
An Adaptive Credit Plan for Covering the Uninsured

by Mark V. Pauly

Introduction

To deal with the problem of large numbers of persons without health insurance, this paper outlines a flexible and adaptive method of using refundable tax credits, supplemented by a full publicly subsidized program for very-low-income households. This flexibility and adaptability is necessary for two reasons: (1) The availability of credits will transform insurance markets in ways that eventually (but not initially) will change how credits might be used. Specifically, credits will cause some uninsured persons to seek coverage, and that influx of new customers may help to transform the markets they enter. (2) There is substantial and (currently) irreducible uncertainty about two key aspects of this system's response to the availability of partial credits. How many will take up insurance for a given credit policy, and how the markets in which they will use their credits will be transformed, are subject to enormous uncertainty that cannot be addressed by better current data collection and/or analysis or simulation. The reason for this uncertainty is that there has been no experience with such a large-scale system of credits or subsidies offered to the target populations; we simply don't know what will happen because we have never seen anything like it. Attempts to extrapolate from other situations we have observed (tax subsidies for the self-employed, behavior of Medicaid recipients) can offer some hints about direction and size of relative effects, but they cannot substitute for actual experience.

Policy analysts typically deal with such behavioral uncertainty in federal programs in one of three ways. One way is to acknowledge the uncertainty frankly, present ranges of values for possible out-

comes, with no pretense that some value in the range is a "best" (or even "better") guess than others, and then suggest a plan that deals with uncertainty and learns from its resolution. Such a plan ordinarily will not be best for any one particular scenario for the unknown variables, but it will be good on average for a wide range of possible scenarios. A second approach is to design an intervention that leaves it to the states to resolve some of the uncertainty, and counts on them to offer different approaches. The third approach is to pick one possible behavioral response, declare it to be virtually certain, and design a policy that fits it. This last approach in policy for the uninsured leads to stalemate, because, for any policy that inspires optimism in some, there will be others with worries and concerns who can block the proposal. Until now we have done virtually nothing about the bulk of the uninsured, because the outcomes are uncertain and undesirable results cannot be ruled out.

The strategy here is to follow the first approach, and to proceed in two stages or phases. We begin with a relatively simple, financially feasible, easily reversible or modifiable intervention, targeted at the uninsured for whom it is most suitable. We embed a scheme to learn from that intervention to alter aspects of the program according to a fixed, transparent, and comfortable process. The first phase of the plan also is intended to be easy to administer and understand, and permissive and encouraging rather than restrictive and intimidating in determining eligible persons and qualified insurance policies. The program initially targets one subset of the uninsured population for credits. As a result, this simple initial program is less than comprehensive and less than perfect. But it is a step forward,

and one that is better than the current situation. In the second phase, the observed outcomes from that intervention set the stage for generalizing the program, and information from that intervention is used to determine the best way to generalize. In this process, change is an indication of learning, not mistakes, and we do not have to wait until every possible glitch is anticipated before moving ahead.

In what follows, we primarily provide details on the Phase I proposal. The alterations to this structure that might take place during Phase II are described later.

Overview

In Phase I, the flexible credit plan divides the under-65 U. S. population into three groups, each treated differently. Lower-middle-income households, which make up two-fifths of the uninsured, are the primary initial target group. *All* families with incomes above the poverty line but below the median (regardless of the age, sex, or relationship of family members) are made eligible for a voucher or credit of a given amount, varying only by whether it is used for individual or family coverage, that can be used to purchase insurance. For budgetary and political reasons, credits are likely to be less than the full premium for a comprehensive insurance policy for all eligible persons. So to maximize the use of the subsidy, few restrictions are placed on the type of insurance for which it can be used, or on the cost of that insurance, but a publicly provided or contracted fallback insurance plan will offer policies financed with the same subsidy on the same terms as private plans. The subsidies take the form of refundable credits or “coupons” redeemable against either all or part of the insurance premium, or redeemable as a tax reduction on presentation of proof of insurance purchase. A key assumption is that an influx of new buyers will improve the functioning of private insurance markets substantially, especially individual markets.

In addition, in Phase I, very-low-income households will become eligible for publicly provided or contracted comprehensive insurance, with no premium share required. People with incomes above

the median (with a few exceptions for high risks and, possibly, those with incomes near the threshold) will not be eligible for the new program initially, but may continue to use the new individual insurance plans, and may retain the tax exclusion for group coverage.

The most important behavior to monitor in planning adjustments for Phase II is that of the emerging private insurance markets, both individual and group other than employment. If these markets are functioning reasonably well, the contribution toward insurance for very-low-income households will be converted in Phase II into a voucher or credit that these households also can use for private insurance, with coverage similar to that of the Medicaid-type plan. If many of the uninsured with incomes above the median also use the new private market, it should be possible to implement a mandate requiring the remaining tiny minority to buy some coverage, and to cap the value of the exclusion, thus turning the exclusion into an adjustment of the income tax base for almost everyone. Finally, the coverage that can be obtained with the credit or coupon alone to buy a “low-priced” plan will be examined to determine if there are any substantial health benefits to lower-middle-income people from adding coverage (at added budget cost). If such benefits do exist, stricter minimum standards and financing to pay their additional cost would be added in Phase II.

There are two novel features in this plan. First, using coupons as a vehicle for credits should improve the take-up rate greatly. Coupons are attractive, solve cash flow problems, and are easy to administer. Second, permission to use the credit for insurance plans with premiums no greater than the credit ensures that virtually everyone in the target group will end up with at least some coverage. There will be universal coverage for everyone, though not for all expenses; non-poor people should be allowed to use cost sharing. Public financial constraints and efficient cost containment mean that such coverage will not fully cover all medical services. There will, however, be some public subsidy for insurance for people who currently receive no subsidy toward any insurance.

To deal with valuation in risk across households

These new credit vouchers or coupons should be thought of as tax reductions for the lower middle class and, thus, treated as tax reductions for all who use them.

and over time, all policies will be guaranteed to be renewable (at premiums that are no higher than those charged to average risks). In addition, plans requiring no additional premiums must be rated on an adjusted community rating basis, but premiums for coverage beyond this level may be risk rated if insurers wish to do so. A high-risk pool is an option in Phase II if many high-risk individuals are still paying very high premiums, but this outcome is unlikely (for reasons discussed below). The public alternative plan(s) will be regulated, rated, and subsidized on the same basis as private insurance. States may continue to regulate individual insurance, and may add additional subsidies to the credit (in various ways), but the states will be responsible if regulation results in fewer people being uninsured than expected.

