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State Tax Incentives versus Premium Assistance: What's the Difference?

Policymakers have long debated alternatives for bolstering private health insurance coverage through employer-sponsored plans and the individual market, acknowledging the rising number of low-income, working uninsured. This issue brief compares two private coverage strategies being considered in the state of Montana to reduce the number of low-income workers and families without access to health insurance: (1) providing tax relief through a state tax credit to individuals and employers who purchase health insurance, and (2) subsidizing employer premiums for low-income children and parents with Medicaid or State Children's Health Insurance Program (SCHIP) funds. In theory both approaches help to reduce the number of uninsured by promoting coverage in the private health insurance market. Here, we provide a framework for state policymakers to evaluate the advantages and disadvantages of each in the context of Montana's unique environment.

State Sponsored Tax Incentives

Eleven states currently use some form of tax relief to encourage low-income individuals or small employers to purchase health insurance coverage in the private market (State Coverage Initiatives, 2003). Some states have implemented health care *tax credits*, where qualifying medical expenditures, premiums, or other fixed amounts may be subtracted directly from an individual's or employer's income tax liability. Other states allow parties to *deduct* amounts paid for private health insurance premiums from taxable income before tax liabilities are determined. Most proponents of tax incentives agree that in order to target low-income individuals, states should pursue *refundable advanceable tax credits*—that is, credits that are provided irrespective of tax liability and in advance of the time premiums are due (Feder et al., 2001). Table 1 provides a description of the various tax relief policies used by states to encourage private health care coverage.

Two similar tax relief proposals were deliberated, but not passed, by the Montana Legislature in 2003 (HB204, HB216). Both contained many of the features considered important in expanding coverage for low-income individuals. For example, HB 204 (Montana Health Care Affordability Act) provided refundable, advanceable tax credits ranging from $40 to $200 per individual per month depending on age cohort; and targeted low-income individuals with family incomes less than 175 percent of the Federal Poverty Level (FPL), and employers with nine or fewer employees who do not have any employees earning $150,000 or more per year in compensation.

If successful, this type of tax relief proposal would help to fill the coverage gap that exists between poor children and parents who are eligible for Montana's Medicaid and Children's Health Insurance Plan (CHIP) programs, and those who do not have access to or who cannot afford to purchase employer-sponsored insurance. Results of the 2003 Montana Employer Survey indicate that of employers not currently offering health insurance coverage,

19% would do so with a tax credit of 40% or more, and an additional 48% would do so with a tax credit of 50% or more.

An Alternative to Tax Incentives: Premium Assistance Under SCHIP

An alternative strategy to tax credits would be to use public funds—through Medicaid or SCHIP—to directly subsidize the cost of employer-sponsored health insurance premiums for low-income individuals. Some premium assistance programs provide subsidies directly to employees, and others provide subsidies directly to employers. Since the early 1990's, federal regulations have provided states with the option of providing employer-sponsored insurance in lieu of enrolling eligible individuals in Medicaid through the Health Insurance Premium Payment (HIPP) program. Because of cumbersome federal requirements, as well as administrative complexities at the state level, enrollment in HIPP programs over the years has been modest.

Recent changes, both legislative and regulatory, have generated state interest in premium assistance programs. For example, under SCHIP (passed in 1997) states can implement premium assistance programs for low-income children and families. According to initial guidelines (proposed in November 1999) states were required to comply with very specific rules that would serve to limit the displacement of existing private coverage and to ensure a comprehensive benefit set for all participants. Responding to numerous state comments on the proposed rules, the Centers for Medicare and Medicaid Services (CMS) ultimately relaxed some of the rules considered to be administratively burdensome. Table 2 briefly describes premium assistance options implemented in six states under SCHIP.

