Uninsured and Affordable Health Care Coverage, The
Before the U.S. House of Representatives Committee on Energy and Commerce
Subcommittee on Health

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Mr. Chairman, members of the committee, I appreciate the opportunity to appear before you today to discuss ways to expand health insurance coverage. My name is Alan Weil and I direct the Assessing the New Federalism project at the Urban Institute, a 36-year-old non-profit, non-partisan research institute here in Washington, D.C. Before coming to the Urban Institute I was executive director of the Colorado Department of Health Care Policy and Financing, which is the state Medicaid agency.

There is an emerging consensus that public subsidies must be provided to assist the 40 million Americans who lack health insurance. The disagreement that remains centers around the form of those subsidies. Some advocate tax credits, while others advocate expanding existing public programs such as the State Children’s Health Insurance Program (SCHIP) or Medicaid.

In my testimony today I will argue that the latter approach—building upon existing public programs—holds far more promise for improving health insurance coverage. The case for tax credits rests entirely on theory and ignores the practical difficulties of providing meaningful coverage in a complex, varied health care system. Existing public programs also have limitations, but they have a 35 year track record of providing comprehensive, cost-effective and stable coverage to those in need.

Tax credits suffer from five problems—problems of availability, adequacy, amount, administration and accountability.

The most serious problem with tax credits is that of availability. Most tax credit proposals are designed to encourage people to purchase coverage in the individual health insurance market. Insurers in this market routinely deny coverage to those with any identifiable health problems. When coverage is offered, rates are many times higher for older adults than for those who are younger. Administrative costs routinely exceed 30 percent. These insurance practices are understandable—they are the only way companies can make money operating in a market where they take on the substantial risk associated with enrolling people with high health care needs. Yet, only a minority of states have adopted regulations to limit these and other practices. Thus, regardless of the size of the tax credit, health insurance simply will not be available to those who most need it.

The second problem with tax credits is that of adequacy. The size of the credit—$1000 for an individual and $2000 or $3000 for a family in most proposals—does not even cover half the cost of the typical health insurance plan. Analysts agree that few families of modest means can or will pay the balance with their own funds. Tax credit users will primarily end up in plans with deductibles that run in the thousands of dollars, with many excluded services, or significant limitations on coverage. These limited benefit packages will leave families in exactly the position they find themselves today: deferring needed care because of cost, at risk of bankruptcy if they get sick, and placing a tremendous financial burden of uncompensated care on the entire health care system. In addition, all experiments attempted to date show the same thing: most Americans, and particularly those of limited financial means, are simply not interested in bare bones coverage.

The third problem with tax credits is that of the amount. Tax credits suffer from the Goldilocks fallacy: no tax credit amount is just right. Everyone agrees a tax credit that is too small will not increase insurance coverage at all. However, a tax credit large enough to help a substantial number of people obtain health insurance is also large enough to draw a substantial number of people out of the employer market, thereby raising premiums for small businesses and shifting costs from the private sector to the taxpayer. A similar cost shift would occur on the boundary between tax credits and public coverage for the very poor. Since a fixed dollar tax credit has health insurance purchasing power that varies by a factor of more than five to one depending upon where a person lives, it is impossible to set a credit amount that strikes some theoretically correct balance between helping no one and undermining the existing health insurance system.
Models that estimate how many people will take advantage of a tax credit, how many will drop existing coverage, and how many previously uninsured will gain coverage are very sensitive to the assumptions they use. It is very risky to use positive results from one model to justify a multi-billion dollar expenditure on tax credits.

The fourth problem with tax credits is that of administration. At a minimum, a tax credit must be refundable and paid in advance if it is to help a working family purchase coverage. Unfortunately, even with these provisions many families will be unaware of the credit, fail to take advantage of it, or not take it in advance because they will worry they will have to pay the government back if they receive a small wage increase during the year. The existing Earned Income Tax Credit provides important evidence. Very few families claim the credit in advance even though it is available. In addition, low-income Hispanic parents—a group disproportionately likely to be uninsured—are less likely to know about the EITC than other low-income parents, and, even those who do know about it are less likely to have received the credit.

The fifth problem with tax credits is that of accountability. Most people rely upon their employer or a public agency to provide them information about their health plan, assist with problems, and monitor the quality of coverage. But people in the individual market are on their own. If their coverage is cut, their premiums rise, or there is a dispute over their benefits, they must fend for themselves. If the federal government is providing financial incentives to purchase coverage, they will expect plans to be available. Consumer outcry among those who are denied coverage or who are mistreated by their health plan will create immense pressure for the federal government to act, but if it does so it will step into an area of long-standing state control, prompting a destructive battle over federalism.

Existing public programs have their limitations, but they also have a 35 year track record. They provide real, comprehensive, cost-effective stable coverage. They target spending on those most in need, and they minimize incentives for the private sector to drop coverage. Public programs have gone through a positive transformation in recent years. They have simplified applications and enrollment processes, crafted new market-based benefit packages, improved education about coverage options, and have been tackling old problems like how to assure access to critical services like dental and mental health care.

At a time when the nation faces tight fiscal constraints and growing numbers of uninsured, it is essential that limited resources be spent where they will be most effective. If the goal is to reduce the number of people without health insurance, spending money on tax credits is a huge gamble paid for with taxpayer funds. By contrast, states were poised to make substantial progress on the issue of health insurance until fiscal circumstances recently took a sharp turn for the worse. Even a modest expenditure of federal funds could revive the state and local creativity we observed just a year ago. This would be an expenditure based upon a track record, not a theory and a computer model.

Other Publications by the Authors

- Alan Weil