented below. Unless otherwise noted, all data are taken from the publication, 1997 *Colorado Health Source Book: Insurance, Access, and Expenditures* (Abel, 1998).

The Insured

- Most Coloradans—an estimated 85%, have health insurance coverage.
- The elderly are the most likely to be insured; 98% are covered, mainly through Medicare. Persons 18-24 years of age are the least likely to be insured; 70% are covered.
- The vast majority of Coloradans who are insured have subsidized coverage. Either their employer or the government pays a significant portion of their cost of coverage.
- 65.1% of all Coloradans are covered under an employer-sponsored plan (Abel, 1998; Liska, Brennan and Bruen, 1998).
- Among people who are employed, 82.3% are insured.

- Together Medicaid and Child Health Plan Plus currently cover about 300,000 Coloradans (Colorado Department of Health Care Policy and Financing).

The Uninsured

- An estimated 580,000 Coloradans—1 in 7 people—are uninsured.
- Of those who are uninsured, 75% have incomes under 300% of the federal poverty level (FPL). This is equivalent to \$24,000 per year for a single person and \$49,000 per year for a family of four.
- 25% of Coloradans with family incomes less than 300% FPL are uninsured, compared to 6.9% of those with higher incomes.
- 82% of uninsured working age adults are employed at least part-time; 36% are employed full-time, all year.
- Colorado industries with the highest rates of uninsured workers are: agriculture, forestry, fishing, entertainment and recreation services, personal and repair services, and retail trade.
- The main reason people are uninsured is that they cannot afford coverage.

Health Care Expenditures, Costs, and Employers Offering Coverage

- Government funds account for 39% of health care spending in Colorado, private health insurance for 36%, and individual out-of-pocket expenditures for 25%.
- In 1996, the average cost of group coverage in Colorado was approximately \$2,000 per year for a single person and \$5,000 for family coverage (Branscome, et al., 2000).
- Overall, 56% of Colorado employers offer health insurance. For firms with fewer than 10 employees the figure is 42%. For firms with more than 1,000 employees it is 96% (Branscome, et al., 2000).
- 18.5% of Colorado employers who offer insurance offer a choice of two or more plans. More than half of employers with at least 1,000 employees offer such a choice (Branscome, et al., 2000).

Option 1: Expand Existing Programs

Brief Description

- Existing programs for low-income uninsured persons (e.g., Medicaid, Child Health Plan Plus, etc.) would be expanded. The income thresholds for these programs would be raised, perhaps to 250% of the federal poverty level (FPL)¹, and the asset test would be loosened or abolished.
- A premium subsidy program would be offered to low-income workers so they could afford coverage offered at the workplace.

How the Program Would Work

This approach would build on the current system. Employer-sponsored coverage would continue to be voluntary. No one would be required to have coverage nor would anyone be insured automatically. This approach would simply expand and perhaps consolidate existing programs that offer subsidized insurance to people who cannot afford to buy coverage on their own or to pay the required premium for employer-sponsored coverage.

The uninsured would be defined as falling into two categories. The first would be uninsured individuals who lack affordable coverage options given their current disposable incomes. This might, for example, be defined as all uninsured persons with incomes under 300% FPL—a group that accounts for more than three-quarters of Colorado’s uninsured. The

second category would be dubbed “the personally self-insured.” This second category would include people who can reasonably afford health insurance coverage given their current disposable incomes but who choose not to buy coverage. Public policy would focus on the uninsured lacking affordable coverage options.

Working with the private sector, policy makers would expand subsidy programs to ensure all Coloradans have access to affordable coverage. This could be done by expanding and building on the wide variety of special programs that currently exist or by consolidating these programs. Examples of existing programs that could be expanded include Medicaid, Child Health Plan Plus (CHP+), Medicare, and the Colorado Uninsurable Health Insurance Program (CUHIP). The programs could be structured so that the government-paid portion of the cost of enrolling in the program declined as family income increased.

As is true under the current system, eligible individuals would have to apply for coverage under the expanded programs. They would have to demonstrate they did not have access to affordable coverage, either because their incomes are too low or because they are priced out of the market as a result of pre-existing medical conditions.

Financing

In order to minimize the need for state funds to expand existing subsidized insurance programs, the state would likely

start by expanding those programs that provide the greatest federal matching rates. The most important are CHP+, where the federal government matches every dollar in state funds spent on the program with \$2 in federal funds, and Medicaid, where there is a dollar-for-dollar federal match.

“Colorado has one of the leanest Medicaid programs in the country. It covers just 5.1% of the state’s nonelderly population compared to a national average of 12.2%.”

The major sources of funding for program expansions in other states have been state general funds, new tobacco taxes, and provider taxes. New York is using part of its tobacco settlement money to pay for a recently enacted plan to extend coverage to a third of its 3.2 million uninsured people (Body, 1999).

Judith Glazner, a health care economist, recently examined various program expansion options for reducing the number of uninsured in Colorado. One of the scenarios she costed out assumed that uninsured persons with incomes less than 185% FPL would receive a 100% premium subsidy; those with incomes between 185-250% FPL would pay 2.0% of their incomes for premiums; and those with incomes between 250-300% FPL would pay 3.0% of their incomes for insurance. Assuming high participation rates, she calculated that such a program would reduce the number of low-income uninsured Coloradans by 229,000. The total cost would be \$108 million in federal funds and \$212 million per year in state funds (Glazner, 2000).

Related Experience

Over the past ten years, Colorado has expanded eligibility for several subsidized health insurance programs and created some new ones. For example, it has raised the Medicaid income eligibility threshold for children under age 6 to 133% FPL, established a children’s health insurance plan called Child Health Plan Plus (CHP+), and set up a subsidized insurance program for medically uninsurable individuals called the Colorado Uninsurable Health Insurance Program (CUHIP). Together Medicaid, CHP+, and CUHIP cover about 300,000 Coloradans.

Still, in terms of program eligibility, Colorado has one of the leanest Medicaid programs in the country. It covers just 5.1% of the state’s nonelderly population compared to a national average of 12.2% (Liska, Brennan, and Bruen, 1998).

Several states have attempted to significantly reduce their uninsured populations by expanding existing subsidized health insurance programs. Many have done so by

lowering or eliminating asset tests, raising income thresholds, or expanding the categories of persons eligible for their programs. Several of the more noteworthy of these programs are described below. These descriptions are taken from a recently released paper on state access reform initiatives published by the National Academy for State Health Policy (Riley and Yondorf, 2000).

- **Oregon** (population 3.3 million) passed a law in 1989, The Oregon Health Plan, which, among other things, expanded the state's Medicaid program to cover everyone below 100% FPL. In addition, the law called for the state to develop a prioritized list of Medicaid benefits to be delivered through managed care. Benefits would be reduced according to priority to meet budget constraints. Funding for the Oregon Health Plan comes from state general fund revenues, federal matching funds, and a 30-cent increase in the tobacco tax that was passed by the voters as part of a 1996 referendum. As of August 1999, 362,909 non-elderly persons were enrolled in the Oregon Health Plan. Of these, 114,303 were eligible solely due to state expansion reforms. The Family Health Insurance Assistance Program was created in 1997. Operating since 1998 and funded solely from state revenues, the program serves nearly 7,000 people. The program subsidizes premiums paid by low-income workers (below 170% FPL) for individual or employer-based insurance on a sliding fee scale. The program has a waiting list nearly twice the size of current enrollment.

According to the latest U.S. Census Bureau statistics, an average of 14.3% of Oregonians were uninsured during the period 1996-1998 (U.S. Census Bureau, 1999). During this same period, 15.1% of Coloradans were uninsured.

- **Minnesota** (population 4.7 million) adopted a comprehensive approach to reform called MinnesotaCare in 1992. Among other things, the program provides health coverage to children, parents, and siblings with family incomes under 275% FPL. Funding for the program comes from premiums, tobacco and provider taxes, and federal matching funds. Single adults and households without children are eligible for MinnesotaCare if their incomes do not exceed 175% FPL. Sliding scale premiums are charged for enrollees with incomes over 150% FPL. Only those who have not had private health insurance within the last four months are eligible for the program. The program provides preventive and primary care but limits the amount of covered hospitalization, except for children. As of July 1, 1998, 103,815 individuals were enrolled in MinnesotaCare. A state-sponsored purchasing pool was also established for state and local public purchasers and another for small businesses. The plan included insurance reform and a tax exemption for the self-employed.

According to the latest U.S. Census Bureau statistics, an average of 9.3% of Minnesotans were uninsured during the period 1996-1998 (U.S. Census Bureau, 1999).

- **Tennessee** (population 5.4 million) restructured its Medicaid program in the 1990's to significantly expand access to coverage. Persons eligible for TennCare, the new Medicaid program, include prior Medicaid beneficiaries, uninsurable citizens with pre-existing conditions, and citizens not otherwise eligible for employer-sponsored or public programs. Enrollees below 100% FPL pay no premium; those between 100% and 200% FPL pay based on a

Expand Existing Programs

sliding-fee scale; and those over 200% pay full cost. At the end of FY 1999, enrollment in TennCare was 1,312,969, or one-quarter of the state's population. Of these, 512,969 would not have been eligible for subsidized coverage prior to

“A significant portion of the uninsured may have little or no experience with using health insurance.”

