Economic and Social Research Institute

Issues in Coverage Expansion Design

Options for Financing Health Coverage Expansion

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Covering America

REAL REMEDIES FOR THE UNINSURED

The present U.S. health care system is financed by a mix of revenue sources. Employer-sponsored group health coverage is funded by employer and employee premium payments, supplemented by tax subsidies. Households pay out of pocket for some services and pay premiums either as employees or as individuals. Government programs are supported by general revenues and payroll taxes. And all three groups indirectly share in one way or another in paying the costs of the safety net systems and charity care that support health care for the uninsured. Anyone proposing major reforms to extend health insurance coverage to the millions of Americans who are uninsured will have to decide whether to use existing financing sources, add new ones, or substitute one single source for the diverse array of funding streams under the current system. This paper develops a framework for describing and assessing the alternative ways to finance health coverage for the uninsured.

Stresses on the Current System

Each of the major funding streams supporting coverage and access to care for Americans is under stress today.

For consumers, there is the issue of how to pay for rising premiums and co-payments and deductibles, as costs rise and employers feel the need to shift some of those costs back to employees.

For employer coverage, there are many issues:

- how to control double-digit increases in health coverage premiums;
- how to assess the desirability of having employers select and manage health plans for their workers versus transferring those responsibilities—along with greater responsibility for spending decisions—to individual workers;
- how to "level the playing field" for people who obtain health coverage through the workplace and those who buy coverage on their own;

The **Coverage Expansion Design Series** explores issues that policy makers designing comprehensive expansions of health coverage need to address. This series is a part of the *Covering America* project, which promotes serious consideration of a diverse range of comprehensive proposals to provide affordable health coverage for the millions of uninsured Americans. The project has published 13 proposals for major expansion of health coverage written by leading health analysts and researchers. The proposals are available from the Economic and Social Research Institute or on line at www.esresearch.org.

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- how to use public dollars to support but not supplant employer contributions to health coverage (avoiding "crowd out");
- how to provide incentives to expand employer coverage for low-income households; and
- how to address the regressive impact of current tax subsidies without undermining coverage that already exists.

For government, there are issues involving both Medicare and Medicaid. Medicare is confronting critical issues about:

- how to protect the trust fund from other government budget demands;
- how to make the program actuarially sound as the population ages and costs continue to increase sharply;
- how to modernize the program to add prescription drug coverage and more effective purchasing techniques; and
- how Medicare coverage should dovetail with private coverage.

For Medicaid, there are questions about

- how to keep in check the natural tensions between state and federal governments regarding who should pay for what;
- how to address the variable financial resources and commitments of states;
- how to use public funding to leverage employer contribution to health coverage; and
- how to control health care costs under a jointly financed entitlement program.

The present health care system relies on all three of these funding sources—households, employers, and government—and it is likely that a future system will do so also, though probably not in the same proportion.[1]

The stresses that confront these funding sources in the current system could be either relieved or exacerbated by efforts to expand coverage. Designers of reform would be wise to keep the current difficulties in mind as they think of alternative financing strategies.

Net Costs, Social Costs, and Financial Costs

In any new proposal to cover the uninsured, the *net* cost to society is reflected in the *new* health care resources used by those who previously lacked coverage. Although they may delay or forgo cost-effective primary and prevent care services, uninsured people do, of course, consume health care even though they have no coverage. In simple terms, if an uninsured family would consume $4,000 worth of health services over a year's time in the absence of health insurance, and with coverage would spend $5,000 on health care (assuming nothing else changed), the real net cost of assisting this family is $1,000. That is, they were already using $4,000 of medical resources. Only the additional $1,000 worth of medical resources they use up is the new real cost to society, in the sense that the medical resources used for this purposes are not available for other uses.

In terms of financing health care for the uninsured, it would be enough of a challenge to determine how to raise the $1,000 in the example. But the fact is that the financing implications go beyond the $1,000. When they had no insurance, the family's $4,000 of medical costs were paid by some combination of household revenues, charity care, and bad debt. But a system to cover the uninsured will likely change who pays that $4,000.

[1] In the proposals developed through the Economic and Social Research Institute's *Covering America* project, the additional costs of covering the uninsured are paid for by various combinations that may include federal general revenues, state matching payments, payroll taxes, consumer premiums, savings from limits on tax exclusions, and other sources. These are outlined in the table that follows this document.

