

# Targeting Subsidies: Employers versus Individuals

## Timely Analysis of Immediate Health Policy Issues

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### Individual vs. Employer Subsidies

Recent congressional proposals and reforms advocated by the presidential candidates have renewed the debate about whether the problem of the uninsured is best addressed through subsidies to employers or to individuals. The large number of the uninsured working for small businesses provides some political support for subsidizing these firms in an effort to increase coverage. However, in this paper, we argue that it is more efficient to provide subsidies directly to individuals and families than to employers. Subsidies directed specifically to the low-income population will lead to less displacement of private spending because that population has low rates of private coverage. In addition, subsidies based on income treat those in similar economic circumstances the same, eliminating equity concerns associated with treating low-income people differently based on their place of employment.

Because employer subsidies are provided based on employer characteristics and the limited information that employers have about their workers (and because workers within a firm can vary significantly), subsidies are much more difficult to target effectively to individuals with the greatest needs. Plus, employer subsidies do not eliminate the need for individual subsidies. Many employers will not voluntarily begin to offer coverage and not all the uninsured are attached to the labor force, so low-income individuals will continue to need additional financial support in order to afford coverage.

### Overview – The Public Policy Debate

Dramatic and persistent coverage disparities between workers in small and large firms and between low- and high-income workers have led to years of debate over whether the issue of uninsured Americans would be best addressed by subsidizing small employers or by subsidizing low-income individuals themselves. This brief delineates the important advantages of subsidizing individuals and families, as opposed to employers, in achieving the goal of reducing the number of uninsured by providing targeted financial assistance to those most in need. Individual subsidies to the low-income population lead to less displacement of

current private spending and eliminate the inequities that result from subsidizing workers differently as a function of their workplace choices. However, individual subsidy programs must take into account and plan for potential declines in the likelihood that individuals will obtain their health insurance coverage through employment settings.

The introduction of bipartisan Senate legislation earlier this year has brought this debate back into sharp focus. The Senate bill, the Small Business Health Options Program (SHOP) Act of 2008, introduced by Senators Richard Durbin (DE), Olympia Snowe (ME), Blanche Lincoln (AR), and Norm Coleman (MN), would provide annual tax credits to the self-employed and to employers of up to 100 workers to offset the cost of

providing coverage to their workers.<sup>1</sup> In addition, it would create a health insurance purchasing pool through which small employers and the self-employed could purchase affordable health insurance. The central issue is whether this legislation would make for sound policy or whether resources would be better targeted to low-income individuals, those most likely to have problems affording coverage.

### Coverage Disparities by Firm Size and Income

While employer-sponsored insurance (ESI) is the most common form of health insurance coverage in the United States, the rates of worker coverage vary dramatically by size of employer and by worker income. Fully 33 percent of workers in small firms (those with fewer than 25 employees) are uninsured, compared with 13 percent of workers in the largest firms (1,000 workers or more) (Table 1, right-most column, bottom section). Fifty percent of poor workers are uninsured, as are 40 percent of near-poor workers (those with incomes between 100 and 200 percent of the federal poverty level), compared with only 5 percent of workers with incomes at or above 500 percent of the poverty level (Table 1, right-most column, top section).

In addition to having the highest rates of uninsurance, workers in small firms account for a large share of total uninsured workers. Thirty-five percent of uninsured workers are employed in firms of fewer than 25 workers, and 49 percent work for firms of fewer than 100 (Table 1, column 4, bottom section).

**Table 1. Characteristics of Uninsured Workers, 2006**

	Workers (millions)	Percent of Workers	Uninsured (millions)	Percent of Uninsured	Uninsured Rate
<b>Total Workers<sup>k</sup></b>	<b>147.1</b>	<b>100.0%</b>	<b>27.6</b>	<b>100.0%</b>	<b>18.8%</b>
<b>■ Federal Poverty Level</b>					
<100%	12.8	8.7%	6.4	23.1%	49.8%
100–199%	23.3	15.8%	9.4	33.9%	40.2%
200–299%	24.3	16.5%	5.5	19.8%	22.5%
300–499%	37.6	25.6%	4.0	14.3%	10.5%
500%+	49.0	33.3%	2.4	8.8%	5.0%
<b>■ Business Size (# Workers)</b>					
Self-employed	13.5	9.2%	3.7	13.5%	27.6%
<25	29.6	20.1%	9.8	35.4%	33.0%
25–99	17.8	12.1%	3.7	13.6%	21.1%
100–999	24.0	16.3%	3.7	13.5%	15.5%
1000+	41.0	27.9%	5.3	19.3%	13.0%
Public Sector	21.2	14.4%	1.3	4.8%	6.2%

Source: Urban Institute tabulations of the 2007 Urban Institute tabulations of the 2007 Annual Social and Economic Supplement to the Current Population Survey.