TennCare but became eligible as a result of the state's expansion reform. TennCare's implementation has been the subject of considerable scrutiny. It has been marked by difficult transitions to managed care, angry providers complaining about low reimbursement and administrative problems, problems in delivering behavioral health services, continued budgetary conflicts, occasional freezes in enrollment, increased costs and considerable turnover in key leadership. However, a recent study by Blumstein and Sloan (1999) concludes that, despite its controversy and unstable financing,

TennCare has resulted in health care coverage for over 60% more patients than under traditional Medicaid.

According to the latest U.S. Census Bureau statistics, an average of 13.0% of Tennesseans were uninsured during the period 1996-1998 (U.S. Census Bureau, 1999).

- **Rhode Island** (population 1 million) in 1993 began RItCare, a managed care program for pregnant women and children up to age 18 with incomes under 250% FPL. The state also created a small, state-funded, private coverage buy-in. Licensed child care providers and centers with which the state contracts for subsidized child care are eligible for coverage. Home-based providers are enrolled in RItCare; child care centers receive a subsidy of 50% of the premium for employer-sponsored insurance. In 1999, the Legislature provided state funds to enroll all undocumented children to age 19 from families below 250% FPL. Rhode Island has also extended its Medicaid program to cover those previously ineligible by establishing income disregards and reducing or eliminating asset tests. Using this provision, Rhode Island covers parents of RItCare eligible children up to 185% FPL. No asset test is applied to either the children or their parents. RItCare served 92,000 individuals, representing almost 10% of the state's population in November 1998.

According to the latest U.S. Census Bureau statistics, an average of 10% of Rhode Islanders were uninsured during the period 1996-1998 (U.S. Census Bureau, 1999).

Significant Implementation Issues

Although expanding eligibility for existing subsidized health insurance programs may raise fewer implementation issues than the creation of new programs, there are significant implementation issues nonetheless. These include:

- Getting people who are not used to using an insurance model to enroll. A significant portion of the uninsured may have little or no experience with using health insurance, having relied instead on community clinics and emergency rooms for their care. Indeed, some may be unwilling to participate in an insurance program that requires them to make premium contributions to cover services they may be used to getting at no cost from local indigent care providers or hospital emergency rooms (Glied, 1999).
- Dealing with what some see as the welfare stigma of government-sponsored programs that discourages some eligible people from applying to those programs.
- Streamlining and making the eligibility determination process more user-friendly. Some people find the current eligibility determination process to be unpleasant, time-consuming, or demeaning,
- To the extent that this approach involves employer or employee subsidies for insurance purchased at the workplace on behalf of low-income employees, greatly expanding existing, limited administrative systems to administer the subsidies.
- Successfully marketing and enrolling eligible individuals who may be unaware of the program or unaware that they are eligible for the program. One study found, "In 1994, among children under 11 who did not receive cash assistance but who were income eligible for Medicaid, fewer than 40 percent enrolled in Medicaid. More than half of those who did not enroll were uninsured" (Summer, 1997).
- Controlling crowd out (where people drop private coverage to get government-sponsored coverage), while still making sure the uninsured have access to affordable care. The typical means of controlling crowd out is for public programs to have a waiting period (say three or six months), during which the applicant cannot have been covered by private insurance. However this means that some families will be forced to "go bare" in terms of health coverage during the waiting period. This can be problematic for a low-income family where the head-of-household may change jobs two or three times a year or frequently has short periods of unemployment when he/she is not covered.
- Making sure the state is not creating an incentive for employers who currently offer coverage to their low-income employees to drop such coverage, because the employees qualify for publicly subsidized coverage.
- Dealing with adverse selection. Low income families who are newly given access to subsidized health insurance but who are required to pay some part of the premium (for example those at 185% FPL) may wait until they become ill to enroll in the program.

Major Pros and Cons

Pros:

- Builds on the administrative infrastructure of existing programs.
- Experience in other states suggests that aggressive programs to expand Medicaid coverage and include whole families can make a significant dent in the number of uninsured persons under 200% FPL (Holahan, et al., 1998).
- Involves no mandates.
- Provides more accurate assessment of financial need than tax-based approaches, in part because assets as well as income can be taken into account (Glied, 1999).
- Allows program benefits to be tailored to the particular population each program serves.

Cons:

- Continues administratively expensive and inefficient “patchwork” approach that requires means testing and eligibility determination.
- From experience in other states, we know that 5-11% of the population still won’t be covered.
- Raises issues of “crowd out” wherein some employers and some low-income employees may drop existing coverage in order to take advantage of the expanded government programs.
- Compared to some other options, enrollees may have a more limited choice of plans or providers.

¹ Federal poverty level income equivalents are as follows:

Annual Income Federal Poverty Level Equivalents by Family Size			
	100% FPL	200% FPL	300% FPL
Single person	\$8,050	\$16,100	\$24,150
Two persons	\$10,850	\$21,700	\$32,550
Three persons	\$13,650	\$27,300	\$40,950
Four persons	\$16,450	\$32,900	\$49,350
Five or more persons	Add \$2,800 per additional person	Add \$5,600 per additional person	Add \$8,400 per additional person

Option 2: Require “Proof of Coverage” and Use a Safety Net Plan

Brief Description

- Everyone would be required to show they have health insurance coverage. Coverage could be provided by one’s employer, purchased individually, or, for eligible persons, obtained through Medicaid, Medicare, or CHP+. Families with low incomes would be eligible for premium subsidies on a sliding scale basis.
- Those who could not provide proof of insurance would be automatically enrolled in a government-sponsored Safety Net Plan and would be billed for their coverage (perhaps through the income tax system) on a sliding fee scale.

How the Program Would Work

Under a required “proof of coverage” model everyone would be required to have health insurance. Coloradans could comply with the requirement in a number of different ways. They could sign up for employer-sponsored coverage, if it is offered where they work. They could purchase individual coverage. If they meet eligibility requirements, they could enroll in an existing government-sponsored program, such as Medicaid or Medicare.

The program could be structured so that employers would be allowed to give their employees vouchers for the purchase of individual coverage. Purchasing cooper-

atives would be authorized to accept the vouchers and offer coverage at group rates. To help low-income families pay for their coverage, the government could institute health insurance tax credits, provide direct subsidies, or expand eligibility for Medicaid. To help medically uninsurable individuals who are not eligible for group coverage, the price of coverage under the Colorado Uninsurable Health Insurance Plan (CUHIP) could be structured to be more in line with standard group coverage rates. (Currently CUHIP charges most enrollees premiums that are 25-35% higher than standard individual health insurance rates.)

A unique feature of this approach is that the state would authorize creation of a statewide safety net of providers capable of providing comprehensive health care throughout the state to those without insurance. The Safety Net Plan would probably include all the state’s current essential community providers (e.g., community health centers, public hospitals, etc.) plus any other providers who agreed to participate in the plan. Persons who are not enrolled in another insurance plan would automatically be deemed to be in the Safety Net Plan. Indeed, the presumption would be that everyone is in the Safety Net Plan unless they can prove that they have other coverage. Premiums for the plan would be based on income. Individuals in the Safety Net Plan would be automatically billed for their coverage on a sliding scale basis. For instance, those with incomes under 150% FPL might be charged either nothing or a nominal fee. Those with incomes between 150% and 200% FPL might be charged \$30

Require “Proof of Coverage” and Use a Safety Net Plan

per month, etc. At middle and higher income levels, people would be charged a premium that covered actual per person average costs. The billing could be done through the income tax system, by a private organization charged with billings and collections, as a payroll deduction, or using some other mechanism. To encourage people to either get private coverage or sign up for an existing government program for which they qualify (e.g., Medicaid, CHP+, etc.), premiums and copayments would be higher under the Safety Net Plan than under these other programs.

“Supporters of a required “proof of coverage” model argue that it places responsibility for coverage where it should be--on the individual.”

Enforcement of the required “proof of coverage” model could occur in several ways. For example, Coloradans might be required to show proof of insurance for the previous year as part of their income tax filing. For any period during the prior year when they were uninsured, they would be billed on a sliding scale basis. Also, providers might be prohibited from

delivering care unless a person could produce a valid health insurance card, unless that person required emergency or urgent care. Alternatively, insurers might be required to inform the state when an individual drops coverage or is no longer eligible for their plan.

The logic of this approach includes several elements. First, supporters of a required “proof of coverage” model argue that it places responsibility for coverage where it should be—on the individual. Second, it ends the inequity of the current system where costs are shifted from those who do not purchase coverage or enroll in government programs to those who do. Third, it ensures that traditional safety net providers actually get reimbursed for the care they deliver. Fourth, it starts from the presumption that everyone is insured and must pay for their coverage on a sliding scale basis and that individuals can only opt out of the government-mandated program by getting private coverage. Fifth, it ensures that no one will ever have a gap in coverage. If you do not have other coverage, you are automatically in the Safety Net Plan and will be billed accordingly.