Objectives, Assumptions, and Rationale

To design a system that adapts to different outcomes, we need to set priorities among these different outcomes. The two most important of these are fairness and efficiency. The problems associated with these are: everyone is for fairness but defines it differently, and there is only one definition of efficiency but not everyone is for it.

An efficient outcome is one that matches consumers with the insurance policy they prefer (given the subsidy) and whose costs and premiums are minimized. With respect to the effect of the subsidies, the objectives and goals of the providers of those subsidies—taxpayers—are important. One would usually include as social objectives improved health status, control of infectious diseases, and longer life expectancy, but goals dealing with the dignity, privacy, convenience, and satisfaction with care and coverage may also matter. We assume that the key to efficiency is to offer *neutral incentives* to both low- and middle-income people for choosing

among insurance plans, and to offer *targeted subsidies* for those poor enough to need help.

A fair outcome is one in which people who are similar in income and health status are treated the same, but the amount lower-income families must spend on care and insurance should be limited. How limited, and how low is “low-income,” are political decisions.

We do *not* enshrine or condemn particular ways of providing insurance or even particular types of insurance (as long as they do not lead to worse health outcomes). Specifically, there is no intrinsic merit to employment-based group insurance or insurance provided by the government, non-profit firms, or for-profit firms, and no intrinsic flaw in HMO coverage or in rationing care (which logically must occur) by one means over another.

We want to outline a tax credit proposal for the uninsured that uses private market arrangements as much as possible. In other words, we give private markets the benefit of the doubt.

The strongest benefit from private markets is their ability to satisfy consumers with varying desires. If everyone wants the same amount of some product or activity, government provision can work reasonably well; the “public good,” in which all must consume the same quantity, provides the classic example. Health insurance is not a “public good” that all must share equally. Rather, people differ in how much insurance they want, how they want their insurer to perform, and how much they value different aspects of plan performance. These differences in preferences apply both to the level of financial protection and to the degree to which physician-patient decisions are constrained by insurers. In addition, these preferences are not entirely dictated by a family’s income; people at given income levels will still choose different coverage. One key unknown is *how much* variation there is in private demands.

The production efficiency benefits that competitive markets can furnish also matter. Even here we assume that the key issue is not so much current cost but rather the rate at which costs will grow over time, and that government provision or production can be as efficient as private-sector provision or production.

For various reasons, not enough tax reduction can or will be made available to fully subsidize insurance that makes all care free at the point of service for everyone. There need to be limits, either on what fraction of the market price insurance covers or on the amount of services providers are permitted/encouraged to supply. We do not advocate such constraints, or the partial coverage they imply, but we do recognize reality.

Related to these constraint and diversity issues, we posit that not all undesirable possible behaviors should be regulated. Put slightly differently, we assert that regulations forbidding things that almost no one ever does are not appropriate. One reason for not trying to prohibit everything undesirable that happens only occasionally is the cost of monitoring and administration and the desire for administrative simplicity; the other reason is that passing such regulations often opens new avenues for additional political influence, lobbying, and legal action.

Coverage and Eligibility

The proposed credit will be a fixed-dollar amount for persons with incomes at certain levels. (We tentatively suggest \$1,500 for individuals and \$3,500 for families.) The key design parameters that will need to be specified in a political process are the dollar amount of the credit, the definition of the income levels (and possibly other characteristics) that trigger eligibility, and what kinds of insurance are eligible for the credit. Some assumptions about plausible values for these parameters are made below, but the choice of their levels is ultimately a political one.

One uncertainty, if we specify insurance coverage and eligibility, is how many of the eligible persons will apply for the credits, and, of those who obtain the credit, how many were formerly uninsured. Will many of the eligible uninsured pass up

the credit? Will many of the insured claim the credit? Will there be some uninsured people who are not eligible for the credit?

The other uncertainty is the performance of markets in which consumers use the credit. The individual and small-group markets will be most affected. We know that how markets behave is influenced by the demands, information, and tastes of buyers who use them, which implies that the influx of a large number of insurance buyers who are different in important ways from buyers already in these markets will virtually guarantee that the market will change. But how? Will insurers be more or less concerned about the risk level of new buyers? The Health Insurance Portability and Accountability Act (HIPAA) now requires that individual and small-group insurers treat those already insured who become higher risk the same as all others they insure, so will the additional premium for this “guaranteed renewability” feature rise or fall? Will the Internet allow new products, more choice, and lower premiums, or will it just add to the confusion?

In the current private health insurance market, only relatively high-income people receive substantial tax subsidies. In current public insurance markets, especially Medicaid, the subsidy is so large that the net premium is zero or close to it. We have no experience with significant tax credits for lower-middle-income families. This means that we cannot predict with any degree of accuracy how they will respond, and that no additional information is available to refine these estimates.

With regard to insurance markets, most potential tax credit recipients are of approximately average risk and would have to use the individual or small-group markets to obtain coverage, but we have no experience with the consequence for such markets of an influx of a large number of average-risk buyers in those markets subsidized to pay moderately high premiums. In current markets potential customers are not willing to pay high premiums or, if they are, it is because they are unusually high-risk.

Our approach here is to begin with the subset of the uninsured likely to be most in need of and responsive to the new credit. (If this policy is effective in prompting the previously uninsured to seek

TABLE 1

Segment	Income as % Poverty	Proportion of Uninsured	% with Private or Employment-Based Insurance*
Low	Less than 125%	33%	31%
Medium	125–300%	40%	69%
High	Greater than 300%	27%	90%

*Includes private individual insurance, private group insurance, and insurance furnished by state and federal governments to employees and dependents (including military).

Source: Current Population Survey, March Supplement, available at bls.census.gov/cps/ads/adsmain.htm, 1999.

coverage, we think that the presence of large numbers of new demanders will make it easier—and perhaps inevitable—to change the way in which insurance is produced and priced for everyone.)

As shown in table 1, we divide (for a sample plan) the current population of uninsured Americans into three groups: low-income households with family incomes below 125 percent of the poverty line (about 33 percent of the uninsured); those with family incomes above 300 percent of the poverty line (about 27 percent), and those with family incomes between 125 percent and 300 percent of poverty (about 40 percent of the uninsured). The last group will be the primary target of a credit-based intervention.