**Table 2. Employer Offer and Take-Up among Employees, 2005**

	Employees (millions)	Offer	Take-Up	Own ESI	Any ESI
<b>Total Employees</b>	<b>113.6</b>	<b>78.6%</b>	<b>83.2%</b>	<b>65.4%</b>	<b>77.4%</b>
<b>■ Federal Poverty Level</b>					
<100%	7.7	39.8%	63.5%	25.2%	30.4%
100–199%	17.1	60.3%	78.2%	47.1%	51.7%
200–299%	19.0	76.9%	86.1%	66.2%	73.9%
300–499%	31.7	84.9%	86.0%	73.0%	86.2%
500%+	38.0	90.3%	83.1%	75.1%	93.1%
<b>■ Firm Size</b>					
Under 10	14.5	45.7%	77.9%	35.6%	52.6%
10–24	10.9	62.8%	76.8%	48.2%	63.1%
25–99	15.6	78.1%	79.3%	61.9%	74.9%
100+	72.6	87.6%	85.2%	74.7%	85.1%

Source: Urban Institute tabulations of the 2007 Urban Institute tabulations of the 2007 Annual Social and Economic Supplement to the Current Population Survey.

Note: Wage group estimates exclude cases with missing wage values; thus, the total number of employees reported in the wage group category is slightly lower than the total number of employees overall. A worker is deemed to have an employer offer of health insurance if their employer sponsors coverage and the worker is eligible to enroll in it.

The source of these differences seems largely attributable to differences in rates of offering health insurance across firm sizes. In 2005, only 46 percent of workers in firms of fewer than 10 workers were offered and were eligible to enroll in an ESI plan at their workplace, compared with 88 percent of workers in firms of 100 or more employees (Table 2, column 2, bottom section). As a

consequence, some have concluded that subsidizing small firms in order to increase the rate at which they offer health insurance to their workers is the logical approach to reducing the number of uninsured.

Others counter with concerns about whether employer subsidies are sufficiently well targeted to the

uninsured, whether they would have the desired effect on coverage, and whether it makes sense to induce more small employers to provide insurance, given their relative inefficiency as purchasers. Skeptics of the employer subsidization approach often suggest targeting subsidies to low-income workers specifically, while providing

non-employment-related sources for them to obtain coverage using those subsidies. A focus on income differences as opposed to employer-size differences is supported by the fact that rates of having and being eligible for an ESI offer also vary dramatically by income, ranging from 40 percent of workers with family incomes below the poverty level to 90 percent for workers with family income of at least 500 percent of the federal poverty level (Table 2, column 2, top section).

In this paper, we discuss the advantages and disadvantages of employer versus individual subsidization in their ability to target financial assistance to those most in need of coverage. We start by explaining why small firms are less likely to offer ESI than are large firms, and why offers are more likely to be made in firms with higher-income workers. We use this background to describe the expected relative effectiveness of expanding coverage via employer versus individual-level subsidies. We then consider specific design and policy issues associated with employer and individual subsidies.

## Why ESI Offer Rates Vary by Firm Size and Worker Incomes<sup>2</sup>

Employers offer health insurance as a tool for attracting the workers they want to hire. In competitive labor markets, such a benefit may be critical to hiring the most qualified workers. In less competitive labor markets, or in labor markets where health insurance is not as highly valued by the types of workers being hired, employers are less likely to offer health insurance. An employer's decision to offer coverage is a function of the price of insurance faced by the employer and the workers' willingness to trade wages for health insurance. The former varies with employer size (larger firms can purchase the same benefits at lower prices than can smaller firms) and the latter varies with worker income (lower-income workers tend to prefer additional wages to employer health insurance contributions).