Conceptually, the required “proof of coverage” and use of a safety net plan approach has some similarities (albeit limited) to the requirement banks have that in order to get a car or home loan, you must maintain insurance on the car or home. If you do not purchase such coverage, or allow it to lapse, the bank will automatically charge you for the coverage.

Financing

The major sources of financing for the required “proof of coverage” and use of a safety net plan model would be the traditional ones. They include employer contributions to employee coverage,

individual and employee payments for premiums, and state and federal funds to assist low-income persons.

Because individuals would be required to have health insurance, the pressure on employers to offer coverage would likely increase. More and more workers would insist that an employer provide coverage as part of the basic employment benefit package, because otherwise the worker would have to buy coverage on his own. Studies show that 89% of employees with access to employment-based coverage enroll when it is offered (Cooper and Schone, 1997). However, only 56% of Colorado firms offer health insurance (Branscome, et al., 2000). Thus, if more employers were to offer coverage in response to worker demand, the number of people with employer-sponsored coverage should increase significantly. Currently approximately 150,000 uninsured Coloradans live in families where the head of household works full-time, full-year. They account for 26% of the uninsured (Abel, 1998).

The required “proof of coverage” should also prompt more people to sign up for existing government-sponsored programs for which they are eligible but not enrolled. This would occur because the Safety Net Plan, in which people would be automatically enrolled unless they could show proof of other coverage, would intentionally be structured to be less attractive than existing state-federal programs. Benefits under the Safety Net Plan would be less and enrollee contributions, premiums, deductibles and copayments would be higher than, for instance, under Medicaid or CHP+.

Part of the cost of the program could be paid for through tax credits. (See Option 4: Refundable Tax Credit for more information.) Families with below-average incomes could qualify for a tax credit to help them pay for their portion of the cost

of employer-sponsored coverage. If they did not have access to an employer plan, they could get a tax credit for the purchase of individual insurance. Or, they could default into the Safety Net Plan and pay for coverage on a sliding scale basis.

Related Experience

There are no states or countries that have enacted a system that requires “proof of coverage” and uses a Safety Net Plan. However, some lessons can, perhaps, be learned from Hillsborough County, Florida, which has had a Safety Net Plan-type program in place for several years. The experience with mandatory individual auto insurance and student health insurance requirements is also instructive.

- **Hillsborough County, Florida.** Although it does not mandate individual coverage, Hillsborough County, Florida, has established an innovative program for those with low-incomes who are uninsured. This program has some similarities to the Safety Net Program proposed in this paper. The Hillsborough County Health Care Plan is a comprehensive managed care plan for uninsured residents who do not qualify for other health coverage. It was established in 1994. The program is administered by the county’s Community Health and Human Services Department and serves 24,000-27,000 uninsured participants with incomes under 100% FPL (Health Resources and Services Administration, 1999). Coverage is financed through a limited local-option sales tax increase of a half-cent, which raises \$51 million per year, and an appropriation of \$26.8 million in county property taxes. It is estimated that the plan serves about 60% of the eligible population (Taubman Center, 1995).

Require “Proof of Coverage” and Use a Safety Net Plan

- **Requiring health insurance as a condition of college enrollment.** Many colleges and universities require proof of health insurance coverage as a condition of student enrollment.

“This approach helps traditional safety net providers, who care for the poor and medically underserved, by guaranteeing payment for services delivered.”

Massachusetts has a law on the books that requires all full-time students to be insured. Unless a student can show that he already has coverage (often under his parents’ plan), he is automatically enrolled in a plan sponsored by the college or university, and billed for coverage. It is estimated that, across the country, approximately 11% of college students are uninsured (Deloitte and

Touche, 1998). Thus, mandating student coverage can noticeably affect overall uninsurance rates, particularly in states such as Colorado with relatively large university and college populations; this is exactly what happened in Massachusetts with passage of its mandatory student insurance coverage law.

- **Mandatory auto insurance.** All drivers are required to have auto insurance. Yet large numbers of drivers are still uninsured. According to the National Association of Independent Insurers, in 1997 an estimated 14% of drivers were uninsured nationwide. The major reason most drivers are uninsured despite the auto insurance mandate is the same reason most people without health insurance are uninsured—cost. Families whose incomes are in the lowest 20% of incomes spend seven times the percentage of their household income on auto insurance as do families in the top 20% (Joint Economic Study Committee, 1998).

Significant Implementation Issues

- Establishing sophisticated tracking systems to determine whether or not, at any given time, an individual actually has private insurance coverage or should be counted as being in the Safety Net Plan.
- Establishing benefit standards in order for a plan to qualify as meeting the mandate for coverage.
- Making sure people pay for their coverage. If the state uses the individual income tax collection system as a premium collection mechanism, thousands of people who do not currently file a return will be required to

Five Approaches to Achieving Health Insurance Coverage for All Coloradans

do so. If another approach is used, what would be the sanction for nonpayment?

- Developing systems for estimating appropriate payments to the Safety Net Plan to cover the continually shifting enrollment in the program.
- Making sure the state is not creating an incentive for employers who currently offer coverage to their low-income employees to drop such coverage, because the employees qualify for publicly subsidized coverage.
- Determining what sorts of rate setting and underwriting rules would be needed to ensure there is a level playing field in the individual, employer-sponsored, purchasing cooperative, and government-sponsored markets. Otherwise some of these markets may experience serious adverse selection.
- Making sure that healthy individuals don't avoid purchasing coverage until they're sick, at which time they simply “enroll” in the Safety Net Plan.

Major Pros and Cons

Pros:

- Ensures that all Coloradans with below-average incomes would be covered.
- Helps traditional safety net providers, who care for the poor and medically underserved, by guaranteeing payment for services delivered.
- Arguably places responsibility for coverage where it should be—on the individual.

Cons:

- Involves setting up a whole new government bureaucracy to track who is and isn't privately covered, and to bill people.
- Difficult to enforce.
- Determining rates for Safety Net Plan coverage may be complicated and create perverse incentives depending on whether age, experience, and/or community rating is used.

Option 3: Employer Mandate

Brief Description

- All employers would be required to contribute to the cost of coverage for their employees in one of two ways. Employers could directly offer coverage at the workplace (“play”), or they could pay a fee to the government instead (“pay”).
- Employees whose employer selected the “pay” option would be offered a choice of plans through a privately run purchasing cooperative funded with the “pay” fees. Alternatively, they could be issued vouchers to purchase coverage.
- Low-income, unemployed persons would get government subsidized coverage either through the purchasing cooperative or by expanding existing government programs, such as Medicaid.

How the Program Would Work

Under this approach, employers would be required to offer coverage to their employees and would have to make a minimum contribution to coverage. In lieu of doing this, they could pay a fee to government. Employees whose employer chose to pay the fee instead of offering coverage would be given coverage options through a privately run purchasing cooperative funded with the employer fees. Alternatively, the employer fees could be

given to uninsured workers in the form of vouchers that they could use to buy private, individual coverage. The program could be structured either to require employees to accept coverage if it is offered at the workplace or to allow employees to choose whether or not to accept the offer. Government would provide subsidies to low-income employees and perhaps low-income and/or small employers to help them pay their share of coverage. Non-workers and the unemployed would have access to subsidized coverage through the expansion of existing public programs such as Medicaid, or through the purchasing cooperative.

Mandating employer coverage for employees is not a new idea. Hawaii has had an employer mandate in place since 1974. All other industrialized nations, in one way or another, require employers to pay part of their nation’s health bill. According to one observer, “Even President Nixon, no radical reformer, embraced the concept of a national employer mandate in 1974—albeit to avoid proposals for more far-reaching reform” (McDonough, 1999).

Employer mandate proponents argue that we should build on our largely employer-based insurance system. Among Coloradans under age 65, 72% are covered by employer-sponsored plans (Liska, Brennan and Bruen, 1998). When employees have access to employer-sponsored insurance, 89% sign up for coverage (Cooper and Schone, 1997). However, only 56% of Colorado employers currently offer health insurance (Branscome et al., 2000). Thus, if all employers were

mandated to provide coverage, there should be a substantial decline in the number of uninsured.

Financing

By definition, the major source of financing for an employer mandate would be employers. However, employees would likely also be required to contribute something to the cost of their coverage, as is the case in Hawaii. (See description of Hawaii's employer mandate in the following section.) Funds would also be

needed to subsidize the cost of coverage for the unemployed and non-working poor.

It has been estimated that a payroll tax of 7-12% for companies without their own policies may be needed to finance coverage for the currently employed but uninsured (Minnesota Family Council, 1993). In Colorado, among employers who offered coverage to their employees, the average annual total premium in 1996 was \$1,912 per employee, 82% of which was paid by the employer. The average 1996 total premium for family coverage was \$4,740, 64% of which was paid by the employer (Branscome, et. al., 2000).

