

Premium Subsidies for Low-Wage Workforce: What Is An Appropriate Price Point?

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EXECUTIVE SUMMARY

The majority of California's uninsured are young, low-income workers (Brown, 2000). Premium assistance programs targeted to this subgroup are intended to minimize the number of uninsured by inducing employers to offer health insurance and increasing employee take-up and individual purchase. Research to date has found that in order for premium assistance programs to be effective, the subsidy must be large, appropriately target beneficiaries and take into account disparities in health costs associated with age and gender. A major challenge has been determining the size of credit sufficient to encourage employer offering and individual employee take-up.

The following analysis provides an overview of current research evaluating the advantages and disadvantages of premium subsidies and the impact of premium subsidies or tax credits on increasing employer offering of insurance, employee take-up and individual purchase. Based on analysis of the literature gathered and observed outcomes of pilot premium assistance programs in California, a premium subsidy in the amount of 50% seems likely to result in the greatest impact in decreasing the number of uninsured.

Introduction

Premium assistance programs are a promising approach to induce employers to offer health insurance, as research shows that 80% of employers consider cost to be the major factor in their decision to offer or not offer health coverage (The Resource Group, 1999). Premium assistance is characterized by the provision of a public subsidy to help individuals or employers pay the cost of either public or private insurance.

Premium assistance can be structured in numerous ways, one of which is a refundable tax credit. Tax credits consist of a specified dollar contribution provided if health insurance is obtained. Tax credits can be offered to businesses to expand employer-based coverage or can subsidize employees to aid in their share of the cost of the premium. Tax credits may also target individuals to aid in their purchase of non-group coverage.

In order to effectively increase rates of employer offer, employee take-up, and individual purchase of health care, premium assistance or tax credits must be significant and the decision to take-up must be very price elastic. Even in the case that employers decide to offer coverage, the amount of subsidy must be sufficient to encourage employers to pay a sizeable portion of the premium and thereby induce employee take-up (Meyer & Wicks, 2000). The following is a brief summary of current research examining the potential subsidy price point at which maximum participation is achieved.

Tax Credits for Employer-Sponsored Insurance

Studies have shown that employers strongly support the provision of health coverage for their workers; however, the rising costs of premiums is forcing them to cut back on offering healthcare benefits or shift more costs to employees (Collins, et al, 2004). A study conducted by

the California Small Business Association (CSBA) found that small employers are somewhat receptive to the provision of tax credits (The Research Group, 1999), as a means to increase coverage.

An analysis of the association between variations in tax credits and an employer's willingness to offer health insurance suggests a price elastic association (Gruber, 1999). In other words, if a tax credit results in a premium price decrease of 1 percent, health insurance purchase should also increase by 1 to nearly 3 percent. However, actual experimentation with premium subsidies or tax credits yields a different picture. In the early 1990's, several pilot programs in different states offered tax credits and premium subsidies to employers to induce them to begin offering health coverage. The subsidies were small (for example, \$25 to \$35 per employee per month) and subsequent employer offer rates were low. Most sites achieved less than 10 percent participation rates after more than a year in operation (Silow-Carroll, 2000).

A study conducted by the Economic Social Research Institute (ESRI) for the Commonwealth Fund suggests that the tax credit needs to be about half the cost of reasonably comprehensive coverage in order to induce a significant proportion of employers to begin offering coverage (Meyer & Wicks, 2000). This estimate is based partly on results from a 1991 Harris poll of small employers (those with fewer than 50 workers) who do not offer coverage. The survey results revealed that 31 percent were "very likely" to purchase insurance if the government subsidized one-third of the cost (Health Care Outlook Survey, 1991). However, the study warns that employers tend to overstate their intentions, and the proportion that would actually purchase coverage given such a subsidy is estimated to be lower (Health Care Outlook Survey, 1991). Therefore, in order to have a noticeable impact on the number of uninsured, Meyer and Wicks suggest that a tax credit equal to half the cost of the premium is needed.