Unlike wages, employer payments toward workers' health insurance are not taxed. Such a tax advantage is not generally available when an individual purchases health insurance directly, via the nongroup insurance market. So, there is a substantial financial incentive for workers to take part of their compensation as health insurance. Given that marginal tax rates increase with taxable income, this tax exclusion is of much greater value to those with higher incomes than to those with lower incomes. In addition, making a trade-off of wages for health insurance is a more difficult choice for those with less disposable income. Even for those lower-income workers who would prefer to make such a trade-off, the minimum wage limits the extent to which employer health insurance costs can actually be passed back to these workers. These realities combine to explain why lower-income workers would be less likely to seek out jobs with insurance offers and why employers with higher percentages of lower-income workers would be less likely to make such offers.

While smaller firms tend to have lower average-wage workers than do their larger firm counterparts, these wage differentials do not wholly explain the differences between small and large firms' likelihood of offering insurance. Additional factors relate to the pricing of health insurance. First, insurers apply higher administrative loads to insurance purchased by small firms than to insurance purchased by large firms. This is because a significant share of insurers' administrative costs is fixed (i.e., they do not vary by the size of the group); consequently, those administrative costs will be a larger percentage of benefits when spread over a small group than over a large group.<sup>3</sup> Second, the variance of expected health care costs decreases as group size increases. In other words, a risk-pooling economy of scale accrues only to groups, and to greater degrees in larger groups. This price disadvantage for smaller groups can be substantial.<sup>4</sup> Therefore, it is not surprising that small firms are significantly less likely to purchase insurance on behalf of their workers than are large firms.

In sum, while increasing the offer rate among small employers might appear an obvious strategy for increasing insurance coverage, doing so means pressing for an expansion of coverage by purchasers that are relatively inefficient at buying health insurance. Because small employer purchasers face higher prices for the same benefits and tend to face significant barriers related to having a lower-wage workforce, inducing a substantial share of currently non-offering small employers to provide ESI absent a mandate would be difficult.

## Employer Subsidies

### Background

The SHOP Act represents one approach to structuring employer subsidies, but employer subsidies can be structured in various ways. Subsidies to support the purchase of insurance coverage can be provided at different levels to employers of different sizes, they can be provided to employers based upon the number or share of low-wage workers that they have, they can be offered to employers with an average employee wage below a specified threshold, or they can be offered according to some combination of firm size and wage rate rules (e.g., firms with fewer than 25 workers and more than 50 percent of workers earning less than \$10 an hour). The subsidy levels can be set at an absolute dollar level or a share of premium (perhaps subject to an upper limit), and they can vary by whether the worker purchases single or family coverage, by the wage of the workers, or by the price of available insurance in the area.

Subsidies can also be available only conditional on certain levels of employer and/or worker contributions toward insurance.<sup>5</sup> Larger subsidies that make family health insurance affordable are more likely to increase employer offer rates, although they will also be more costly to the government that is financing them.

### The Issues

***Employer Subsidies Target Employer Characteristics, Not Worker Characteristics.*** Even given the diversity of design options, it is difficult to use employer

**Table 3. Characteristics of Uninsured Workers, 18–64, Income Distribution by Firm Size, 2006**

	Workers (millions)	Percent of Workers	Uninsured (millions)	Percent of Uninsured	Uninsured Rate
<b>Total Workers<sup>k</sup></b>	<b>147.1</b>	<b>100.0%</b>	<b>27.6</b>	<b>100.0%</b>	<b>18.8%</b>
<b>■ Family Income Relative to the FPL Self-Employed Workers</b>					
<100%	1.2	8.6%	0.7	18.4%	57.2%
100–199%	1.8	12.4%	0.9	23.2%	50.2%
200–299%	2.0	13.9%	0.7	19.1%	36.9%
300–499%	3.3	23.3%	0.8	20.5%	23.6%
500%+	5.9	41.8%	0.7	18.8%	12.1%
<b>■ Family Income Relative to the FPL Firm Size of &lt;25</b>					
<100%	4.0	13.4%	2.4	23.9%	58.1%
100–199%	6.6	22.0%	3.5	35.4%	52.6%
200–299%	5.6	18.6%	2.0	20.5%	36.0%
300–499%	7.1	23.4%	1.3	13.5%	18.8%
500%+	6.8	22.5%	0.7	6.7%	9.7%
<b>■ Family Income Relative to the FPL Firm Size of 25–99</b>					
<100%	1.6	8.7%	0.8	20.9%	49.3%
100–199%	3.5	18.9%	1.5	39.1%	42.6%
200–299%	3.3	17.9%	0.8	20.1%	23.0%
300–499%	4.9	26.5%	0.5	13.7%	10.6%
500%+	5.2	28.1%	0.2	6.2%	4.5%
<b>■ Family Income Relative to the FPL Firm Size of 100–999</b>					
<100%	1.9	6.7%	0.9	27.1%	45.7%
100–199%	4.0	14.2%	1.4	35.0%	34.9%
200–299%	4.9	17.6%	0.8	21.1%	17.0%
300–499%	7.6	27.3%	0.6	14.2%	7.4%
500%+	9.5	34.1%	0.3	8.0%	3.3%
<b>■ Family Income Relative to the FPL Firm Size of 1,000+</b>					
<100%	4.1	7.2%	1.7	27.1%	41.5%
100–199%	7.4	13.2%	2.1	34.2%	28.5%
200–299%	8.5	15.1%	1.1	18.2%	13.3%
300–499%	14.7	26.2%	0.8	12.4%	5.2%
500%+	21.5	38.3%	0.5	8.1%	2.3%