In 1997, there were approximately 275,000 Colorado working age adults who worked either full-time or part-time during the entire year and were uninsured (Abel, 1998). Assuming an average cost per worker for employee-only coverage of \$150 per month, and assuming a minimum employer contribution of at least 50%, employers who do not currently sponsor coverage would have to pay at least \$247.5 million per year to cover uninsured working adults under an employer mandate. Another \$247.5 million would have to be raised from employees and/or the government for the required employee contribution to coverage.

Related Experience

- **Hawaii** has had an employer mandate since 1974. Under the Hawaii Prepaid Health Care Act, all employers must offer coverage to their employees who work 20 or more hours per week. Employees are required to accept coverage. The law specifies a benefit structure. Excluded from the law's provisions are dependents, government and part-time employees, and family-owned businesses. Low-income families who do not get coverage through the workplace in Hawaii are

“When employees have access to employer-sponsored insurance, 89% sign up for coverage. However, only 56% of Colorado employers currently offer health insurance.”

eligible for coverage under a state-subsidized health insurance program called QUEST. A premium supplemental fund provides subsidies for the purchase of health insurance to employers with less than eight employees and to bankrupt firms. In 1994-95, employer-sponsored plans covered three-quarters of non-elderly Hawaiians (Liska, Brennan and Bruen, 1998).

According to the latest U.S. Census Bureau statistics, an average of 8.7% of Hawaiians were uninsured during the period 1996-1998 (U.S. Census Bureau, 1999).

- **Other states.** Several other states have pursued employer coverage mandates but none has actually implemented one. *Massachusetts* passed a law in 1988 calling for the imposition of a play-or-pay mandate. Under the law, all employers were to be assessed a new \$1,680 per worker per year tax, though employers who bought insurance coverage for their employees were exempted. The act called for revenues from the tax to finance coverage for uninsured workers and their families. *Oregon, Washington, and Minnesota* followed suit in the early 1990s and passed their own forms of employer mandates. Each of these states anticipated requesting a federal ERISA waiver to enact their laws, but either the federal government resisted this approach or the state repealed the employer requirement before an official ERISA challenge was developed. (For a definition and discussion of ERISA, see the first bullet in the next section.) According to one researcher, “Small business opposition was critical in altering the political consensus within each state” (McDonough, 1999).

“Mandating employer coverage is not a new idea. Hawaii has had an employer mandate in place since 1974.”

Significant Implementation Issues

- Obtaining an exemption from the federal Employee Retirement Income Security Act (ERISA) of 1974. ERISA strictly limits states from imposing requirements on employee health plans. Only one state, Hawaii, has secured an exemption from ERISA, and that is largely because its employer mandate pre-dated implementation of the federal law. Some have argued that play-or-pay laws might avoid the ERISA issue. This is because such laws neither require employers to provide health coverage nor specify any plan requirements. Instead they impose an employer tax to finance care and allow employers a tax credit if they already provide coverage. However, this argument has not been tested in the courts (Butler, 1994).

- Taking steps to make sure employers don't leave the state in order to avoid the mandate. It is not known how serious a problem this may actually be. Most large employers already provide health insurance benefits. Many small employers who do not currently offer coverage cannot easily pick up and leave the state just to avoid the employer mandate.
- Deciding how out-of-state employers with in-state employees would be treated. Would they be subject to the mandate for their Colorado employees? If so, would they have to conform their plans' benefits to minimum state requirements? If not, would this create an incentive for employers to avoid locating in Colorado in order to avoid the mandate?
- Developing the administrative systems to implement and enforce a play-or-pay system. This includes establishing or expanding Colorado's sole, private existing health care purchasing cooperative to make coverage available to uninsured workers whose employers pay instead of play. Alternatively, if vouchers were used, a system of administering the vouchers would have to be developed.
- Finding ways to stop employers from trying to circumvent the law by hiring workers on a part-time basis or classifying some employees as independent contractors.
- Adverse selection. Under a play-or-pay program, employers with older or sicker workers may calculate that they're better off going the "pay" route because the per employee cost is less than the cost of coverage in the private market place. Conversely, employers with young healthy workers are likely to pick the "play" option if they can get cheaper coverage in the private market. As a result, the actual cost of coverage through the purchasing pool may be very expensive unless it is subsidized by the state.
- Carefully designing targeted subsidies to employers who, without the subsidy, may be forced to lower wages or eliminate jobs in response to the employer mandate.
- Establishing minimum benefits for an employer plan in order for it to meet the mandate.

Major Pros and Cons

Pros:

- Is based on an existing model in Hawaii, which has had an employer mandate for 25 years.
- Builds on current employer-sponsored coverage model that is currently the single major source of coverage for Coloradans today.
- Deals with the issue of crowd-out, since employers would have to provide coverage and employees would have to sign up for coverage.
- Preserves market place competition.

Cons:

- Employers with a large proportion of low-income employees would be hit the hardest.
- Still requires a patchwork of government programs to cover the unemployed and probably dependents of the employed.
- Requires development of a new bureaucracy to cover employees whose employers “pay” instead of “play.”
- Raises labor costs for some employers who may respond by reducing wages or eliminating jobs. (National Center for Policy Analysis, 1994)

Option 4: Refundable Tax Credit

Brief Description

- Uninsured workers and their families would be eligible for a refundable tax credit to cover a portion of their cost of purchasing health insurance.
- The tax credit would be refundable to benefit the roughly one-third of uninsured persons who have no tax liability. The credit could be adjusted to provide a greater benefit for lower income families.

How the Program Would Work

This approach relies on tax reform as the centerpiece of efforts to ensure coverage for all. Various groups have floated tax reform proposals.¹ Here we focus on an approach that is receiving widespread attention, which was developed by a conservative from the Heritage Foundation, Stuart Butler, and a former Democratic Hill staffer from the Progressive Policy Institute, David Kendall. (For more information see Butler and Kendall's article, "Expanding Access and Choice for Health Care Consumers Through Tax Reform," 1999.)

This approach assumes that all of the elements of the existing system would continue to be in place, including government programs for the poor and seniors and a reliance on employer-provided insurance for most full-time workers. The new element would be that uninsured workers and families who are ineligible for other federal health insurance programs

would be offered a refundable tax credit to cover part of the cost of private, individually-purchased health insurance. With a refundable tax credit, taxpayers whose tax credits exceed their income tax liabilities receive the difference in the form of a tax refund (see "refundable tax credit" in the glossary for an example of how this type of credit works). A tax credit is an amount subtracted from the taxpayer's income tax liability, unlike a deduction, which merely reduces adjusted gross income or taxable income (Weiss and Garay, 2000).

The credit would be refundable in order to benefit the roughly one-third of the uninsured who have no tax liability and have the greatest need for assistance. The advantage of a refundable tax credit over a tax deduction is that it is worth as much to a low-income as a high-income family. Workers who wished to continue their current coverage could do so under today's tax policy, which excludes employer-paid coverage from income and payroll taxes. However, employees would also have the option of getting their coverage elsewhere, such as through specially created pools or unions, and would get the same tax relief as would be available through job-based coverage.

The tax reform approach takes as its basic premise that:

The tax treatment of health insurance is the chief source of the problem. Large subsidies (tax deductions or exclusions) are available to affluent Americans with employer-provided insurance, but most working families without that coverage get little or

no help to pay for insurance or for the direct costs of care. (Butler and Kendall, 1999)

In Colorado, 60% of the uninsured (351,000 people) live in families where the head of household is employed. This includes nearly 150,000 uninsured persons living in

“The tax reform approach takes as its basic premise that the tax treatment of health insurance is the chief source of the problem.”

families where the household head works full-time, full-year (Abel, 1998). It is these families who are most likely to take advantage of a health insurance tax credit.

Under the tax credit approach, uninsured working and temporarily unemployed families would purchase insurance on their own and then subtract from their income tax liability the amount they paid in premiums, up to whatever cap is placed on the allowable tax credit. The value of the tax credit could be set as a percentage of the premium paid or as a flat amount per family. It could also vary based on demographic factors, health risks, or

income, with the allowable credit being greater the lower the income of the family.

For families who cannot afford to pay the upfront cost of health insurance and then wait a year to get their tax credit, there are several options. First, workers could make an adjustment to their withholding to account for their expected tax credit. Second, following on a proposal put forward by U.S. Senator Tom Daschle, insurers could be allowed the option of reducing their tax withholding for each eligible person who voluntarily assigns the value of his or her credit to that insurer, in return for reduced premiums (Butler and Kendall, 1999). Third, the state might offer “loans” that would be payable once a family had filed their tax return and received any refunds they were due. Fourth, low-income individuals could be issued tax credit vouchers to purchase coverage from purchasing pools or to buy into government-sponsored health insurance programs (Bunce and Lack, 1999).