Presumably less would be paid by the household and much less by charity care or bad debt. Very likely, more would be paid by government or employers, with the burden of these payments falling on taxpayers, in the first instance, and on workers, in the second. So the difficult question of deciding who should pay is made more difficult by the fact that the new system will have to finance not just the $1,000 but much of the $4,000. The net cost to society is still only $1,000, but new financing has to be found for much of the $5,000. Shifting the burden of costs to different payers is, of course, likely to raise controversy.

Of course, most major reform proposals involve financing arrangements that affect the source of funding for more than the uninsured. For example, an approach that offered subsidies (say, tax credits) to everyone below some income level (say, twice the poverty level) would provide subsidies to some people who already buy coverage and pay for it in some other way. The new system has to find a source of funding to pay for coverage for these people also. Depending on the nature of the new system, the sources of financing could be dramatically altered. For example, a single-payer system would shift all of the funding to government (though the new net cost to society would still be unchanged).

So, although the real additional cost to society to cover the uninsured is relatively small, a system to provide coverage for them is likely to involve major shifts in who pays the financial bill for large portions of medical spending. Making the decision about how to redistribute that bill among the possible payers is the difficult part of the financing question.

Before turning to the question of how to distribute the financing burden, it is important to note that all the costs of any financing system are ultimately borne by consumers. Consumers pay in one of the following ways: out-of-pocket payments for medical services; insurance premiums; higher taxes; lower wages or higher costs for final goods and services (when employers pay but pass on part or all of the premium); or reduced stock prices or corporate dividends (when employers pay but cannot pass on the cost). Consumers ultimately bear both the financial and the real resource costs. But different financing systems affect *which* consumers ultimately pay the bill, so the choice of a financing system is important in terms of its affect on different people's welfare.

The Financing Decisions

Deciding on a financing system requires making many difficult judgments. The most obvious is deciding who pays the initial bill. Whereas the *ultimate* source of financing is individuals, there are real political and operational consequences attached to whether the *proximate* source of financing—the entity responsible for paying the healthcare bill—is the government, employers, or consumers.

Who Pays "Up Front"?

Thus, the first element of the financing decision is a determination of *what parties put the money "up front" for new coverage.* If, as argued earlier, contributions will be expected from each of the three sources—households, employers, and government (state or federal)—the issue is how the burden should be distributed among them.

Households. Few would argue that households should be absolved of all financial responsibility. Consumers can pay directly for services, in the form of copayments and deductibles, or they can pay premiums. Alternatively, they could be mandated to acquire coverage, which has the advantage of forcing the "free-riders" (who could afford coverage but fail to get it) to pay their fair share.[2] People disagree vehemently about the extent to which households should directly pay the bill. The proponents of imposing relatively high financial responsibility for consumers argue that such payments, especially copayments and deductibles that are paid at the point of service, help to create cost consciousness and thereby constrain cost escalation.

Others, particularly those who are proponents of managed competition, favor having households pay significant premiums. The ideal approach, in this view, is to have the premium subsidized at some fixed-dollar level, high enough to make adequate coverage affordable, with consumers paying the full premium above that level, so that they have strong incentives to choose high-value plans. According to this view, cost control is achieved by giving people incentives to choose cost-effective health plans.

Yet another group of reform proponents would minimize household payments, arguing that access to health care should be a right and that it is a responsibility of government to provide such access to all. They also frequently argue that imposing significant payment requirements on consumers is likely to discourage the use of necessary services and will therefore produce higher costs in the future.

Employers. The principal argument for having employers absorb a significant share of the funding burden is a pragmatic one: they already fund a major portion of the cost for working people,[3] and continuing to assign

[2] Imposing an individual mandate, which some have proposed as a way to ensure universal coverage, amounts to requiring households to pay a premium or, alternatively, what economist sometimes refer to as a "head tax."

[3] It is worth remembering that employers' heavy involvement in the financing of health care is encouraged by the tax provision that allows employees to exclude from taxable income the amount that their employer con-

responsibility to them makes the political burden of funding an expanded program much easier. But there are other reasons as well. Many would argue that employers have been an effective force for holding down costs, making the system more efficient, and improving quality. Unless they have a strong financial stake in financing health care, employers' motivation to push for better performance would disappear. Admirers of the role employers have assumed question whether, without them, there would be effective pressure to improve the quality and efficiency of the medical delivery system. Finally, friends of the employer-sponsored system argue that large employers play a major role as poolers of risk for a large segment of the population, and that without this pooling function, problems that arise from risk segmentation and premium rating based on risk would be worse than they already are.[4]

Those who are more critical of the employer-funded system counter by saying that the employers' financial role puts them in the position of imposing their values and objectives on the health care system and allows them to dictate the options available to their workers; yet what workers and their families want and need may be at odds with their employer's preferences. Employer control might be viewed as particularly inappropriate if, as economists generally argue, the costs of employer-paid premiums are borne, at least in the long run, by employees in the form of lower money wages.