Source: Urban Institute tabulations of the 2007 Annual Social and Economic Supplement to the Current Population Survey.

Note: Family is defined as the health insurance unit, which includes spouses and dependent children.

subsidies as a mechanism for efficiently targeting assistance to the uninsured. This is largely the result of the fact that employers generally hire a mix of low-wage and high-wage workers, even within small firms and even within firms with low average wages. Plus, low wage

is not necessarily synonymous with low income.

The low-income uninsured are spread across firm sizes and are employed in firms with higher-income workers as well as with insured workers. As a consequence, offering subsidies to

particular types of firms will often direct financial assistance to some of those in the population that the policy intends to target as well as to some of those that it does not.

While small firm workers are more likely to be low income than larger firm

workers, as Table 3 (column 2) shows, only 35 percent of small firm (fewer than 25 employees) workers have family incomes below 200 percent of the federal poverty level (another 19 percent have incomes between 200 and 300 percent of the poverty level) and only 33 percent of small firm workers are uninsured (Table 1, last column). Further, employers have information on their workers' wages, but not on their workers' family incomes. Since low-wage workers are not always in low-income families (i.e., a low-wage worker may have a highly paid spouse), targeting subsidies to low-wage workers can be problematic. Consequently, subsidizing an employer with a low average wage or even providing subsidies based upon the number of low-wage workers in a firm will mean subsidizing some high-income workers as well.

In addition, subsidies targeted to small firms would miss many low-wage workers employed in larger firms who do not have an offer of employer coverage. Forty-three percent of low-income uninsured workers are employed in firms of 100 or more workers.<sup>6</sup> Research by Ferry and colleagues clearly shows that subsidies directed at individuals by income level are much more effectively targeted to the uninsured than are subsidies directed at those with low wages or in small firms.<sup>7</sup>

***Even Large Price Reductions will Not Necessarily Change Employer Offer Decisions.*** Employer subsidies of the levels being discussed are not likely to significantly change the rate at which small employers offer health insurance. Reschovsky and Hadley have estimated an elasticity of employer offer with respect to price of about 0.5 (i.e., a 10 percent reduction in premiums would result in a 5 percent increase in the share of firms offering coverage).<sup>8</sup> Other researchers have estimated different elasticities, but they are generally in this stated range.<sup>9</sup> Elasticities in the range of 0.5 would increase employer offer rates marginally. For example, 41 percent of small firm (fewer than 25 workers) establishments offered health insurance to their workers in 2005. A 30 percent reduction in

premiums would increase that employer offer rate by 15 percent, moving it from 41 to 47 percent, still less than half of the offer rate of establishments in firms of 50 or more workers. The effect would be even smaller if not all workers benefited from the employer subsidy. For example, if subsidies were only available to low-wage workers, the program might only benefit a small share of a given employer's workforce, thus not sufficient to change the employer's decision to offer health care coverage. The increase in employer administrative burden could also be a deterrent to changing the offer decision.