We recommend that eligibility for fully subsidized, complete comprehensive coverage at a publicly chosen insurer (Medicaid, Children's Health Insurance Program [CHIP], the insurance plan for state employees, or an insurance with the same coverage and policies as Medicare) be extended to all low-income households, regardless of whether they include children or able-bodied adults. All poor people would receive free comprehensive insurance. (These households will also be eligible for the coupons described below, but we would expect few to use them.) Households with incomes between 125 percent and 300 percent of poverty (roughly median income) would receive a credit, but it would be large enough to cover only part of the premium for complete and comprehensive coverage.

At the upper end of the distribution of eligible incomes, the voucher could be “phased down” (over a range from 275 percent of poverty to 325 percent of poverty) to equal the average value of the employment-based group insurance exclusion. For instance, for a typical family at 325 percent of poverty with an employment-based policy with a premium of \$6,000 and a 28 percent marginal income tax rate combined with the payroll tax, the value of the exclusion would be \$2,580; if the marginal income tax rate were 15 percent, it would be \$1,650. Therefore, phasing down the family voucher to a value of about \$2,000 might be reasonable.

The key group might be described as “lower-middle income people” or “middle-income people below the median.” As we have defined the groups, this group contains the most uninsured people. However, about 69 percent of people in this group are already insured, with private or employment-based coverage; even at the low end of the range, most people obtain such insurance. That is, most people in this group are able to “afford” coverage, but some (for a variety of reasons) do not purchase it.¹ More important, for reasons we describe below, this group's characteristics suggest that it would be most affected by and would most benefit from a moderate but not complete insurance tax credit.

¹ M. V. Pauly, and M. K. Bundorf. “Is Health Insurance Affordable for the Uninsured?” Working paper, Stanford University School of Medicine, November 2000.

Finally, while it is difficult (and awkward) to make distinctions here, one might argue that, relative to those with higher incomes, credits will have a greater impact on the health of this population.

This group is very heterogeneous with regard to almost all characteristics. Whether we look at the total lower-middle-income population or the subset of that population that is uninsured, there is substantial representation of all age groups under 65, all employment options, and all expense risk levels. One common characteristic that will be important is that more than 80 percent of this population is in families with at least one worker; lower-middle-income families in America (whether insured or not) work for a living. But for other characteristics, there are variable (and offsetting) influences. For example, the uninsured are more likely, other things being equal (including age), to be in fair or poor health, but they are more likely than the insured to be young. The effect of lower average age offsets the effect of the greater likelihood of being in poor health, so, overall, their risk level is no higher than average.

Most of the uninsured in this subpopulation (as in the overall set of uninsureds) have been privately insured before and have been uninsured for less than a year (although some are uninsured for a long time). Thus, this subpopulation has had access to and experience with private insurance, and most would be expected to have access again. A potentially important implication of this typical orientation toward the private insurance market is that single publicly run insurance programs might not be best for (or strongly desired by) this group. If buyers will have to pay some part of the premium for a comprehensive policy (as they must), they may not want to be channeled into Medicaid, S-CHIP, or even a Medicare clone. Instead, we hypothesize that, other things being equal (including the depth of coverage and the premium the person must pay), most people in this subpopulation would opt for private insurance, and for a variety of plans, ranging from reasonably costly but permissive at one extreme, to high-deductible, low out-of-pocket limit, and downright cheap at the other. This hypothesis, in turn, implies that more of these buyers would be more likely to be willing to be insured if the plan

could be private (as well as public) than if it has to be public only. Some people in this population almost surely would prefer a public insurer offering a public plan: one chosen somehow in the political process and managed at some level by government employees. Others will prefer a private plan that they can stay with, even if their incomes rise or they get decent jobs.

These considerations direct us away from a strategy of extending Medicaid/CHIP-type plans up the income scale to the income range for this subpopulation of lower-middle-income persons, but push us toward making sure that one of the available plans is a public one. Thus, in our ideal arrangement a public plan of some type is an option, but not an obligation, and the “terms of trade” among all plans should be neutral and reflect only true cost and quality differences. This public insurer could offer a variety of plans, including the “low-cost” plan described below.

Subsidies

Credits toward purchasing qualified health insurance should be made available to all lower-middle-income, legal residents of the United States. In the ideal arrangement, one might prefer to vary the value of the credit with family income in a continuous fashion. However, in the interest of administrative simplicity and making the process of using the credit as easy as possible, we think it desirable to start with a single value for lower-middle-income families with a given number of dependents. As a rough rule of thumb, we think the credit should be somewhere between half and two-thirds of the premium for a decent basic policy. Both the proportion of premium covered and the definition of a decent policy are subject to adjustment (although they are obviously related).

Roughly speaking, one might assume that the average premium for a decent family coverage policy would be \$5,000 to \$6,000 per year; therefore, a credit averaging about \$3,500 would fit the specifications; the analogous amount for a self-only policy would be about \$1,500. Credits would be updated in proportion to the growth in actual premiums paid

in transactions. At the high end of the income range (say, between 275 percent and 325 percent of poverty), the credit might be phased down gradually to equal the average value of the exclusion. This phase-down could be accomplished by end-of-the-year adjustments in income taxes.

However, the actual premiums that would be quoted in the individual market would vary with age. The self-only premium for people under age 30 would be less than \$1,500, for example, whereas that for someone age 64 (even in reasonably good health) would be about \$3,000. Should these effects of age be offset? There is no easy answer, nor are there hard data, for this question. A fixed-dollar (unadjusted) approach will pay for decent coverage for more people, but they will be young. A proportional approach, or some other method that increases the credit when the premium increases because of age, will provide better incentives for decent coverage for older people. However, evidence suggests that older people are willing to pay more for coverage; they have a clearer idea of their need for benefits, and they behave more responsibly. In contrast, younger people are most likely to be uninsured. The real issue here is precisely what is not known—how many people of which ages would buy coverage under different plans, and how many older people with difficulty in obtaining coverage would compensate us for covering a large number of young people?

In the first phase, in the interest of simplicity, we propose a uniform credit, independent of age. We can then see what pattern of insurance purchasing emerges. If this program appears to be ineffective in affecting the coverage choices of middle-aged people, the credit could be age-adjusted to some extent. Doing so, however, would cause some potential conflicts with employment-based insurance, as we discuss below.