Exactly *how* employers might be expected to contribute to financing is a slightly different question. Of course, it is certainly possible to design a financing structure that would make employers pay but not give them control over the nature of coverage. The major employer-based financing options (besides the current voluntary participation) are through payroll taxes, some other form of employer tax, or a mandate that they provide coverage.

Government. Almost no one would claim that government should not play a major role in financing health coverage and access to health services. Virtually all policy makers agree that government has some responsibility to provide coverage for at least certain categories of people who cannot afford to buy coverage on their own. And major coverage expansions will almost certainly require new government funding, since lack of affordability is the principal reason that many employers, employees, and individuals fail to buy coverage. Of course, there are many who are wary of extending government's reach and would thus prefer to minimize government's role in funding coverage expansion. But almost no one argues that achieving anything close to universal coverage can be achieved without some degree of additional government money.

As policy makers make decisions about the relative financing role of government versus private payers, they need to remember that decisions about who is to pay the bill may have an important effect on the efficiency of the health system—its ability to satisfy consumers' need and preferences, to employ the optimum mix of resources, to encourage innovation, and so forth. Because the financing decision determines how the health care bill will be shared, it influences who will have the strongest incentives to control costs and be concerned about efficiency. A system that is financed almost solely by government, as a single-payer system might do, would probably have quite different incentives than one that required employers and consumers to share heavily in the financing obligation. In deciding among financing options, it is important to consider the implications for the system's efficiency.

Issues in Government Funding

Since most of the uninsured have relatively low incomes, they cannot be expected to use just their own resources to pay for care. Much of the funding must come from other sources. Under many proposals, the bulk of new financing for health coverage expansion flows through government, raising the issue of how to generate these public revenues. Certain kinds of proposals would generate part of the needed financing by redirecting existing subsidies. For example, if other kinds of subsidies were provided for low-income people, savings from Medicaid, S-CHIP, or disproportionate share hospital (DSH) payments could help finance the new program. Alternatively, policy makers could raise revenue by eliminating the tax provision that allows employees to exclude from taxable income the amount that employers contribute to health insurance premiums. But major reform is likely to require funds in addition to those that might be generated by redirecting existing subsidies. Thus, a consideration of the funding sources that government might use is appropriate.

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tributes on their behalf toward the premium for health insurance. Not only has the tax exclusion encouraged employer-based coverage relative to other options that do not enjoy the same tax advantage, it has made a dollar's worth of employer compensation in the form of (untaxed) health insurance worth more than a dollar's worth of (taxed) money wages. This has encouraged workers to buy more health insurance—less cost-sharing and more comprehensive benefits—than they would have done had they been paying out of their own pockets. In economic terms, this is an inefficient result, because more resources are allocated to the production of health services than is optimal—because the consumers are not paying a price that reflects the full resource costs of production. It also contributes to health care cost escalation.

[4] For a detailed discussion of these issue, see Elliot K. Wicks, "Coping with Risk Segmentation: Challenges and Policy Options," Issues in Coverage Expansion Design, No. 2, Economic and Social Research Institute, Feb. 2003.

Criteria for Assessing Funding Sources

Before turning to the specific government funding options, it is important to discuss some of the criteria to be considered in making choices among the options.

- *Horizontal equity.* A key consideration in choosing how to collect funds is maintaining equity among those taxed. One important element of equity is horizontal equity—equal treatment of equals—or, in other words, equal treatment of people who are similarly situated, which usually refers to their income and family circumstances. This principle is not very controversial: virtually everyone agrees that equals should be treated equally, though there may be some disagreement about how to determine who are equals.
- *Vertical equity.* Vertical equity refers to the fair distribution of costs (taxes) or benefits among people who have different circumstances, which, in general, is measured by differences in their ability to pay. Ability to pay is typically based on income, so that application of the principle would mean that people with higher incomes should shoulder more of the tax burden than those at lower income levels. Although ability to pay is typically defined in terms of income, a case could be made that assets should also be considered. For example, eligibility for federal student financial aid is based not only on income but some categories of family financial assets as well. Trying to take assets into account, however, increases the administrative complexity of measuring ability to pay because wealth is harder to measure than income.