***Employer Subsidies May Displace Significant Amounts of Private Spending.*** Employer subsidies also have the potential to displace a significant amount of private spending. The probability of having ESI increases with income. Unless subsidies are specifically targeted to low-income workers, it would be hard to avoid giving subsidies to many of those who currently have coverage. Thus, if employer subsidies do little to result in more firms offering coverage, the principal impact would be to help employers who are now offering and contributing to their workers' coverage. Only some of these new subsidies will go to those without coverage. It is extremely difficult to exclude those employers previously covering some of or all their workers from subsidization. Attempting to do so creates inequities, with employers in similar financial situations treated differently, disadvantaging those employers and workers who have made potentially difficult financial trade-offs in order to provide insurance and to stay insured. Such rules might also provide incentives for those currently providing coverage to drop it, in order to become eligible for financial assistance.

***Employer Subsidies Are Unlikely to Increase Take-Up of Employer Offers.*** Approximately 30 percent of uninsured workers currently have access to an offer of employer-sponsored insurance (either through their own employer or through that of a spouse or parent) but do not take it up.<sup>10</sup> Subsidies directed to employers will not directly increase the take-up rate of these workers. The

exception would be if employers who previously provided coverage use the new subsidy to lower the workers' share of the premium instead of using it to offset the employers' own contribution.<sup>11</sup> Roughly half of the recent decline in ESI among poor workers is attributable to declines in take-up of offered coverage; take-up declines account for about 27 percent of recent declines in ESI among workers overall.<sup>12</sup> Subsidies to help offset employee costs would be required to stem the declines in take-up among low-income workers.

***Continuing Need for Individual/Family Subsidies and Guaranteed Sources for Purchasing Coverage.*** Because employer subsidies alone will not induce all employers to voluntarily offer coverage to their workers, and because some of the uninsured are not connected to the workforce at all, significant expansions of coverage will require that the government also provide individual/family subsidies and a source for purchasing coverage directly to individuals. Such subsidies could be used to purchase coverage through existing insurance options (e.g., state or federal employee plans, the State Children's Health Insurance Program (SCHIP)), or through a new purchasing pool created for this purpose (for example, one like Massachusetts' Commonwealth Connector).<sup>13</sup>

Finally, any policy attempting to build on the current system needs to recognize that small employers are not efficient purchasers of coverage. Not only are the administrative costs high, but small employers are also not able to bargain effectively with insurance companies over premiums. Providing incentives for small employers to purchase coverage on their own is unlikely to be an efficient solution to low coverage rates. The better approach is to develop options for small groups to purchase coverage either through existing purchasing entities or through new ones, as described above.

## Individual and Family Subsidies

### Background

Individual and family-level subsidies can be provided on an income-related basis

(e.g., with subsidies highest for the low income and decreasing as income goes up) or at a flat level regardless of income (e.g., a fixed refundable tax credit). Individual and family subsidies can be provided directly to individuals in the form of vouchers for the purchase of coverage, can be paid directly to the public or private insurer with which the individual enrolls, or can be structured as refundable tax credits that reimburse individuals for all or a part of the insurance costs they incurred in the prior year.

The simplest form of individual subsidy is one in which a flat dollar amount is provided to those purchasing coverage. The amount may or may not vary with income, but it does not vary with the amount that the individual actually spends on coverage. Alternatively, individual subsidies could be set as a percentage of the premium, with an upper limit on the allowed premium. The percentage of the premium covered could decrease with increasing income. Another option is to structure the subsidy schedule as a cap on individual and family insurance payments at a percentage of income. The percentage of income cap could increase with increasing income. That is, the government subsidies would cover health insurance costs exceeding a specified percentage of a family's income. Again, a maximum allowed premium could be set as well.

The larger the subsidies provided, the greater voluntary participation will be and the more comprehensive the coverage individuals will be able to afford in terms of covered services, broadness of provider networks, and out-of-pocket cost protection. Of course higher subsidies also bring greater government costs and increased need for new sources of revenue and greater redistribution of financing responsibilities.

### The Issues

#### *Income-Related Individual/Family Subsidies Are Most Target Efficient.*

Because the likelihood of being uninsured falls dramatically as income rises (from 50 percent of poor workers to 5 percent of workers at or above 500 percent of the poverty level, as

shown in Table 1), providing assistance that increases as income falls would provide the greatest support to those least likely to have insurance without a subsidy. In addition, Ferry and colleagues have shown that providing subsidies specifically to low-income individuals and families is a more target efficient mechanism for subsidizing the uninsured and results in less displacement of existing private spending than providing subsidies to small firms or low-wage workers.<sup>14</sup> This means that income-related subsidies lead to a lower government cost per newly insured person than would be the case when using employer subsidies or subsidies that do not vary with income.