Financing

Financing for the tax reductions or credits for the lower-middle-income population (125 percent to 300 percent of poverty) will be accommodated by federal budget revenues. Those who purchase coverage more generous than the low-cost plan will use

their own resources, either through direct payment of premiums or through indirect payment by employees as part of their total compensation in lieu of money wages. Financing for full coverage for those below 125 percent of the poverty line will be provided by a combination of state and federal revenues, with existing levels of state payments for Medicaid and S-CHIP to be retained.

These new credit vouchers or coupons should be thought of as tax reductions for the lower middle class and, thus, treated as tax reductions for all who use them. Since virtually all eligible persons should be expected to claim and use their credit coupons, it should be possible to estimate the gross value of the tax reduction fairly precisely. However, since use of the credit offsets the value of the tax exclusion, the net tax reduction will be somewhat more difficult to estimate, because it requires knowledge of the distribution of the value of the exclusion and, more important, because persons at the upper end of the income eligibility range who now benefit from the exclusions may or may not prefer to use the credit coupon rather than continuing to use the exclusion.

Insurance and Risk

The two most common ways in which private insurance is provided in the United States both have problems. The most dominant form, employment-based group health insurance, suffers from lack of portability across jobs and lack of good matching between the types of plans employers or unions choose to offer and what each employee (or perhaps even most employees) really want. We know that workers are dissatisfied with employer-chosen managed care plans (and, to a much greater extent, when there is only one managed care offering), and we know that employers do not feel that they can take enough out of wages to pay for unrestricted indemnity insurance plans. The result is a compromise between offering restrictive inexpensive plans and more costly plans with “parachutes” in the form of point-of-service features or preferred provider organizations (PPOs) with very large provider networks. On the other hand, the non-group insurance market uses a much larger share of the premium

dollar to cover administrative costs, and may make it difficult for some “non-average” risks to obtain coverage at premiums they find acceptable. Policy makers, therefore, tend to dislike both currently available vehicles for providing health insurance, and often imagine that there could be potential group-purchasing arrangements, rather than the job-based setting for individuals or small firms, that could offer a wide range of choices to voluntary participants and keep premiums low. At a minimum, many feel that the market in which credits may be used should be organized into some type of “quasi-group” setting and regulated to prevent risk rating. This hope may well not be realized, however, so we need to design a plan that does not depend on it.

There are two reasons why individual plans are so expensive that reinforce each other. It is costly to offer a large variety of plans to one buyer at a time; the plan finally selected will be costly because it is custom-designed. But when the plan is costly for the benefits it provides, more effort has to be made to persuade people to buy it, so commissions are generous. There is a kind of catch-22 in that insurance is hard to sell because it is expensive, and then it becomes expensive because it is hard to sell.

Currently about 10 million people under age 65 buy coverage in this customized and costly individual market. Eighteen million more people would receive credits and become potential customers in a reformed situation. If the credit is set on the generous side and a wide variety of policies at different costs are eligible, many of these buyers will be eager to obtain insurance. It is possible that the flow of large numbers of heavily subsidized demanders who are known to be average risks (or better) could help individual markets to function better. The subsidy itself should simplify one of the most difficult and costly tasks in the current individual market. Commissions (and some part of general administrative expense related to billing) are substantial, and they serve primarily to compensate agents and brokers for persuading people to buy insurance. (Since brokers typically offer plans from a variety of companies, they put little effort into selling one firm's product rather than another's). But with a significant subsidy, there should be much less need for

an expensive sales effort. The credit or coupon only becomes valuable if it is used for insurance, so people will want to use it.

There is evidence that when significant subsidies to purchase are offered, private administrative costs are reduced substantially. When Blue Cross of New Jersey was required to heavily subsidize individual coverage, administrative expenses were only 15 percent of premiums. Private insurers in Chile sell to customers who receive credit for the payroll taxes they have already paid; even though the coverage has had upper limits until recently, the loading is still about 18 percent.²

Not only might the creation of a mass of new demanders allow for lower administrative costs, it also might help provide direct help to avoid the other serious problem with individual insurance: difficulties in dealing with risk variation. If individual insurers do not charge higher premiums to higher-risk individuals, they will have to set (average) premiums so that insurance is too expensive for average-risk individuals compared with what it provides. A credit will greatly diminish this problem, for several reasons. As noted above, the lower-middle-income uninsured are reasonably good risks, so the proportion of high risks in the pool of potential individual market buyers will greatly diminish. With fewer high risks to worry about, firms would rationally put less effort into trying to identify high risks to charge them higher premiums. The benefit from identifying a high risk is the avoidance of high claims that only a small minority incurs. But if the proportion of such risks drops in half, say, the screening cost to identify one such risk doubles, which is bound to lead to less underwriting at the margin. Even though insurers know that the bulk of benefits will be paid to a few insured persons, if the proportion of such persons is few, it does not pay to incur underwriting expenses to discover who they are. Moreover, with a generous enough subsidy, many lower risks will still find insurance a good deal, and will stay in the pool rather than for-

² C. Sapelli and A. Torche. “The Mandatory Health Insurance System in Chile: Explaining the Choice between Public and Private Insurance.” Submitted for publication, *International Journal of Health Care Finance and Economics* (2000).

going coverage. The threshold level of new buyers that can alter insurer underwriting practices is not known.

This vision of what the insurance market might look like obviously is not guaranteed to materialize. However, if we offer generous credits with only modest amounts of premium rating regulation, we will soon know whether enough good-risk buyers will enter the market to make it a reality. Of course, if we are right, even fairly strict premium regulation would not be constraining. If the behavior a regulation is designed to constrain is going to be rare anyway, why not play it safe and regulate it? The most obvious answer is that writing, monitoring, and reporting to comply with regulations have a cost of their own.

So there are a number of regulatory options here, none of which is fully satisfactory. In Phase I we would propose a compromise strategy in which any low-cost plan must be sold under modified community rating, while plans with more generous coverage could charge higher premiums to those (given age, sex, and location) whom they identify as high risks. In all cases, insurers would be permitted to impose modest waiting periods for people who did not enroll during an initial “open season.” However, we think that this will be rare, because all persons would, at a minimum, be enrolled initially in a low-cost plan.

An important reason why few high risks should need new coverage is that a kind of risk regulation already exists in federal law that helps to provide substantial protection to high risks. This is the requirement that all non-group insurance be sold with a guaranteed renewability provision (section 148.122 of HIPAA), in which the insurer must promise not to raise premiums selectively for those already insured who become high risk; in return, the initial premium to low risks is slightly higher than it would be otherwise. Over time, unless there is enormous turnover among insurance plans, this provision should result in almost all high risks paying average-risk premiums.