Financing

Butler and Kendall suggest several ways of financing the tax credit. Of course, their proposal is designed with the federal, not state, income tax system in mind, but the state could consider similar approaches with respect to its own tax system. The possible sources of revenue to finance refundable tax credits they suggest include:

- Eliminate the itemized tax deduction for health care under which taxpayers with health care expenses that exceed 7.5% of their income can take an itemized deduction.
- Introduce a cap on the tax deductibility of job-based coverage that would end the current open-ended tax subsidy for coverage. Couple this with a loosening

of flexible spending accounts so that money deposited into such accounts can rollover from one year to the next instead of being lost if not spent by the end of the year. The provision about flexible spending accounts would be included to make the capping of the tax deductibility of job-based coverage more palatable.

- Reduce subsidies for uncompensated care. The logic here is that by increasing insurance rates through the refundable tax credits, the costs faced by traditional uncompensated care providers should also decline.
- Incorporate health credits into proposals to cut taxes.

A Colorado refundable tax credit would reduce the total amount of taxes collected by the state. If 350,000 individuals (equivalent to about 60% of the uninsured) took an average annual tax credit of \$1,000 per person per year (which would cover about half the cost of coverage), state tax collections would be reduced by \$350 million. This would be by far the state's largest tax credit. According to the Colorado Department of Revenue, for fiscal year 1999, Coloradans claimed \$140 million in tax credits for such things as enterprise zone credits (\$19.7 million), property/rent/heat tax credits (\$9 million), and enterprise zone investment credits (\$24.5 million).

Related Experience

A number of states have enacted specific tax incentives to encourage employers and individuals to get and keep health insurance by lowering the effective price of coverage (Riley and Yondorf, 2000). For example:

- **North Carolina** adopted a tax provision in 1998 specifically aimed at helping low-income families. The law allows for a refundable state income tax credit for families who do not have access to tax-free benefits at the workplace. The tax credit is \$300 per child for families with incomes less than 225% FPL and \$100 per child for families with incomes above 225% FPL, up to \$100,000 income for a family of four. Effective January 1, 2000, North Carolina also allows a credit for creating jobs or worker training if health insurance is provided for the positions for which the credit is claimed.
- **Maine** recently enacted a program targeted at very small employers who provide coverage to their low-income employees. Maine's law, enacted in 1998, establishes an income tax credit for eligible employers who provide dependent health care coverage for low-income employees. Firms with four or fewer low-income employees are eligible if the employer makes available a health plan to low-income employees who work specified hours and the employer pays at least 80% of the cost of employee benefits and at least 60% of dependent benefits.
- The **Massachusetts** Insurance Partnership provides tax credits for small employers of low-income workers up to 200% FPL to offer group coverage.
- In 1987, **Oregon** established a tax credit program for small employers purchasing certified plans, under which the value of the credit declined over a period of five years from \$25 per employee per month to \$6.25. However, the state eliminated the program in 1995, in large part due to low enrollment levels (Lipson et al., 1997).

Federal experience. At the federal level, there are two tax credit programs that may offer some insights about using refundable tax credits to deal with the problem of the uninsured. These include the Earned Income Tax Credit and the 1991-1993 Health Insurance Tax Credit. Each is briefly discussed below.

- **Earned Income Tax Credit.** This is a refundable tax credit that is available to low-income families with earnings from work. The benefit varies depending on income level and number of children. For example, a family of four could earn up to \$28,682 in 2000 and, as a result of the Earned Income Tax Credit, owe no income taxes whatsoever. The estimated cost of the Earned Income Tax Credit for fiscal year 2000 is \$29.8 billion nationwide, of which \$25.8 billion (87%) represents budget outlays for the refundable portion of the credit (Joint Economic Committee Staff, 2000). Among families eligible for the Earned Income Tax Credit, 80-85% take the credit (U.S. Government Accounting Office, 1994.) It should be noted that to qualify for the Earned Income Tax Credit, no particular action (such as buying insurance) is needed on the part of the eligible individual, apart from filing a return and claiming the credit.
- **1991-1993 Health Insurance Tax Credit.** In 1990, Congress enacted a law that permitted individuals who were eligible for the Earned Income Tax Credit to receive an additional refundable tax credit for a portion of the cost of health insurance coverage for their eligible children. The law was in effect only from January 1991 through December 1993. Credits of up to \$428 per year were available for families with annual incomes under \$21,250. About 25% of the approximately 9 million families eligible for the program took advantage

of it. This relatively low take-up rate was attributed primarily to two factors: lack of awareness of the program, and the small size of the credit (Meyer, Silow-Carroll, and Wicks, 2000). It is not known what, if any, effect the availability of the Health Insurance Tax Credit had on the number of families who chose to purchase coverage for their children.

Significant Implementation Issues

Several significant implementation issues would need to be dealt with under a refundable tax credit approach to ensuring that all Coloradans have health insurance coverage. For example:

- Structuring a tax credit that is both fair and workable. To be “fair,” the tax credit should provide the greatest benefit to those most in need—families with the lowest incomes, those with serious health problems, people for whom health insurance consumes a large share of their income, etc. Yet varying the credit to account for this array of factors makes it much more complex to administer.
- Providing a tax credit that is large enough to encourage the uninsured to purchase coverage but not so costly to government as to be infeasible. Several studies have shown that in order to reduce uninsurance rates significantly, subsidies for the purchase of insurance must be very high—60% or more (Marquis and Long, 1995; Glazner, 2000). For example, most non-elderly Coloradans who have health insurance get their coverage through the workplace, where the employer subsidy is substantial. In 1996, Colorado employers paid an average of 82% of

employee-only coverage (\$1,566 per year) and 64% of family coverage (\$3,037 per year) (Branscome, et al, 2000). Yet, as noted earlier, it is difficult to target tax credits only on those who would not have purchased coverage without the tax credit incentive.

- Controlling for unintended negative effects of a refundable tax credit on the traditional employer-based health system. Kendall and Butler warn:

“A refundable tax credit builds on the existing tax system, which is already an important source of subsidy for health insurance.”

If a tax credit for individuals were worth much more than the job-based tax exclusion either in general or for a large group of people, then people would migrate away from job-based coverage, which might destabilize the system . . . Another potential problem is the migration of relatively healthier people away from job-based coverage if they found that their tax credits buy more in the individual market because of discounts for their younger age or better health.

- Targeting tax credits only on those who would not have purchased coverage without the tax incentive. For example, in 1996, Congress expanded the deductibility of health insurance premiums to the self-employed (initially limiting it to 25% of health insurance costs). Although the federal provision relates to a tax deduction, not a tax credit, the experience may be instructive. According to researcher Sherry Glied (1999), “The expansion helped the self-employed purchase coverage and placed them on more equal footing with those employed by others. The expansion also increased health insurance coverage for this group. Nonetheless, between 90 and 95 percent of those who benefited from the program had held insurance coverage prior to its introduction.”

Analysts at the Economic and Social Research Institute also list the following tax credit administration and implementation challenges (Meyer, Silow-Carroll, and Wicks, 2000):

- Matching the timing of subsidies to the timing of required premium payments, possibly through some sort of advance payment mechanism.
- Determining whether to make cash subsidy payments directly to taxpayers or to create a mechanism for directing payments to insurers or employers.
- Determining whether to implement insurance market reforms to ensure that coverage is accessible and affordable to those who are sick.
- How to verify whether employer coverage is available, if the subsidy is limited to those without access to employer-sponsored insurance.

- Defining and monitoring “qualified” insurance plans if the subsidy is limited to such plans.
- Determining whether subsidies should vary (as do health care costs) by such factors as age, health status and location.

Major Pros and Cons

Pros:

- Puts control of the tax credit and the choice plans to which it applies in the hands of families, not employers or the government (Butler and Kendall, 1999).
- Builds on existing tax collection and tax refund system. The tax system is already an important source of subsidy for health insurance coverage (Glied, 1999).
- Promotes individual choice of insurance plans rather than government or employer selection.
- By creating a uniform system of subsidies, eliminates the potential for second-class status that often accompanies programs directed at the poor alone (Glied, 1999).

- To the extent that a refundable tax credit simply reduces taxes, there is no need for annual appropriations to fund the program (Glied, 1999).

Cons:

- Studies show that tax strategies are generally not an effective mechanism for reaching low-income uninsured families, particularly if they do not have steady employment (Feder and Burke, 1999).
- Difficult to structure a tax subsidy so that most of the benefit does not go to the already insured (Gruber and Levitt, 2000).
- Even very generous tax credits that are linked with timely payment of credits to coincide with premium due dates would only reduce the number of uninsured by about 30% (Sheils, Hogan and Haught, 1999; Gruber and Levitt, 2000).
- The efficiency of tax policies, in terms of the cost per newly insured, falls as more of the uninsured are covered (Gruber and Levitt, 2000).

¹ For example, tax reform proposals have been put forward by the American Hospital Association, American Medical Association, Health Insurance Association of America, and U.S. Chamber of Commerce. Both Republicans and Democrats in Congress have also introduced tax reform bills to help the uninsured. For a comparison of recent major tax reform proposals, see “Health Coverage 2000: Meeting the Challenges of the Uninsured—Comparison of Proposals,” Robert Wood Johnson Foundation, 2000.