However, income-related individual subsidies may still result in significant displacement (or crowding-out) of current coverage.<sup>15</sup> Efforts to prevent crowd-out, such as denying eligibility for subsidies to those previously insured, create inequities. Programs may be perceived as unfair if they disadvantage those who were previously making sizeable payments to get coverage relative to those who went uninsured, and they may undermine support for reforms. Subsidizing individuals with current coverage is fairer but more costly.

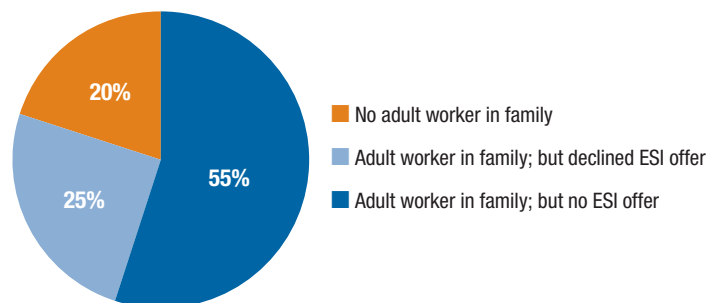
***Voluntary Participation Outside Employer Settings May Be Low.*** Take-up rates may not be particularly high in voluntary arrangements outside employer settings.

Research shows that many individuals will not take up individual insurance even with reasonably generous subsidies.<sup>16</sup> Reducing stigma attached to receiving government support, ensuring that the time and hassle costs of enrolling for coverage are low (perhaps by using employers to assist with enrollment tasks), and making adequate coverage accessible at an affordable price outside the employment setting will be critical to achieving high levels of participation absent an individual mandate. Such strategies must include eliminating any financial liquidity constraints that might prevent individuals from having access to subsidies at the time premium payments are due, or any uncertainty about what the total subsidy amount will be before enrollment. The latter two are of particular concern under a refundable tax credit structure, where the subsidy is received once tax returns have been filed and subsidy amounts may be determined retrospectively using full-year taxable income. Strategies can likely be developed for effectively addressing these issues, but they require specific program design efforts to do so.

#### ***A Guaranteed Source for Purchasing Individual/Family Coverage Is Necessary.***

Because 75 percent of the nonelderly uninsured do not have access to an employer-sponsored insurance offer (see Figure 1), an accessible non-employment-related source for purchasing coverage is necessary. Over half the uninsured

**Figure 1. Distribution of the Non-Elderly Uninsured by Access to ESI Offer**



Source: Urban Institute tabulations of a merged file of the 2005 Current Population Survey Contingent Worker & Annual Social and Economic Supplements.  
 Note: "Family" is defined as health insurance unit, which includes spouses and dependent children.

have at least one adult worker in their family but none with an offer of employer-based coverage, and 20 percent have no attachment to the workforce. Most states allow private nongroup insurers to deny issue of coverage to individuals based upon health status, as well as charge higher premiums to applicants based upon their medical history. Many states also allow private nongroup insurers to exclude benefits for particular types of care from issued policies, based upon enrollees' health experiences. As a consequence, even provided a government subsidy, many individuals would not have a guaranteed source available for purchasing adequate affordable coverage.

As suggested in the discussion of small employers, these issues for individual purchasers can be addressed by developing new insurance purchasing pools or by opening access to existing pools (e.g., government employee plans, SCHIP) for individual purchasers. Providing income-related subsidies only through such pools would attract many low-income healthy enrollees, helping to offset adverse selection in the pools that might result from their accessibility to the high-need population. However, it might also be necessary to subsidize coverage in the pool to further compensate for adverse selection, thereby keeping premiums affordable and attractive to voluntary enrollees of all levels of medical need.

Having subsidies provided only for coverage obtained through purchasing pools also simplifies the process of setting subsidy amounts consistent with available premiums for adequate coverage. The purchasing pool could set basic benefit levels for insurance provided there, negotiate premiums, and collect relevant data on enrollee health care risk from participating plans. Because the types of plans and benefit packages could be limited within the pool, information could be gathered and analyzed relatively easily and uniformly, without having to deal with the complexities of highly heterogeneous plan offerings in the outside market. Without subsidies being directly related

to premiums for a particular level of coverage, there is no guarantee that low-income individuals would be able to access affordable coverage with meaningful benefits.