Guaranteed renewability protects people against increases in premiums because of the onset of high-risk conditions. It does this by offering insurance

that guarantees that a person's premium will only increase at the same rate as the premiums of all who buy that insurance plan. Such a promise is financially feasible for insurers because they charge what is, in effect, a “two part” premium—one part to pay for current-period expenses and the other to cover any above-average premium for those who began as average or low risks but became high risk. Both common sense and economic theory³ suggest that a risk-averse low risk should prefer to stay with such a plan rather than switch to one in which the insurer has a reputation for increasing the insurance premium of people who become sick. For such a guaranteed renewability arrangement to work, however, people have to be willing to buy insurance, even when they are not high risk. If they choose to buy insurance only after they get sick, such behavior will prevent any insurer, regulated or not, from being able to cover its benefits costs with moderate premiums. For any voluntary market to work, there needs to be a penalty on low risks who try to stay uninsured until they get sick. If a credit makes insurance affordable for lower risks, there is no longer any justification for such irresponsible behavior, and penalizing those who wait to buy insurance until they become high risks before seeking insurance makes sense.

A guaranteed renewability requirement should require minimal enforcement and, indeed, almost all individual policies contained this feature even before HIPAA required it. Nothing is completely without cost; guaranteed renewability will lock higher risks into particular insurance companies, but that prospect should make prospective buyers more careful in the first place. The key point is that, with guaranteed renewability, all persons who keep buying health insurance will be protected against high premiums, even if they become high risks.

Finally, since almost everyone can buy at least a low-cost policy at modified community rates, there should be few high-risk customers who were formerly uninsured. To the extent that the low-cost insurance already covers catastrophic expenses, the

³ M. V. Pauly, H. Kunreuther, and R. Hirth. “Guaranteed Renewability in Insurance.” *Journal of Risk and Uncertainty* 10 (1995): 143–56.

If credits or coupons are widely offered, it is reasonable to assume that profit-seeking insurers will try to sell their insurance to people who are receiving substantial subsidies to pay for it. Thus, our strategy is to rely on insurers to market insurance to their customers, rather than use government agencies to enroll clients.

impact of risk differences on the cost of *incremental* coverage should be smaller. There would still be a modest reward for buying more comprehensive coverage with guaranteed renewability, however, in the form of no waiting period and, possibly, no higher premiums. Indeed, theoretical research suggests that a good way to deal with adverse selection is to combine a subsidized community-rated base policy with risk rated add-ons.

Administration and Regulation

The Role of Employers

The great majority of people with private insurance in the United States obtain it in part because they receive a portion of their compensation in the form of tax-shielded health insurance premiums. That is, the employment contracts for most American workers entail a compulsory diversion of compensation to health insurance; the wage-benefits package includes a partially paid health insurance premium available to all workers. A worker who declines to use this employer-enforced contribution may be able to save the other part of the premium, labeled “employee share,” but the “employer” portion generally is not returned to individual workers who decline coverage.

Employees and employers both prefer to arrange compensation for employees in this fashion because it is the only simple way to obtain a substantial reduction in the amount of employee income subject to income and payroll taxes, and because it tends to lower insurer administrative cost (though limiting plan choice).

We propose that any tax credit, in contrast, not be limited to workers who choose this form of group insurance. Instead, all people at the target income levels would be eligible for the credit if they obtain insurance at least as costly as the credit. The

credit would go to the newly insured who were formerly uninsured, those who obtained their insurance by spending their wages on non-group coverage, those who divert part of their wages to group coverage, and those who formerly chose employment-based coverage and now have some other method of arranging insurance. The size of and eligibility for the credit would depend only on whether the person obtained insurance, not on how he or she obtained it.

In contrast to the current situation in which employment-based group insurance is subsidized, but other ways of obtaining insurance are not, incentives would be neutral. Therefore, credits would be available to those with “employer paid” insurance; neutrality would be achieved if credits were set equal to the difference between the value of the exclusion and the value of the credit (or, in the alternative, workers using the credit could simply report total employer premiums as taxable income). For those firms able to offer attractive plans at lower premiums than their employees would pay in the non-group market, we expect that employer provision would continue.

There would be some potential shifting of workers out of the group market into the individual market, compensated by increases in money wages, especially for very small and poorly run groups. These workers indeed might be better off with individual insurance if it were not much more expensive than their (small) group coverage and offered them a variety of plans that better matched their needs and were portable across jobs. A defined contribution strategy is another good way to implement such a transition. This change would make many lower-wage workers better off than they are now, either because they would obtain coverage for the first time or because they are able to choose the coverage they prefer.

Some fear that allowing insurance to have the same tax treatment in both group and non-group settings would somehow “break the pool” in employment-based group insurance and harm higher-risk working families. We think that this is extremely unlikely. Employers would *not* be required to let workers (individually or collectively) out of the pool, so there would be no way for individual low-risk workers to impose costs on fellow workers. Moreover, the empirical evidence strongly suggests that the current reduction in money wages to pay for group insurance is greater for older workers and women, other things being equal. Younger workers who seek a relatively inexpensive individual policy would not expect (if their company dropped its coverage) to get back very much in money wages, so that individual insurance would not be a very good deal.

Finally, the proportion of people in *employment-based* group insurance who are truly high risk is quite low. The reason is simple: to get such insurance, someone in the household must be able to work. Among workers themselves, very few people have high-cost chronic conditions. There are high-cost dependents, however, but the availability of public programs for the disabled also draws off most of the high risks. In effect, people in employment-based pools have already been pre-screened, and their premiums (in virtually all regulatory regimes) depend on the risk levels of insured workers and their dependents, not on the average risk level in the population or even the average risk level among all workers and their dependents.

This pre-screening helps to keep down the possibility of adverse selection, so there is some merit to linking insurance to the employment relationship for at least some workers (though not necessarily all). There are some other reasons to maintain a connection. Employers have an interest in seeing that workers do not miss work because of illness and, thus, disrupt the production process; for workers who are key members of production teams, lost output can be substantial. Much of the long-term incidence of improved productivity through reduced absenteeism and greater “presenteeism” (higher productivity on the job) will be transformed

into higher worker wages. The payroll mechanism may be a good vehicle for ensuring regular deductions from salary to pay premiums, and starting a new job may be a good time for people to think about adding insurance benefits. But the best way to decide whether these advantages offset the disadvantages of letting the employer select and manage the worker’s insurance is to let workers make neutral choices.