Option 5: Single Payer System

Brief Description

- The current system of financing care would be replaced by a wholly government-financed system.
- Everyone would automatically be covered by the system.
- The program could operate in one of two ways. Using a model based on the Federal Employees Health Benefit Plan or Medicare, the government would offer several different, comprehensive, private health insurance plans. Using a Canadian approach, the government would cover every person with the same package of benefits.

How the Program Would Work

The cornerstone of this approach is that the wide array of financing, insurance, eligibility determination, and subsidy mechanisms that characterize today's health care system would be replaced by a single system. All funds currently spent on coverage, whether public or private, would go into a pool that would finance the single payer system. All residents would be covered automatically. The pool could be administered directly by the government, a health care trust, or an authority. The new system would replace the current patchwork of health insurance programs for different populations (e.g., job-based insurance, the uninsurable health insurance program, Medicaid, Medicare, the Colorado

Indigent Care Program, CHP+, short-term insurance, etc.).

There are many different types of single payer systems (e.g., Medicare, the German insurance system, the British national health program, etc.). Here in the United States, two single payer approaches to universal health insurance have received widespread attention in recent years. The first is based on the Federal Employees Health Benefit Plan (FEHBP); the second is based on the Canadian health insurance system.

FEHBP. The Federal Employees Health Benefit Plan covers more than 9 million federal workers and retirees, including senators, representatives, and Congressional staff. In 1999, the program offered its enrollees 250 different health plans at a cost of \$18 billion (Congressional Research Service, 1997). In 1997, federal employees in Denver had a choice of 11 different FEHBP plans (e.g., CIGNA, Rocky Mountain HMO, Prudential, etc.). Choices included managed fee-for-service plans, health maintenance organizations, and a point-of-service product.

Under an FEHBP single payer approach, FEHBP would be expanded to include everyone. Each year, during an open enrollment period, people would be given a wide choice of private health insurance plans from which to select. They would indicate their selection on a form supplied by the private administrator of the FEHBP and then the government or private administrator would pay the carriers based on the number of people who signed up for each plan. Funds would come from a pool

created to finance universal coverage. (See financing discussion below.) If this model were to be adopted in Colorado only, the state could build on the Colorado state employee health benefit plan. This plan covers 61,000 people, including 29,000 employees and their dependents. Currently

“Those who prefer an FEHBP to a Canadian single payer system claim that FEHBP creates competition rather than relying on ‘bureaucratic price controls,’ and allows patients a choice of different health plans.”

state workers can choose from among nine HMO and two preferred provider organization plans, not all of which are available in all parts of the state. Those who prefer an FEHBP to a Canadian single payer system claim that FEHBP creates competition among private plans rather than relying on “bureaucratic price controls,” and allows patients a choice of different health plans (Serafini, 1998).

Canadian System. In Canada, provincial governments cover every patient with the same package of benefits. Everyone has a card entitling them to standard medical care, including mental health services, prescription drugs, long-term care, and equipment. Patients can visit the hospital or doctor of their choice. Boards in each province (either elected or appointed) oversee the plan, negotiate fee schedules, and set budgets. The private health insurance industry is not involved in the financing of care covered by each province’s comprehensive health plan. Total expenditures for health care are limited based on global lump-sum budgets.

Those who prefer a Canadian to an FEHBP single payer system claim that, in part because the Canadian system prohibits private insurance for services covered by the plan, it would save at least \$40 billion a year in insurance industry profits and overhead if implemented nationally in the United States. It is also argued that it would radically simplify paperwork for doctors and hospitals, save more than half of the billing and administrative costs of hospitals, and give patients the right to see any provider (Canham-Clyne, 1995).

Financing

There are a number of ways a single payer system could be financed. The key is that whatever funding sources are tapped, the

revenues would flow into a single pool to finance care for all. To the extent possible, the state would draw down all available federal matching funds, including for people who would otherwise qualify for Medicaid or CHP+. The state would also include in the pool the dollars currently spent on health insurance programs that are fully funded by the federal government and in which some Coloradans are currently enrolled, such as Medicare.

In Canada, the federal government funds about half of total national expenditures out of general income taxes. The provinces fund their programs with general income taxes or earmarked “premiums” (a type of tax) paid by individuals or paid through employers (*A Challenge for Colorado*, 1989).

In order to capture the estimated \$3.1 billion that Colorado employers and individuals currently spend each year on health insurance (Abel, 1998), the state might impose a health insurance payroll tax on employers and workers. Alternatively, the state could increase the income, corporate, sales, sin, or other taxes to pay for the program. It could also impose new taxes, such as a provider tax.

Some have argued that the total cost of a single payer system would be significantly less than any other approach to universal coverage. This is in large part because of the administrative efficiencies that accompany a single payer system. Examples of areas where there would be significantly reduced expenses include insurance sales and product development, medical underwriting, coordination of benefits, premium billing and collection, eligibility determination, and subscriber education and information. FEHBP’s administrative costs account for 0.1% of total benefit payments (Thorpe, Florence, and Gray, 1999). Various studies have estimated that a Canadian-style system could save the United States between 6.3%

and 11% in overall costs, solely as a result of administrative savings (Woolhandler and Himmelstein, 1991; U.S. General Accounting Office, 1991; Sheils, 1992).

According to Physicians for a National Health Plan, health care costs under a Canadian-style universal health plan do not need to increase over what they are now in order to cover everyone.

It would, however, produce a major shift in payment toward government and away from private insurers and out-of-pocket payments. Individuals and businesses would pay the same amount for health care, on average, but the payments would be in the form of taxes. The taxes contributing to [a single payer system] can be found for businesses, for instance, by adding up the amount spent currently by business for health care. This would approximately add up to a 9% tax increase for midsized and large employers. Applying the same approach to individuals, we find that taxes would need to be raised by an average of approximately 2% to finance the system. (Physicians for a National Health Plan, 1999)

Related Experience

Medicare is the single largest type of single payer program operating in the United States. As noted earlier, Canada (as well as a number of other countries) has extensive experience with a single payer system. In the early 1990s, Vermont considered but did not implement a single payer system. These experiences are briefly reviewed below.

- **Medicare** is the nation’s health insurance program for 34 million aged and 5 million disabled persons. Most of the dollars to pay for the program come from a 1.45% payroll tax paid by both employees and employers. The program is also financed with general

revenue and enrollee premiums. Medicare covers 1 in 7 Americans. The program's budget in 1999 was approximately \$212 billion and accounted for 12% of the federal budget. Medicare beneficiaries have a choice between the traditional, fee-for-service Medicare program or, where they are available, one or more HMO plans. Over the long-term, per capita Medicare spending has grown at the same rate as private insurance. More recently, however, the growth in total Medicare spending has slowed, increasing only 1.5% in 1998 and declining by a projected \$1 billion (0.5%) in 1999 (*Medicare at a Glance*, 1999).

The Medicare program has been criticized on a number of fronts. Providers have complained about inadequate reimbursement, delays in processing bills, and the burden of regulation. Some beneficiaries are upset about their inability to access certain providers, the lack of prescription drug coverage under the program, high out-of-pocket costs, and the withdrawal of some HMOs from the program. Others complain about fraud, abuse and waste. Despite these complaints, Medicare as a government-financed health insurance program appears to have broad public support. However, there have been discussions about modifying the program, for example to make it look more like FEHBP or to allow for medical savings accounts.

- **Canada.** The Canadian system pays for universal coverage of at least physician and hospital care, but many provinces cover long-term care, drugs, and other services as well. Hospital services are paid for out of global hospital budgets. Physician services are paid on the basis of fee schedules negotiated between the provinces and their medical societies.

Canada also controls costs by setting billing limits and restricting hospital resources. Health expenditures in Canada accounted for 8.9% of the gross domestic product in 1997, compared with a figure of 13.6% in the United States for 1995 (Canadian Institute, 1999; Employee Benefit Research Institute, 1997). As is true in the United States, Canada has had to deal with increasing cost pressures. There are occasional health worker strikes and reports of some physicians leaving Canada to practice in the United States. For certain types of procedures, patients report significant delays in getting appointments (National Center for Policy Analysis, 1994). However, there appears to be fairly widespread support in Canada for the health system and no move to substantially change it.

- **Vermont** enacted Act 160, the Vermont Universal Access Bill, in 1992. The legislation established the Vermont Health Care Authority and charged it with developing comprehensive plans for universal health insurance for Vermonters. It also directed the Authority to do the planning necessary for financing universal coverage. In 1994, the legislature rejected a proposal by the governor to adopt one of the Health Care Authority's universal access plans. The plan advanced by the governor included an employer mandate, income-based subsidies for individuals and employers, and an expansion of the Medicaid program. Under the plan, all moneys from employers, individuals, Medicaid, and Medicare would be pooled in a single fund for payment of premiums to managed care organizations, which would provide a defined set of services. The legislature was unwilling to raise the taxes necessary to finance any version of the plan. Attention had been

diverted to national health reform efforts, and Vermont policy makers had become overwhelmed with the complexity and difficulty (including federal barriers such as ERISA) of comprehensive health reform. In addition, the provider and insurance communities had become increasingly wary of the Health Care Authority's regulatory powers. In the wake of this failure, Vermont retrenched and pursued incremental health reforms. In 1997, much of Act 160, which had created the Health Care Authority, was repealed in a reorganization bill (Riley and Yondorf, 2000).