***The System Is Not Currently Prepared for a Large-Scale Decline in Employer-Based Coverage.*** Subsidization approaches that increase incentives to purchase coverage in the private nongroup market will tend to undermine the employer-based system, potentially dramatically decreasing the current 61 percent share of the nonelderly population obtaining coverage through employers.<sup>17</sup> Without reforms to the ways in which individuals can purchase coverage on their own (e.g., the purchasing pools discussed above), combined with sufficient subsidies, such an approach may even increase the number of uninsured, particularly among the low income and those with higher than average health care needs. So, for example, simply “leveling the playing-field” of the tax treatment of employer and nongroup insurance is not as innocuous as it might sound.

Even in the context of providing adequate and subsidized coverage through universally accessible purchasing pools, it may be difficult for policymakers to raise sufficient revenue to finance significant increases in coverage without continued support from employers. While large employers are likely to continue providing coverage directly to their workers even under such reforms, small employers and new businesses may be less likely to do so.<sup>18</sup> Maintaining employer involvement can be accomplished by imposing participation requirements on all or some employers (e.g., through “pay or play”-type mandates), the continuation of at least some of the tax advantage associated with employer-based insurance (e.g., capping the current tax exclusion but not eliminating it), providing some new employer subsidies in conjunction with individual subsidies, or by imposing crowd-out prevention strategies in a subsidized purchasing pool, such as those used by Massachusetts under its reform.<sup>19</sup> While these approaches create some inequities and inefficiencies, they can be effective in guaranteeing

continued employer participation in the health insurance arena. If, over time, non-employer-based options for obtaining insurance coverage are fully operational and proven to provide adequate substitutes to the employer-based system, such approaches can be phased out and eliminated.

## Conclusions

Individual and family subsidies have some important advantages over employer subsidies. They are better at targeting lower-income people, the largest segment of the uninsured. Subsidies directed specifically at the low-income population will lead to less displacement of private spending because that population has low rates of current private coverage, although some displacement is still likely to occur. Subsidies based upon income treat those in similar economic circumstances similarly, eliminating the equity concerns associated with treating low-income people differently based upon their place of employment and prior decisions to purchase coverage.

Because employer subsidies are provided based upon employer characteristics and the limited information that employers have about their workers (e.g., they know their wages but not their family income) and because workers within a firm can vary significantly, subsidies are much more difficult to target effectively to individuals with the greatest needs. In addition, employer subsidies do not eliminate the need for individual subsidies, as many employers will not voluntarily begin to offer coverage, low-income workers will continue to need additional financial support in order to afford coverage, and not all the uninsured are attached to the labor force.

Given these issues, it is probably best to rely primarily on individual and family income-related subsidies. Subsidies could be made available for workers and spouses with incomes up to at least 300 percent of FPL through a purchasing pool. Subsidies could be based on a benchmark premium in the purchasing pool and could limit individual financial exposure to a specified percentage of income. Workers with employer coverage through

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the purchasing pool could be offered similar protections. This arrangement would result in subsidies provided to people not only based on income, but to the extent that there was adverse selection into the pool, it would provide support to individuals with high health care costs. This combination of policies in a voluntary system would probably reduce the number of uninsured by about half. Further progress would require mandating that individuals and families obtain coverage.

Policymakers may want to keep health insurance offers by small employers as

high as possible, given recent national trends, in order to reduce the level of new government revenues that must be raised to make coverage affordable for all. If such is the case, particularly in the early years of a reform, it is important that employer subsidies be specifically targeted for low-wage workers in small firms. The advantage of some targeted employer subsidies is that they may help to keep some small employers providing coverage, and those employer contributions can offset some of the costs of insurance that would otherwise fall to government.

Minimum employer contributions to the cost of coverage could be required in order to qualify for subsidies, thus ensuring that employer subsidies would be lower than full individual subsidies. Employer subsidies would be available only through a purchasing pool that would be responsible for coordinating individual and employer contributions with employer subsidies and individual/family subsidies. Such an approach would have the greatest impact on coverage if employer participation was mandated.