Since vertical equity involves issues about how to *redistribute* purchasing power among the population, it is inevitably controversial. There is no agreement about how to distribute the burden of taxes, and there seems to be no fully objective way to determine what amount of redistribution is fair. Nevertheless, there are some commonly used terms for categorizing the extent of vertical equity. They are based on the way the tax affects the distribution of income before and after the tax. A *proportional* tax is one that requires everyone at every income level (assuming income is used as the measure of ability to pay) to pay taxes that equal the same proportion of income. Thus a proportional tax leaves the shares of income going to higher- and lower-income people unchanged. A *progressive* tax would require higher-income people to pay a higher proportion of their income; the tax *rate* is higher the higher the income. A progressive tax redistributes income: lower-income people are left with a larger share of after-tax income than they had before the tax, and the opposite is true for higher-income people. A *regressive* tax requires lower-income people to pay a higher proportion of income in taxes.[5] Thus a regressive tax redistributes income from lower-income groups to higher-income groups. As noted, there is not complete agreement on what degree of redistribution is fair, but there is some consensus that the overall impact of taxes should not be regressive, since that would involve a redistribution of income from the poor to the rich.

- *Efficiency-related incentives.* Assuming its only purpose is to raise revenue, the ideal tax would not distort people's behavior. In particular, it would not discourage work or entrepreneurial activity or reduce savings levels. But taxes on income can reduce the monetary rewards of working and thereby encourage people to work fewer hours, retire earlier, take longer vacations, etc. Certain kinds of taxes on wealth could discourage savings. These effects need to be carefully assessed in choosing among tax options.
- *Stability of funding source.* Some tax sources are highly variable, moving widely in response to cycles in the economy, changes in consumer behavior, etc. Since the level of funding required to finance health care coverage is unlikely to decline when the economy is in decline, it would be desirable to fund the system with a tax that yields relatively stable revenues in the short-run and even grows as the economy experiences long-term growth (since demands for health services are likely to grow over time).
- *Administrative practicality.* Collecting some kinds of taxes involves greater administrative complexity and cost than others, so that the net yield is less. High complexity is also likely to produce some horizontal inequity that can be overcome only by adding greater complexity. The observation has been made that there is often a conflict between administrative simplicity and equity, particularly vertical equity. For instance, many of the exemptions and deductions that are embedded in the individual income tax code are there to improve the vertical equity of the system.
- *Cost control.* Keeping cost escalation in check is an important objective in designing coverage expansions. Some financing choices may make the job easier or harder. For example, a tax source that grows more rapidly than income makes it harder for policy makers to point to funding constraints as a reason for keeping spending down. Taxes that are explicitly earmarked for health coverage—for example, a payroll tax on employers—may be more likely to create pressures for cost control than would be the case if the funding comes from general revenues, where

[5] Note, however, that a tax that is regressive may still collect more in absolute terms from high-income people than from low-income people—for example, if a person with an income of $1,000 pays 10 percent ($100), while a person with income of $2,000 pays 8 percent ($160).

the effect of health spending on revenue requirements is camouflaged by being mixed in with many other uses for general revenues.

- *Political feasibility*. Even if a funding source scored high when measured against all the preceding criteria, it might be the wrong choice if it proved politically infeasible. Of course, the political feasibility is to a large degree dependent on how people judge that the tax measures up against these various criteria.

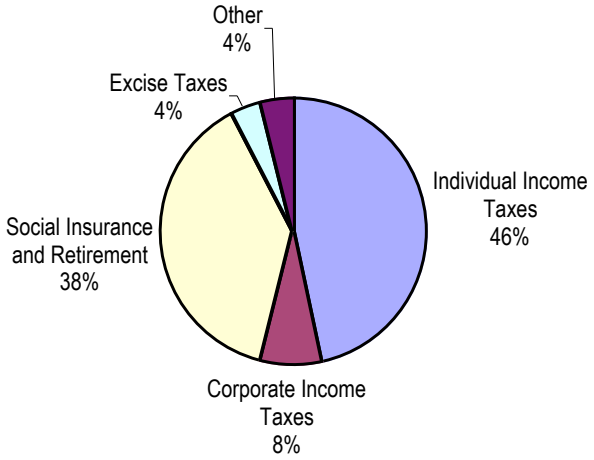
Each of these considerations is difficult enough to deal with in isolation, but the problem is, of course, that there are major trade-offs among them. A financing approach that scores high with respect to some criteria will not fare so well when measured against others. Deciding which trade-offs to make is the most difficult part of the decision.