States have even more flexibility in developing SCHIP premium assistance programs under the new Health Insurance Flexibility and Accountability (HIFA) demonstration initiative. To a large extent, HIFA allows for waivers of the benefit package and employer cost-sharing mandates that exist for premium assistance programs under SCHIP. Specifically, states with approved HIFA waivers are *no longer* required to:

- demonstrate the cost-effectiveness of enrolling eligibles in employer-sponsored coverage over direct coverage;
- assure a comprehensive benefit set (i.e., meet the "SCHIP benchmark plan") for optional and expansion enrollees;
- limit enrollee cost-sharing;
- establish a minimum employer contribution; nor
- implement a six-month waiting period, whereby applicants cannot be covered at the time of application, or within the previous six months.

Several states—including Arizona, California, Delaware, Illinois, Maine, New Jersey, New Mexico, Oregon, and Washington—have proposed employer-sponsored insurance programs or feasibility studies as part of a broader HIFA waiver request (Williams, 2003).

A Framework for Evaluating Policy Options

Generally speaking, there are several similarities between tax credits and premium assistance programs. Both, for example, are strategies that seek to bolster employer-sponsored insurance markets, and thus take advantage of employer contributions. Also, in a time of tight state budgets, both options may be less controversial politically than new or expanded direct spending programs (e.g., Medicaid eligibility expansion). Finally, arguments can be made that access to either a health care tax credit or a premium assistance program may reduce the likelihood that the public coverage available in a state will displace private coverage.

When implemented, however, both strategies have their advantages and disadvantages. Table 3 provides a framework for comparing the two

approaches on cost, flexibility, complexity, affordability, and efficiency.

Our review of the policy literature suggests several observations regarding the relative merits of tax credits versus premium assistance programs. Perhaps most importantly, through enhanced federal financial participation under SCHIP, states implementing premium assistance programs can provide health care subsidies to individuals at a lower cost to state taxpayers than states pursuing state-only tax credit options.

In light of the tight fiscal environments in which most states now find themselves, the benefits of leveraging federal dollars cannot be overstated. The availability of federal resources also means that for any level of state investment in this kind of program, larger health care subsidies can be provided. The larger the subsidy, the more affordable coverage becomes for individuals and employers, and the more likely these parties will be to choose to participate in the program.

On the other hand, the increased affordability that comes with sharing premium assistance program expenditures with the federal government is accompanied by less flexibility in program design and more administrative burdens than in the case of tax credits. The introduction of HIFA reduces these concerns considerably, but because premium assistance programs require enrollment activities, employer coordination, and the like, they will always be more administratively onerous than less labor-intensive tax credit mechanisms. Also, the ability of states to effectively target subsidies to low-income individuals without access to coverage may be more efficient using tax credits than employer premium subsidies. This would be particularly true in states where employer coverage rates are low: providing tax credits to individuals allows individuals who do not have access to employer-sponsored insurance to purchase coverage in the individual market.

Conclusion

This issue brief offers a general framework for considering the benefits and costs of various strategies. It focuses solely on the tradeoffs associated with the two approaches, but does not contemplate a host of other relevant issues, including Montana's political environment, fiscal constraints, or programmatic and administrative capacity. Clearly, this information must inform the debate on the potential advantages and disadvantages of these strategies for increasing health insurance coverage.

Finally, it should be noted that, to date, neither tax credits nor premium assistance programs have been shown to substantially increase a state's health insurance coverage rates. These relatively modest outcomes notwithstanding, such approaches are increasingly attractive to states as a complement to broader health care coverage expansion efforts and private sector partnerships.

The opinions expressed in these briefs represent those of the authors. Any questions or comments are welcome and should be directed to shadac@umn.edu.

Table 1: State Sponsored Tax Incentives

State	Type	Eligible Groups	Subsidy	Effective
Colorado	Deduction	Individual, spouse, dependents	100% of premium up to $500	2000
Idaho	Deduction	Individual, spouse, dependents	100% of premium	2001
Iowa	Deduction	Individual, spouse, dependents	100% of premium	1996
Kansas	Refundable Credit	Small employers	$35 per employee per month	2000-2001
Maine	Credit	Small employers with >5 low-income employees	Lower of: $125 per employee with dependent coverage; or 20% of dependent premiums	1999
Missouri	Deduction	Certain employees, spouses, dependents	100% of premium	2000
Montana	Credit, Deduction	Small businesses (credit); individuals (deduction)	Graduated credit up to $25 per month per employee for small businesses contributing at least 50% of health insurance cost; individuals may deduct 100% of premiums	1991, 1995
New Mexico	Deduction	Individual, spouse, dependents	10-25% of medical expenses based on income and eligibility status	2000
North Carolina	Refundable Credit	Individual, spouse, dependents	$300 (less than 225% FPL), $100 (greater than 225% FPL)	1998-2001
Utah	Deduction	Individual	100% of premium	2000
Wisconsin	Deduction	Employees without employer coverage, spouse, dependents	50% of premium	1993