## Notes

<sup>1</sup>The bill is known as the Small Business Health Options Program Act of 2008, or SHOP Act (S. 2795). Employers can receive the credits as long as they contribute at least 60 percent of the premium on their workers' behalf. The credits are worth up to \$1,000 per employee enrolling in single coverage and up to \$2,000 per employee enrolling in family coverage. The pool is open to firms with up to 100 full-time workers. Self-employed individuals may purchase insurance through the same pool and receive an annual tax credit of \$1,800 for single coverage or \$3,600 for a family.

<sup>2</sup>A significant portion of this subsection was taken from Linda J. Blumberg and John Holahan, 2007, "Expanding Insurance Coverage for Workers in Small Businesses: Lessons from Massachusetts and California," Missouri Foundation for Health, Show Me Series: Report 10.

<sup>3</sup>Congressional Research Service, 1988, *Costs and Effects of Extending Health Insurance Coverage*, Washington, DC: U.S. Government Printing Office.

<sup>4</sup>David Cutler, 1994, "Market Failure in Small Group Health Insurance," Working Paper No. 4870, National Bureau of Economic Research, Inc.

<sup>5</sup>The SHOP proposal is structured as a fixed dollar amount with a minimum employer contribution. Rhode Island's RItE share program is an example of an approach that requires the employer and employee to each pay a share depending on the worker's income, with the state paying the remainder. Both approaches

are intended to maintain private contributions in the system while making coverage more affordable.

<sup>6</sup>Authors' tabulation of the 2007 Annual Social and Economic Supplement to the Census Bureau's Current Population Survey. This calculation includes all workers age 18 to 64 employed in firms, thereby excluding the self-employed. If the self-employed are included, 10 percent of low-income uninsured workers report being self-employed, 52 percent were employed in firms of fewer than 100 employees, and 38 percent were employed in firms of 100 employees or more.

<sup>7</sup>D Ferry et al., "Health Insurance Expansions for Working Families: A Comparison of Targeting Strategies," *Health Affairs* 21.4 (2002): 246-54.

<sup>8</sup>J Reschovsky and J Hadley, "Employer Health Insurance Premium Subsidies Unlikely to Enhance Coverage Significantly" (Issue Brief No. 46), Center for Health System Change, 2001.

<sup>9</sup>M Marquis and S Long, "To Offer or Not to Offer: The Role of Price in Employers' Health Insurance Decisions," *Health Services Research* 36.5 (2001): 935-58.

<sup>10</sup>Lisa Clemans-Cope and Bowen Garrett, 2006, *Changes in Employer-Sponsored Health Insurance Sponsorship, Eligibility, and Participation, 2001 to 2005*, Kaiser Commission on Medicaid and the Uninsured Issue Paper. <http://www.kff.org/uninsured/upload/7599.pdf>, accessed July 1, 2008.

<sup>11</sup>In addition, employer subsidies may indirectly affect worker take-up to the extent that reduced

employer contributions to health insurance would be passed back to workers as increased wages. As wages increase, workers will be somewhat more willing to spend income on health insurance as well as on other goods and services. However, we would not anticipate the magnitude of this effect on take-up to be large.

<sup>12</sup>Clemans-Cope and Garrett 2006 op cit.

<sup>13</sup>While individual subsidies could be used in existing private nongroup insurance markets, this option would not be sufficient to guarantee universal access to insurance coverage because of most states' regulations allowing nongroup insurers to deny coverage to individuals based upon current or past health status.

<sup>14</sup>D Ferry et al. 2002 op cit.

<sup>15</sup>J Hudson, T Selden, and J Banthin, "The Impact of SCHIP on Insurance Coverage of Children," *Inquiry* 42.3 (2005): 232-54.

<sup>16</sup>M Marquis, "Subsidies and the Demand for Individual Health Insurance in California," *Health Services Research* 39.5 (2004): 1547.

<sup>17</sup>Authors' tabulation of the 2007 Annual Social and Economic Supplement to the Census Bureau's Current Population Survey.

<sup>18</sup>Linda Blumberg, John Holahan, et al., "Toward Universal Coverage in Massachusetts," *Inquiry* 43.2 (2006): 102-21.

<sup>19</sup>John Holahan and Linda Blumberg, "Massachusetts Health Care Reform: A Look at the Issues," *Health Affairs* 25.6 (2006): w432-w443.

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