Marketing Subsidized Insurance

One of the challenges to government-managed insurance plans such as Medicaid or S-CHIP is to get poor people who are eligible for subsidized coverage to enroll and accept their subsidies. Even now, nearly a third of those eligible for Medicaid fail to obtain it, and, after its recent “success,” S-CHIP picks up barely a third of the remaining uninsured children. This is unacceptable. Sometimes, one suspects, state governments with budget concerns might not be too worried about a low “take-up rate,” but even when efforts are made, the rate is often (though by no means always) low. It is the low take-up rate for such free insurance that causes some estimates of the impact of credits on coverage to be relatively low.⁴

If credits or coupons are widely offered, it is reasonable to assume that profit-seeking insurers will try to sell their insurance to people who are receiving substantial subsidies to pay for it. Thus, our strategy is to rely on insurers to market insurance to their customers, rather than use government agencies to enroll clients. The main problem that these agencies have faced is the difficulty of limiting enrollment to those eligible, while at the same time encouraging people to reveal the financial information needed to determine eligibility. To do so, they have felt it necessary to impose onerous burdens on potential eligibles, such as New York’s annual obligation to provide face-to-face evidence of income and family composition qualifications to a government official. Our strategy, even in this first phase, but more effectively in the next, is to achieve a high take-up rate by sepa-

⁴ J. Gruber and L. Levitt. “Tax Subsidies for Health Insurance: Costs and Benefits.” *Health Affairs* 19 (1) (January-February 2000): 72–85.

rating the purchase of insurance from the process of establishing eligibility. To do this, we propose to provide potential clients with vouchers or certificates good for \$1,500 or \$3,500 off an insurance plan premium, and sending them (through the mail or some other device) to people with incomes close to what would make them eligible.

The certificate could be transferred to the insurer who provides coverage, along with any initial premium, and then redeemed by the insurer for its face value after a period of continuous coverage. However, the certificate would be coded with the person's Social Security or other taxpayer identification number, and anyone who used the certificate but was ineligible to do so (because family income was too high) would have to make up the difference (and pay a penalty) on his or her income tax return. This device also would provide a convenient way to subsidize people who are eligible for part of the year, and it would provide a way to obtain insurance that would not require the lower-middle-income buyer to advance the full premium before seeking reimbursement. Lower-income families (below 125 percent of poverty), technically eligible for free publicly managed insurance, also would be permitted to use the certificates if they preferred private insurance to Medicaid or S-CHIP.

For people with no "employer-paid" coverage, the credit coupon could simply be turned over to the insurer, which would then redeem it with the government. For those whose employers paid for premiums as part of compensation, eligible employees could attach the coupon to their tax returns, and calculate the net credit as the difference between the value of the credit and taxes on the employer payment. While precise details depend on parameter values, these adjustments also would permit the value of the credit to equal the value of the exclusion for incomes near or slightly above the upper limit.

Initial distribution of the coupon could be done in several ways. Coupons could simply be mailed to those indicating a low expected wage on their tax withholding (W-4) form. These also could be available at post offices or other convenient sites. Insurers could furnish coupons, as well. The coupon would clearly state who is eligible to use it, and

impose end-of-year tax penalties on those who are ineligible. If Publishers Clearinghouse can reach nearly everyone, there must be a program that could work for health insurance.

Finally, those taxpayers with incomes in the range at which they are eligible for the credit, who nevertheless fail to redeem their credit, could be enrolled automatically in a low-cost insurance plan with a premium no greater than the credit. Such a process will require a monitoring mechanism.

Benefits

An important design issue concerns specifying the policy for which the credit may be used. Defining "minimum benefits" is always politically troublesome, because every supplier of medical services will lobby to have generous coverage of its services included. But requiring that everything be covered means that the premium will be very high—higher than any feasible credit, higher than many persons are willing to pay, and higher than taxpayers are willing to subsidize.

A solution to this problem would be to have a fairly inclusive definition of covered services, but permit policies to hold down premiums through deductibles, coinsurance, and upper limits. That is, at least initially, any policy that would qualify for the credit would have to pay for all medical and surgical services and all prescription drugs and medical devices, based on some commonly accepted definition of what constitutes standard (non-experimental) care. However, cost sharing could be imposed, as could managed care rules and incentives for providers. The definition (for medical and surgical services) used for the traditional Medicare plan probably could be used here, but, even if some of the services not typically covered were included in the definition of covered services, the presence of cost sharing would limit the extent to which they would be used as well as their additional cost. Citizens could be free to choose, at additional cost, plans that cover these services with lower levels of patient cost sharing. In effect, we tell people that they may use their individual \$1,500 credit to pay for any policy covering a set of medical and surgical

goods and services that has a premium of \$1,500 or more.

However, one can be certain that, unless the credit is as large as the premium for a generous insurance plan, some people will not be willing to make additional payments to buy some specific generous plans, but will choose either no insurance or a partial-coverage plan instead. Different analysts (and different citizens) have different views on how much coverage they think a family at some income level ought to have. There is a trade-off here. We could put stricter bounds on qualified coverage, making such coverage more adequate. But the credit would not cover the full premium, and then some people would refuse the credit, preferring to remain uninsured rather than pay an additional premium.

In line with our primary objective of covering the uninsured, we think that, at first, there should be virtually no rules about cost sharing. The only rule would be that the policy provide dollar benefits appropriate to its premium. Rather than attempt the surely difficult and probably impossible task of specifying the appropriate levels of cost sharing for every credit recipient, we propose to begin by letting the credit recipients themselves decide what kind of coverage they prefer. Once we know the pattern of coverage, and can check to see what effect it has on access to care and health levels, we can judge whether stricter regulation of the package is needed.

We start in an unrestricted way (and try to stay with light restrictions) because we think that the highest-priority objective ought to be to get at least some health insurance coverage to every American who is not high-income, even if the level of coverage cannot be adjusted (or financed) to be what some regard as perfect in the initial round. We postulate that the law of diminishing returns holds here as everywhere else: the first infusion of coverage will do the most good, and the benefit of latter additions, though probably positive, will be smaller. The way to get almost everyone to buy coverage in response to a credit is to permit people to use the credit as they like, with as much or as little of their own contribution as they prefer. It would be irrational for someone to refuse to use his or her credit on a (private or public) insurance policy that costs

no more than the credit and provides at least some protection against what otherwise would be out-of-pocket payments the person would be forced to make and/or a policy that improves access to some types of care.