The Federal Tax Options

Almost certainly, major programs to expand coverage will require substantial new *federal* funding. Tapping federal revenues has several advantages. First, the revenue-raising capacity of the federal government is great, because there are no legal limits on its taxing authority, and it can tax virtually all possible sources of revenue. Second, the federal government, unlike most state governments, is not prohibited from incurring deficits to cover spending when tax revenues fall off during an economic downturn. Thus federal funding need not be curtailed in periods of poor economic health, the very time when the need for subsidized coverage is likely to rise. Particular states, on the other hand, experience very wide swings in tax revenue in response to cyclical economic changes, and they often have few practical options during economic downturns except to cut services.

Some of the major federal tax options are general revenues, payroll taxes, and a value-added tax.

Federal Revenue Sources, 2002



Source: [DOCID:2004_tab_hist-6], Historical Tables, Budget of the United States Government, Fiscal Year 2004.

General revenues are funds that are not earmarked for a specific purpose, with the primary source being the individual income tax. (As shown in the figure above, the individual income tax accounts for 46 percent of *all* federal revenues, including trust fund revenues.) General revenues are often seen as a appropriate source, particularly because the income tax is generally viewed as more equitable than some other taxes since it is a progressive tax. Also, relatively small increases in tax rates produce large amounts of revenue. On the other hand, the income tax, especially because of its progressive nature, can have a negative effect on work incentives. Raising the tax to a higher level might create incentives for some workers to reduce work hours or even leave the labor force. Higher taxes could also affect the willingness of new and existing entrepreneurs to take on the risk of investing in new plant and equipment and pursuing risky innovations, which in turn could have a negative effect on productivity and ultimately household income.

A payroll tax is another possible candidate to finance expansions of health coverage. This tax is particularly attractive because it is comparable to an employment-based health insurance premium. Since most people with private coverage have that coverage financed by premiums financed partly by employers and partly by employees, a payroll tax to finance health coverage is an extension of that concept. Moreover, a payroll tax yields a large revenue return. On the other hand, the payroll tax is frequently criticized for being regressive. Payroll taxes are frequently "capped," that is, earnings above some level are not taxed. This is not a necessary condition, however, since the Medicare payroll is not capped. A cap makes the tax regressive. Even if most or all of the tax is nominally paid by the employer rather than the employee, most economists believe than in the long run the cost is passed back to employees. If so, the regressivity of the tax is not affected by the extent of the employer contribution. The tax is also regressive because it applies only to earnings, which are the primary, and often the only,

source of income for lower-income people, whereas higher-income people are more likely to be recipients of interest, dividend, and other forms of income not subject to a payroll tax. Adding additional tax on top of the current payroll tax for Social Security and Medicare, when combined with the effects of the income tax, could have some negative effect on work incentives. The magnitude of the effect would depend, or course, on the size of the rate increase.

Another major alternative is a value-added tax (VAT). Common in Europe but unused in the United States, this is a kind of sales tax or consumption tax. It is a percentage amount that is imposed at every stage of production on the difference between the cost of production and the price of sale, that is, on the value added. Producers pay the tax, but the cost is passed on in the price of the goods they sell. One advantage of this tax is that it can generate a large amount of revenue with relatively low tax rates. In addition, since it is a tax on consumed goods, it does not have a negative effect on work incentives; earning more does not require paying more tax. And it has what many view as the positive effect of encouraging savings, since saved income is not taxed. A political advantage is that the impact of the tax tends to be rather invisible to the taxpayers; although the tax is obviously in the price of final goods, the tax is not explicitly added to price of the final good, as with the sales tax, but instead is added at every stage of production. A major disadvantage is that is it a regressive tax: since the rate is constant on all consumption goods, it is proportional for the portion of income that is consumed; but since lower-income people consume more of their income than higher-income people, the net effect is regressive.

These taxes are obviously not the only options for financing major coverage expansion,[6] but most other revenue sources now used by the federal government do not yield much revenue and could do so only if the tax rates were high.

Conclusion

The preceding discussion points to the many and simultaneous finance design challenges for reformers and policymakers. They must determine how much money is needed in the first instance to finance new health coverage and where it will come from. They need to estimate offsetting savings: "federalizing" spending previously shared between the federal government and the states, for example, will generate new outlays by the federal government but some offsetting savings for states. An employer mandate may reduce public sector costs while imposing a new "head tax" on workers. Finally, those developing proposals need to specify how new assistance for the uninsured will be delivered and, at the same time, how to recapture some of the money previously "spent" on uncompensated care while maintaining the safety net services still required.