Significant Implementation Issues

- Under an FEHBP approach, dealing with the economic impact of eliminating the need for insurance agents, since policies would no longer be sold.
- Under a Canadian approach, dealing with the economic impact of replacing the private health insurance industry with a government-run system. It has been estimated that 500,000 people would lose their jobs as a result of a virtual elimination of the health insurance industry under a Canadian-style system (Physicians for a National Health Plan, 1999).
- Deciding how to deal with the fact that "sick" people from other states may move to Colorado to take advantage of the guaranteed, universal coverage system.
- Making the system workable for multi-state employers who currently can buy one or more traditional health insurance plans that cover all their employees, regardless of where those employees are located.
- Developing the huge infrastructure and depth of expertise necessary to negotiate prices with providers and set global health care budgets under a Canadian approach.
- Getting legislation passed in Congress to allow Colorado to fold the Medicaid, Medicare, veterans' health programs, and other federally financed health programs into Colorado's universal system.
- Developing a single benefit package that meets the wide array of Coloradans' health care needs. For example, would the coverage include long-term care, physical therapy for chronic conditions, expensive durable medical equipment, or ongoing home health care for those who need it?
- Responding to the fact that some employers may avoid locating in Colorado to avoid paying the taxes necessary to finance the system. It should be noted, however, that if the single payer system payroll tax is less than what an employer is paying now as a percentage of wages, Colorado could be a more attractive location.

Major Pros and Cons

Pros

- Guarantees that everyone has coverage all of the time.
- Involves the lowest administrative costs.
- Eliminates means-testing and other forms of eligibility determination.
- Under an FEHBP approach gives individuals a large choice of private plans; under a Canadian approach allows individuals to go to any provider.
- Eliminates cost shifting since everyone would be covered.
- Creates an incentive for government to focus on public health and preventive issues in order to minimize the acute and chronic care costs it will otherwise have to pay for.

Cons:

- Causes the greatest disruption to the current system of financing and organizing care. For example, thousands of insurance company employees and insurance agents would become unemployed.
- Difficult for Colorado to unilaterally implement a single payer system.
- Requires huge new government bureaucracy that would replace private, marketplace-based system.
- Requires the imposition of substantial new taxes to replace existing employer and employee direct payments for coverage.

Summary of Major Features of Five Approaches to Achieving Health Insurance Coverage for All Coloradans

Option and Related Experience	Description	Significant Implementation Issues	Major Pros and Cons	
			Pros	Cons
1. Expand government-sponsored health insurance programs				
<ul style="list-style-type: none"> • Oregon Health Plan • MinnesotaCare • TennCare • RiteCare 	<ul style="list-style-type: none"> • Existing programs for low-income uninsured persons (e.g., Medicaid, Child Health Plan, etc.) would be expanded. The income thresholds for these programs would be raised, perhaps to 250% of the federal poverty level, and the asset test would be loosened or abolished. • A premium subsidy program would be offered to low-income workers so they can afford coverage offered at the work place. 	<ul style="list-style-type: none"> • Getting people who are not used to using an insurance model to enroll. • Dealing with the welfare stigma of government-sponsored programs. • Making the eligibility determination process more user-friendly. • Greatly expanding existing administrative systems to administer subsidies. • Developing extensive outreach and enrollment systems. • Controlling crowd out among employees and among employers. • Dealing with adverse selection. 	<ul style="list-style-type: none"> • Builds on the administrative infrastructure of existing programs. • Experience in other states suggests that aggressive programs to expand Medicaid coverage and include whole families can make a significant dent in the number of uninsured persons under 200% FPL. • Involves no mandates. • Provides more accurate assessment of financial need than tax-based approaches, in part because assets as well as income can be taken into account. • Allows program benefits to be tailored to the particular populations the programs serve. 	<ul style="list-style-type: none"> • Continues administratively expensive and inefficient “patchwork” approach that requires means testing and eligibility determination. • From experience in other states, we know that 5-11% of the population still won’t be covered. • Raises crowd out issue, wherein some employers and some low-income employees may drop existing coverage in order to take advantage of the expanded government-paid program. • Compared to some other options, enrollees may have a more limited choice of plans or providers.

Five Approaches to Achieving Health Insurance Coverage for All Coloradans

Option and Related Experience	Description	Significant Implementation Issues	Major Pros and Cons	
			Pros	Cons
2. Require “proof of coverage” and use a Safety Net Plan				
<ul style="list-style-type: none"> Hillsborough County, Florida, Health Care Plan College student proof of health coverage requirements Mandatory auto insurance 	<ul style="list-style-type: none"> Everyone would be required to show they have health insurance coverage. Coverage could be provided by one’s employer, purchased individually, or for eligible persons, obtained through Medicaid, Medicare, or CHP+. Families with low incomes would be eligible for premium subsidies on a sliding scale basis. Those who could not provide proof of insurance would be automatically enrolled in a government-sponsored Safety Net Plan and would be billed for their coverage (perhaps through the income tax system) on a sliding fee scale. 	<ul style="list-style-type: none"> Establishing a sophisticated system to track who has coverage and who is in Safety Net Plan. Establishing benefit standards for qualifying individual plans. Making sure people pay for their coverage. Developing systems to estimate appropriate payments to Safety Net Plan. Controlling employer crowd out. Determining insurance market rules to ensure a level playing field among different types of insurance products to control adverse selection. Controlling adverse selection in the Safety Net Plan. 	<ul style="list-style-type: none"> Ensures that all Coloradans with below-average incomes would be covered. Helps traditional safety net providers who care for the poor and medically underserved, by guaranteeing payment for services delivered. Arguably places responsibility for coverage where it should be—on the individual. 	<ul style="list-style-type: none"> Involves setting up a whole new government bureaucracy to track who is and isn’t privately covered, and to bill people. Difficult to enforce. Determining rates for Safety Net Plan coverage may be complicated and create perverse incentives depending on whether age, experience, and/or community rating is used.

Option and Related Experience	Description	Significant Implementation Issues	Major Pros and Cons	
			Pros	Cons
3. Enact an employer mandate				
<ul style="list-style-type: none"> Hawaii employer mandate Laws passed but not implemented in Massachusetts, Minnesota, Oregon, and Massachusetts 	<ul style="list-style-type: none"> All employers would be required to contribute to the cost of coverage for their employees in one of two ways. Employers could directly offer coverage at the work place (“play”), or they could pay a fee to the government instead (“pay”). Employees whose employer selected the “pay” option would be offered a choice of plans through a privately run purchasing cooperative funded with the “pay” fees. Alternatively, they could be issued vouchers to purchase coverage. Low-income, unemployed persons would get government subsidized coverage either through the purchasing cooperative or by expanding existing government programs, such as Medicaid. 	<ul style="list-style-type: none"> Obtaining an ERISA exemption. Making sure employers don’t leave the state to avoid the mandate. Deciding how to treat out-of-state employers with in-state employees. Developing administrative systems to enforce play-or-pay system. Dealing with employer attempts to circumvent law through use of part-time, contract employees. Controlling adverse selection under “pay” option. Designing targeted subsidies to employers who cannot afford the mandate. Establishing minimum benefits for qualifying employer plans. 	<ul style="list-style-type: none"> Is based on an existing model in Hawaii, which has had an employer mandate for 25 years. Builds on current employer-sponsored coverage model that is currently the single major source of coverage for Coloradians today. Deals with the issue of crowd-out, since employers would have to provide coverage and employees would have to sign up for coverage. Preserves market place competition. 	<ul style="list-style-type: none"> Employers with a large proportion of low-income employees would be hit the hardest. Still requires a patchwork of government programs to cover the unemployed and probably dependents of the employed. Requires setting up a new bureaucracy to cover employees whose employers “pay” instead of “play.” Raises labor costs for some employers who may respond by reducing wages or eliminating jobs.