Finally, if insurance did take the form of full coverage above a deductible, the RAND health insurance experiment reassures us that cost sharing will not have substantial adverse effects on most measures of health status for the non-poor. In the experiment, the only adverse health outcome (beyond some minor effects on vision correction and oral health) was for people initially at high risk for hypertension. For the majority at normal risk and for other high-risk conditions, cost sharing does not appear to harm health, as long as there is catastrophic coverage.⁵

Fit with the Current System

The Role of States

States would have the primary role in administering the Medicaid-like coverage for poor adults. The bulk of the additional cost for this coverage would be provided by the federal government.

States would be permitted to regulate the extent to which premiums for coverage in excess of the low-cost policy vary with risk, but would be penalized if this regulation caused people to remain uninsured or caused disproportionate numbers to choose minimal-coverage (low-cost) policies. Finally, states could provide payments for people with very high costs or chronic illness. Doing so would mean that the low-cost coverage in such states could have a smaller deductible or less-constraining upper limits.

What Improved Private Insurance Markets Might Look Like (and How We Can Get There from Here)

It seems eminently plausible that the influx of large numbers of lower-middle-income workers and their families into non-group insurance markets would

⁵ J. P. Newhouse. *Free for All?: Lessons from the RAND Health Insurance Experiment*. Cambridge: Harvard University Press, 1993.

change those markets. We have offered some optimistic views of how they might change, but the truth is that no one knows for sure what might happen. The usual response of policy designers or policy makers is to abhor uncertainty (as definitely worse than a vacuum) and, therefore, to design many rules and some incentives to configure the outcome. For reasons stated earlier, we are skeptical of such efforts, not only because there really are no experts who know what outcomes will be produced by what rules, but also more generally because we think it important to give the widest scope to possible innovations. This said, we do think that some probable contours of a new market may be worthwhile to forecast and even to contemplate encouraging (or at least not deterring).

The most common reaction to proposals that employees be armed with credits that they can use for different insurance from that which their employers provide (if the employers provide any at all) is to begin to imagine the design of a new and improved type of group insurance, with many choices (all good), well administered. We do not share this vision of a single tidy market for all. We remain skeptical that such quasi-groups generally can achieve anything like the administrative savings now obtained by large groups with compulsory participants. We think there ought to be a “HealthMart” option, but that we ought to think of (and permit or foster) other alternatives. The key to considering alternatives is to note that there must be trade-offs: a scheme can offer a limited set of choices priced in a transparent fashion, but that scheme surely will have a cost in terms of the scope of options (especially new options) offered and, probably, in terms of administrative cost. Another unrealistic view is to imagine that the Internet alone can cut administrative cost and expand choice without being bedeviled by adverse selection and mass confusion (not to mention an inability to generate revenues).

Our proposal in this case is to impose a modest amount of *voluntary* standardization on plans and plan types, and then allow the market itself to sort out how they should be offered. The standardization would allow plans to be designated as meeting certain model types, to facilitate shopping and compar-

ison, but a plan could be non-standard as long as buyers were clearly warned about its type. “Site” or program sponsors could offer assurances or guarantees about the plans they list, but they would then be responsible for the performance of the plans they list. Conversely, an eBay of health insurance could list all legitimate offers cheaply, but make no representation about their quality beyond what is embodied in state regulations.

The public sector would have a role in making information about insurance purchasing and plans available to potential consumers. Information about quality and price is in the nature of a public good, and would not be supplied adequately or in an unbiased fashion in a private market (although development of helpful and accurate guides for federal employees suggests that the same thing could happen for 18 million new insurance customers). Subsidizing the production and distribution of such information would be a good role for government; one vehicle would be to distribute publicly financed vouchers that could be redeemed toward purchasing the buyers’ guide of one’s choice.

Monitoring, Adapting, and Phase II

We recognize that the Phase I plan we have suggested will not achieve universal comprehensive coverage, nor will it necessarily perfect how insurance markets function. That is why we envision a formal monitoring process and a plan to bring the other two groups in the population—people below 125 percent of poverty and people above 300 percent—into the system in a second phase.

What would be the best way to monitor this system’s performance? Possibilities might include the following: State insurance or health departments (which often regulate health insurance anyway) might be one expert entity. Or there might be a federal advisory commission, as there has been for Medicare. It would be desirable to offer incentives to any oversight body to make the process work. For example, states might be rewarded if the number of uninsured in their state in the target income category fell more than expected, and they might be penalized in some fashion if the number fell short, espe-

cially if the shortfall could be attributed to state regulation of rating or costly mandated coverage provisions in the individual or small-group markets.

States also might be given the task of monitoring the effect of credit-subsidized insurance on health status. In addition, they should determine whether the partial coverage plans affordable with the credit amount alone adversely affect health status more than plans with more generous coverage. State health departments already exist, and it is likely that effects vary by state.

The key point here is that monitoring should focus on changes in use of services and, ideally, on changes in health outcomes. In the state-monitored scheme, for example, if a state were able to encourage the use of more services that are effective for health, we would not be especially concerned about the distribution of people who switch from being uninsured to insured. Because the availability of credit certificates increases the competitiveness of firms not offering group insurance in the labor market, those firms that did offer some coverage would be motivated to manage it more effectively to continue to be competitive, and these changes might help health outcomes substantially. Attention also might be given to other consumer goals, such as financial stability and relief of anxiety.

The specific issues to be monitored most closely are the two major policy uncertainties: how many people of what type will take the credit, and how the group market based on groups other than employment will be transformed. If substantial numbers of large firms dropped group coverage, or if small firms with high-risk workers did so, that would indicate that something is wrong. (Remember: the fallback insurer is always available for a person at any risk level, and the low-cost coverage has adjusted community-rated premiums.) Enhancement of a high-risk pool would be the proper response to any evidence of increased risk segmentation. If credits were not claimed in adequate numbers, that would imply that the value of the credits was too small compared with the premium for a good policy. The supply, purchase, and form of any “zero-premium” partial-coverage policies should be monitored, as well.

Quality: What Would a Good (but Imperfect) Low-Cost Plan Look Like?