In summary, scholars, organizations, and political leaders developing new coverage expansion proposals need to properly estimate the new costs involved, specify the financing sources, carefully account for the "offsets," and indicate how the new support will be delivered and managed. In the end, we must recognize that all roads eventually lead back to the household. At issue is the extent to which American households are willing to pay for the net cost of covering the uninsured through their taxes (federal, state, or local), through adjustments in their pay packages (or employment effects where pay cannot be adjusted), or through direct payments into the health care system. While the money will be the same, the politics will be different, as various financing plans create different "winners and losers." ■

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[6] Another option that is often mentioned as a way of financing coverage expansions is a tax on health insurance premiums. This approach has little merit except, perhaps, political expediency. It would be a tax on a form of expenditure that public policy is trying to encourage, so it would be counterproductive. It would almost certainly violate the principle of horizontal equity and probably the vertical equity principle as well. Tax rates would have to be very high to generate much revenue.

Appendix: Overview of Financing Approaches in Covering America Coverage Proposals

The Covering America project has produced 13 proposals for major coverage expansion. The table below summarizes not only the way these proposals deal with the funding side of the task but also how they would delivery the subsidy, since these two elements of reform are often intimately related.

Proposal	New Financing	Delivery of Subsidy
Butler	Savings from elimination of existing tax subsidies	Refundable sliding scale tax credit (based on health expenditures) available to everyone
	Federal general tax revenues	A flat tax credit available to low-income households
	Consumer premiums	Grants to states for low-income coverage
		Continuation of Medicaid and S-CHIP
Feder/	Federal general tax revenues	Expansion of Medicaid and S-CHIP
Levitt/	State revenues (state match)	Enhanced federal match for new coverage
O'Brien/	Consumer premiums	Tax credit for small, low-wage employers
Rowland		
Gruber	Federal general revenues	Subsidies to low-income households (under 300% FPL) for purchase of coverage through state-organized voluntary risk pools
	Federal savings from reduced Medicaid and S-CHIP	
	State maintenance of effort payments	
	Savings from capping tax exclusion for ESI	
	Consumer premiums	
Hacker	Payroll taxes (employer pays)	Employers required to make payroll contribution to enroll workers in Medicare Plus or provide equivalent coverage
	Savings from reduced tax subsidies (for those in Medicare Plus)	
	Federal general revenue	Individuals eligible for Medicaid and S-CHIP enrolled in Medicare Plus
	Consumer premiums	Non-workers buy into Medicare Plus with premiums scaled to income
	State maintenance of effort payments	
	Federal savings from eliminating S-CHIP and reducing Medicaid	
Holohan/	Federal general revenues	States provide full or partial subsidies for coverage in state organized pools for low-income persons (largely replacing Medicaid and S-CHIP in participating states)
Nichols/	State revenues (state match)	
Blumberg	Consumer premiums	States provide subsidies for high risk persons to buy into state pools
	Savings from reduced coverage under Medicaid and S-CHIP	Enhanced match to states
Kronick/	Payroll tax (employer and employee)	States provide "zero-premium" plans for all
Rice	Federal general revenues	
	State payments to federal government	
	Consumer premiums	
	Federal savings from reducing Medicaid and S-CHIP	
Pauly	Federal general revenues	Refundable tax credit (coupons) for lower-middle-income households
	State revenues (state match)	States provide "zero premium" coverage for very low-income households through state's choice of insurer
	Consumer premiums	
Singer/	Savings from capping current tax exclusion	Refundable tax credits for low- and middle- income available to people purchasing coverage through an insurance exchange
Garber/	Federal general revenues	
Enthoven		Continuation of Medicaid and S-CHIP
Weil	Payroll taxes	Employers required to make payroll contribution to enroll workers in MSS (at least one no-cost option) or provide equivalent coverage
	State payment to federal government	
	Federal savings from reduced coverage under Medicaid and S-CHIP	Refundable tax credit for employees in exempt firms
	Consumer premiums	States administer subsidies to pay cost-sharing for low-income households
Wicks/	Federal general revenues	Refundable sliding scale tax credits for all
Meyer/	Tax assessment for those defaulting to Medicare	Automatic enrollment in Medicare for uninsured
Silow-Carroll	Federal savings from elimination of Medicaid and S-CHIP	
	Savings from elimination of ESI tax break	