Source: State Coverage Matrix, State Coverage Initiatives: An Initiative of The Robert Wood Johnson Foundation

Table 2: Characteristics of SCHIP Premium Assistance Programs

State	Program	Eligibility	Enrollment	Effective
Maryland	Maryland Children's Health Program	Children 200% to 300% FPL	162 (11/02)	2001
Massachusetts	MassHealth Family Assistance Plan	Families 150% to 200% FPL, under 200% FPL working for small employer	1,385 (9/02)	1998
New Jersey	NJ FamilyCare	Families to 200% FPL, children to 350% FPL	389 (6/02)	2001
Rhode Island	RIte Share	Families to 185% FPL, children to 250% FPL	2,200 (8/02)	2001
Virginia	Family Access to Medical Insurance Secuity Plan (FAMIS)	Children to 200% FPL		2001
Wisconsin	BadgerCare	Families to 185% FPL; families remain in program until 200% FPL	62 (6/02)	1999

Sources: State Coverage Matrix, State Coverage Initiatives: An Initiative of The Robert Wood Johnson Foundation; and the National Academy for State Health Policy (2003).

Table 3: Refundable Tax Credits Versus Premium Assistance Programs, Advantages (+) and Disadvantages (-)

	Refundable Tax Credits	Premium Assistance
State Cost	− State bears full cost. Greater overall expenditure of state taxpayer dollars for any given level of subsidy.	+ State shares cost with federal government, sometimes with enhanced SCHIP matching rates. Lower overall expenditure of state taxpayer dollars for any given level of subsidy.
Flexibility in Program Design	+ State policy choice. Not subject to rules that accompany federal funding.	− States must comply with federal requirements regarding design of benefits package and cost sharing. These concerns mitigated to a certain extent by HIFA waiver process.
Administrative Complexity	+ Implementation utilizes existing administrative systems. + Requires less coordination and verification of coverage with employers. + Avoids problems associated with shifting employment status among low-income families. − Administrative mechanism for advance payments may be problematic.	− Requires outreach and coordination of coverage with employers to ensure participation. − Requires labor-intensive enrollment process. Must determine enrollees' access to ESI, employer contributions, and relative cost of premium assistance option vis-à-vis direct coverage. − Requires employer submission of detailed information about benefits and employee circumstances.
Affordability for Individuals & Employers	− Smaller subsidy is likely, meaning lower take-up rates among individuals and employers likely. − Tax credit for individuals does not ensure minimum employer premium contribution.	+ Ability to leverage federal dollars may allow for a greater health care subsidy, meaning higher take-up rates among individuals and employers. + Leverages employer premium contribution, which makes cost more affordable for individuals.
Efficiency in Targeting Desired Population	+ Allows state to target individuals if availability of employer-based coverage for low-wage workers is limited. − May rely heavily on individual market, where premiums are rising rapidly and risk-selection by plans is seen as inequitable. − Difficult to minimize amount of subsidy provided to those who are already insured.	− Doesn't help uninsured families that have not received offers of health insurance from employer. − Less efficient if availability of employer-based coverage for low-wage workers is limited. − Difficult to minimize amount subsidy provided to those who are already insured. Establishing firewalls (e.g., requiring eligible individual to be uninsured for a specified time before enrolling) possible, but difficult to enforce.
Political Considerations	+ May be more appealing politically. Tax expenditure versus more direct expansion of public program, even if private coverage is the goal.	− May be less appealing politically. Relies on increase in state and federal spending, rather than indirect state tax expenditure.

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