One of the most controversial aspects of our plan is its acceptance that people may use a moderate-size credit to buy a less than comprehensive policy whose premium is close to the credit. It is easy to argue that this is bad idea if one assumes that people will make poor choices in the plans they choose, or if one believes that nothing less than full coverage will do. (To achieve “first best” optimal coverage, either a mandate or a lavish public budget would be necessary. While we favor a mandate in a politically unconstrained world,⁶ in this paper we assume that mandates are not feasible.) At one extreme, the previously uninsured person could buy a policy with full coverage above a substantial deductible. While, according to insurance theory, this makes perfect sense in an otherwise perfect world, in reality it is likely to be unattractive to some lower-middle-income people because they would expect much of the benefit to substitute for charity care they might have received for free if they contracted a serious illness (and were able to obtain care without insurance coverage).

On the other hand, a first-dollar policy with a very low upper limit would not be especially attractive either (although it would be better than nothing and would appeal to those consumers, fervently believed by politicians to exist, who only want insurance if they can be assured of collecting some money from it). The best cost-sharing pattern might be one with a moderate but not trivial deductible (say, \$500), and as high an upper limit as the credit will buy. Our own analyses suggest that, for the average worker, the upper limit might be on the order of \$6,000 to \$10,000 per year.⁷ Illnesses costing more than \$10,000 could be covered by public insurance for the chronically ill, if states chose to do so. The fallback insurer could assist people who do not understand which low-cost coverage is best.

⁶ M. V. Pauly, P. Danzon, P. J. Feldstein, and J. Hoff. *Responsible National Health Insurance*. Washington: AEI Press, 1992.

⁷ M. V. Pauly and B. Herring. “Expanding Insurance Coverage through Tax Credits: Tradeoffs and Options.” *Health Affairs* 20 (1) (January-February 2001): 1–18.

The other strategy this insurance might follow is aggressive use of closed panels and managed care, but with the option of going “out of plan” with out-of-pocket payments. Given the oversupply of physicians in the United States and the wide range of hospital costs, an effective discount network might be established to fit within or close to the total value of the credit. However, we strongly suspect that, once a person signs up for a frugal plan, the experience of high out-of-pocket payment or strict rationing will prompt that person to put a moderate amount of his or her own money on the line and buy the next step up in insurance policies in the future. There is no doubt, however, that the market for low-cost plans would be stimulated.

Phase II Administrative Changes

Now suppose that a new and improved type of non-group health insurance market does emerge, and that credits substantially reduce the number of uninsured. The next step is to allow those with incomes below 125 percent of poverty to use such private insurers. This would be relatively easy to do; we only need to permit poor people currently using the public fallback insurer to use the same money to buy private insurance that non-poor people do. That is, the comprehensive Medicaid-like coverage already being provided to the poor would be converted into a premium support system, with expenditures converted into vouchers usable for private alternatives.

The other change is that it should be possible to abolish, or at least radically transform, the safety net system. This system is intended to help people who “fall through the cracks” through no fault of their own. If credits for full coverage are offered to people with low incomes, and if lower-middle-income people receive credits large enough to allow them to afford insurance, there should be very few who qualify for the safety net system (perhaps only non-regis-

tered aliens and people who become ill in the midst of a transition from one plan to another). One might convert payment for the services provided by public hospitals and clinics into a pre-paid plan, and allow people to sign up for this type of insurance.

What of the people with incomes above 300 percent of poverty? If a properly functioning private insurance system emerges, we think it might be a good idea to mandate that they buy coverage. The simplest way of doing this would be to levy a tax surcharge equal to the premium for the fallback coverage on people with incomes above the median who are not insured. This system could be put in place easily, and it would affect only a tiny minority of the population who could hardly claim to be financially strained to pay the tax. Mandating coverage for lower-middle-income people (as already noted) will prove to be a more serious problem, and we do not advocate it now. The tax exclusion could be extended at a capped level to all high-income people (that is, to the small minority who currently buy non-group coverage, possibly as part of a tax law change capping the value of the exclusion for all).

Conclusion

This proposal suggests addressing the lower-middle-income uninsured first with a system of generous tax credits to purchase insurance of their choice in a lightly regulated competitive market. If the good outcome that is possible does emerge, then the poor, near-poor, and the well-off could be invited to join this system, with substantial subsidies for the poor and substantial good wishes for the well-off.

If the plan does not work, we could hardly be worse off for trying. We will have settled the controversy over what kind of markets private insurers can expect to offer, and what kinds of roles private insurers should be expected to play in helping to deal with the uninsured. ■

Pauly Proposal

Key Elements

Mark V. Pauly has outlined a new proposal to reduce the number of uninsured that would:

IMPLEMENT A RELATIVELY STRAIGHTFORWARD INTERVENTION that could be easily modified in response to lessons learned from this new approach.

PROVIDE LOWER-MIDDLE-INCOME HOUSEHOLDS with flexible, refundable tax credits or “coupons,” redeemable for insurance premiums or a reduction in taxes, for any licensed medical-surgical insurance policy with a premium at least as large as the credit.

MAKE VERY LOW-INCOME HOUSEHOLDS eligible for publicly provided or contracted insurance, or for equivalent-cost private insurance, with no premium share required.

ALLOW HOUSEHOLDS WITH INCOMES ABOVE THE MEDIAN to retain the tax exclusion for group coverage, until mandated to participate in the new program at some point in the future.

GUARANTEE THAT ALL HEALTH INSURANCE POLICIES are renewable.

About the Author

MARK V. PAULY, PH.D., is Bendheim Professor and Chair of the Department of Health Care Systems, Professor of Health Care Systems, Insurance and Risk Management and Public Policy and Management at the Wharton School, and Professor of Economics in the School of Arts and Sciences at the University of Pennsylvania. Dr. Pauly served as commissioner on the Physician Payment Review Commission, and he is an active member of the Institute of Medicine. One of the nation's leading health economists, Dr. Pauly has made significant contributions to the fields of medical economics and health insurance. His classic study on the economics of moral hazard was the first to point out how health insurance coverage may affect patients' use of medical services. He has explored the impact of conventional insurance coverage on preventive care, on outpatient care, and on prescription drug use in managed care, as well as studying the influences that determine whether insurance coverage is available and the effect of insurance use on health outcomes and cost. Dr. Pauly is co-editor-in-chief of the *International Journal of Health Finance and Economics* and an associate editor of the *Journal of Risk and Uncertainty*.