Five Approaches to Achieving Health Insurance Coverage for All Coloradians

Option and Related Experience	Description	Significant Implementation Issues	Major Pros and Cons	
			Pros	Cons
4. Provide refundable tax credits for the purchase of health insurance				
<ul style="list-style-type: none"> • North Carolina, Maine and Massachusetts individual and employer tax credits. • Federal health insurance tax credit and deduction for coverage purchased by the self-employed. 	<ul style="list-style-type: none"> • Uninsured workers and their families would be eligible for a refundable tax credit to cover a portion of their cost of purchasing health insurance. • The tax credit would be refundable to benefit the roughly one-third of uninsured persons who have no tax liability. The credit could be adjusted to provide a greater benefit for lower income families. 	<ul style="list-style-type: none"> • Structuring a tax credit that is both fair and workable. • Providing a tax credit that is large enough to encourage the uninsured to get coverage but not so costly as to be infeasible. • Controlling unintended negative effects on traditional employer-based insurance system. • Targeting credits on the uninsured. • Matching timing of subsidies to required premium payments. • Determining if subsidies go to tax-payers, insurers or employers. • Establishing minimum benefits for qualifying plans. • Determining if subsidies should vary by age, health status, location. 	<ul style="list-style-type: none"> • Puts control of the tax credit and the choice of plans to which it applies in the hands of families, not employers or the government. • Builds on existing tax collection and tax refund system. The tax system is already an important source of subsidy for health insurance coverage. • Promotes individual choice of insurance plans rather than government or employer selection. • By creating a uniform system of subsidies, eliminates the potential for second-class status that often accompanies program directed at the poor alone. • To the extent that a refundable tax credit simply reduces taxes, there is no need for annual appropriations to fund the program. 	<ul style="list-style-type: none"> • Studies show that tax strategies are generally not an effective mechanism for reaching low-income uninsured families, particularly if they do not have steady employment. • Difficult to structure a tax subsidy so that most of the benefit doesn't go to the already insured. • Even very generous tax credits could not cover more than a sizable minority (30% at most) of the uninsured population. • The efficiency of tax policies, in terms of the cost per newly insured, falls as more of the uninsured are covered.

Option and Related Experience	Description	Significant Implementation Issues	Major Pros and Cons	
			Pros	Cons
5. Establish a single payer system				
<ul style="list-style-type: none"> • Medicare • Federal Employees Health Benefit Plan • Canadian health care system • Proposal introduced but not enacted in Vermont 	<ul style="list-style-type: none"> • The current system of financing care would be replaced by a wholly government-financed system. • Everyone would be automatically covered by the system. • The program could operate in one of two ways. Using a model based on the Federal Employees Health Benefit Plan (FEHBP) or Medicare, the government would offer several different, comprehensive, private health insurance plans. Using a Canadian approach, the government would cover every person with the same package of benefits. 	<ul style="list-style-type: none"> • Under FEHBP approach, dealing with economic impact of eliminating health insurance agent jobs. • Under Canadian approach, dealing with economic impact of lost health insurance industry jobs, and developing a benefit package that meets the needs of all Coloradans. • Stopping sick people from moving to Colorado. • Making the system workable for multi-state employers. • Developing huge infrastructure to negotiate prices with providers and set global budgets. • Dealing with the fact that some employers may avoid locating in Colorado to avoid paying taxes necessary to finance the system. 	<ul style="list-style-type: none"> • Guarantees that everyone has coverage all of the time. • Involves the lowest administrative costs. • Eliminates means-testing and other forms of eligibility determination. • Under an FEHBP approach, gives individuals a wide choice of private plans; under a Canadian approach, allows individuals to go to any provider. • Eliminates cost shifting. • Creates an incentive for government to focus on public health and preventive issues in order to minimize the acute and chronic care costs it will otherwise have to pay for. 	<ul style="list-style-type: none"> • Causes the greatest disruption to the current system of financing and organizing care. For example, thousands of insurance company employees and insurance agents would become unemployed. • Difficult for Colorado to unilaterally implement a single payer system. • Requires huge new government bureaucracy that would replace private, marketplace-based system. • Requires the imposition of substantial new taxes to replace existing employer and employee direct payments for coverage.

Five Approaches to Achieving Health Insurance Coverage for All Coloradans

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Glossary

Adverse selection—A tendency for utilization of health services in a population group to be higher than average. From an insurance perspective, adverse selection occurs when persons with poorer-than-average health status apply for, or continue, insurance coverage to a greater extent than do persons with average or better health expectations.

Children’s health insurance plan—In Colorado, a subsidized health insurance program for children in families earning under 185% FPL. In Colorado, the program is called **Child Health Plan Plus (CHP+)**. The federal government provides two-thirds of the program’s budget and the state funds the remaining third.

Colorado Uninsurable Health Insurance Program (CUHIP)—A program that provides comprehensive health insurance to Coloradans who are denied insurance by private individual insurers because of pre-existing conditions. Currently CUHIP charges about 25% more for coverage than standard individual health insurance rates for people without pre-existing conditions. However, even with this surcharge, premiums do not cover the full cost of covering the uninsurable people enrolled in the program. The state appropriates funds to make up the difference.

Copayment—A form of cost sharing in which a fixed amount of money is paid by the insured for each health care service provided (e.g., \$15 per medical office visit).

Cost shifting—The condition that occurs when health care providers are not reimbursed or not fully reimbursed for providing health care so charges to those who pay must be increased. Typically occurs from providing health care to the medically indigent.

Crowd out—The substitution of private for public dollars. When crowd out occurs, it means that rather than covering the uninsured, a publicly supported insurance program is providing coverage to those who already had access to it. An example would be if an individual or employer dropped private coverage because less expensive, subsidized coverage was available through a government program.

Employee Retirement Income Security Act (ERISA)—A federal act, passed in 1974, which prevents states from regulating employer health plans but allows them to regulate the terms and conditions of health insurance sold in the state. Thus, for example, under ERISA a state cannot require employers to provide health care coverage, but can require that all health insurance policies sold in the state include specific benefits. However if an employer self-insures, state health insurance mandates may not be applied to the self-insured plan.

Essential community provider—A health care provider (e.g., clinic, community health center, hospital) that has historically served uninsured low-income patients, waives charges or charges for services on a sliding fee scale, and does not restrict access to care because of a patient’s financial limitations.

Experience rating—Charging higher rates or lower than standard rates for a group, based on a documented history of making high or low health insurance claims.

Federal poverty level (FPL)—Poverty guidelines based on family income that are established by the federal Department of Health and Human Services and published annually. The guidelines are used to determine individuals’ and families’ eligibility for various federal and non-

federal programs. The guidelines vary based on family size. Currently the federal poverty level is:

<u>Family Size</u>	<u>Federal Poverty Level Annual Income</u>
1 person	\$8,050
2 persons	\$10,850
3 persons	\$13,650
4 person	\$16,450
5 or more persons	Add \$2,800 for each additional person

Health insurance purchasing cooperatives—Public or private organizations that secure health insurance coverage for all members. The goal of these organizations is to consolidate purchasing responsibilities to obtain greater bargaining clout with health insurers, plans and providers, and to reduce the administrative costs of buying, selling and managing insurance policies.

Medicaid—A government-sponsored program that provides medical benefits for certain low-income persons in need of medical care. Medicaid covers families with children, pregnant women, the elderly, and persons with disabilities whose incomes do not exceed specified levels. The program is administered by the states and financed jointly by the federal and state governments.

Medical savings account (MSA)—An account in which individuals can accumulate contributions to pay for medical care or insurance. Under certain circumstances, contributions to these accounts are tax deductible.

Medicare—A federal program for people age 65 and over, for persons eligible for social security payments for two years or longer, and for certain workers and their dependents who need kidney transplantation or dialysis. Moneys from payroll taxes and premiums from beneficiaries are

deposited in special trust funds for use in meeting expenses incurred by those insured under Medicare.

Provider tax—A tax that is paid by a health care provider. Examples include a hospital bed tax, a surcharge on medical bills, and a gross revenues tax on physicians, hospitals, surgical centers, and wholesale drug distributors.

Refundable tax credit—This is a type of tax credit (see definition below) whereby if the value of the credit exceeds a person’s tax liability, he can apply for a refund from the government for the difference. For example, if someone earns \$10,000 and faces a tax rate of 10%, he would normally owe \$1,000 in taxes. However, if he is allowed a 100% refundable tax credit for the cost of a \$2,000 insurance policy, then his tax liability would be reduced by \$1,000 to \$0, and the government would owe him a \$1,000 “refund.” The refund would be for the portion of the refundable tax credit the individual was unable to take because he owed no more taxes.

Safety net provider—A provider (e.g., county hospital, health clinic, migrant health center, etc.) that, as part of its mission and/or operations, provides care for low-income and uninsured patients. Safety net providers include those that serve the low-income and uninsured based on their ability to pay and do not restrict access to services because of clients’ financial limitations.

Tax credit—Under a tax credit, the amount of taxes owed to the government is reduced by the value of the credit. For example, if someone earns \$30,000 and faces a tax rate of 20%, he would normally owe \$6,000 in taxes. However, if he is allowed a 100% tax credit for the cost of a \$2,000 insurance policy, then his taxes are reduced by \$2,000 to \$4,000.

Tax deduction—Under a tax deduction, the amount of income to which taxes apply is reduced by the amount of the deduction. For example, if someone earns \$30,000 and faces a tax rate of 20%, he would normally owe \$6,000 in taxes. However, if he is allowed a 100% deduction for the cost of a \$2,000 insurance policy, then his taxable income is reduced by \$2,000 to \$28,000 and the amount of taxes he owes declines to \$5,600.

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Notes:

COLO R A D O

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