Based on this design, the employer and employees would be jointly responsible for paying 50 percent of the remaining premium cost. In addition, researchers propose a variant that would require the employer to contribute most of the employee portion (for example 25-40 percent above the subsidy received) in order to receive the tax credit. Higher percentages of employer contribution may decrease employer take-up, but would increase low-wage employee take-up. Direct premium assistance toward employee contribution could also accompany employer tax credits in order to maximize employee take-up (Meyer & Wicks, 2000).

Conversely, a study conducted by the University of Washington Health Policy Analysis Program suggests that even substantial subsidies are unlikely to result in a large increase in the number of employers who offer insurance. The study found that a subsidy of 50 percent would increase the number of businesses offering insurance from 5 to 35 percent (University of Washington Health Policy Analysis Program, 2002). The largest estimate is based on employers' reported intentions when given hypothetical price reductions, while estimates based on observed employer behavior are much lower. A retrospective study showed similar results regarding the effect of subsidies on employers' offering. The results of the study suggest that premium subsidies do not significantly result in an increase in the offer rates of employer provided insurance (Gruber & Washington, 2003).

Another limitation of employer subsidies, as pointed out by the study, is that they are designed to reach low-wage workers least likely to afford insurance by using characteristics of their employers (i.e. small low-wage firms). However, a large share of low-wage workers work for businesses not classified as small low-wage firms (University of Washington Health Policy Analysis Program, 2002). It was found that 45% of low-wage workers are in businesses in which at least 1/4 of the workforce earns more than \$10/hour (University of Washington Health

Policy Analysis Program, 2002). The study suggests that the number of workers newly offered insurance through a subsidy directed to small low-wage employers would increase by only 1-4% since the majority of uninsured workers are in large or non-low-wage businesses and would not be affected by the provision of tax credits (University of Washington Health Policy Analysis Program, 2002).

A study by McLaughlin and Zellers (1992) found that a large number of employers not offering insurance also report a lack of demand from workers as a factor in their decision not to offer. It was found that roughly one quarter of uninsured workers are offered, but do not take up, health insurance (Polzer & Gruber, 2003). This suggests that low-wage workers may prefer cash benefits to insurance and that price subsidies offered to employers may not be an effective means to reach individuals that opt not to take up employer coverage.

A research study conducted by Polzer and Gruber (2003) assessed the impact of an employer tax subsidy on the uninsured. The model proposes to offer a maximum credit of \$1,500 to purchase employee only coverage and \$3,500 to purchase family coverage. The credit rate would apply to businesses with fewer than ten employees and whose employees earn on average less than \$20,000 per year. The credit would be reduced as firm size and average wages increased. In order to assess the potential impact of the tax credit, Gruber used an econometric model that makes assumptions regarding marketplace conditions and possible individual circumstances in terms of insurance status and level of income. It was found that an employer tax credit targeting small businesses would decrease California's uninsured by 780,000 or 13 percent and would result in an annual cost to the state of about \$1.9 billion (Polzer & Gruber, 2003).

SB2, a law requiring large and medium employers to either provide health insurance or pay a fee to a state-run health insurance pool to cover their employees, requires the state to implement premium assistance programs for employers through the Medi-Cal and Healthy Families program. A study conducted by UCLA's Center for Health Policy found that such a mandate would result in 400,000 newly insured workers and dependents.

A premium assistance program, implemented under SB2, is designed to make mandatory coverage affordable for the low wage workforce. The program would enable low-income working families to purchase health insurance through the workplace as opposed to enrollment in public programs. The program would enable 447,000 families (working in large firms) and 63,000 individual employees (working in medium firms) to receive state subsidies for their job-based insurance. The cost to the state would be an estimated \$228 million less per year than it would be to cover the same beneficiaries through Medi-Cal or Healthy Families.

A large employer play-or-pay mandate, such as SB2, which would require employers to offer coverage but would not require employees to enroll, may not be the best means for reaching the intended target population for premium subsidies in small low-wage firms. Experience with legislation requiring employers to provide health benefits to their employees indicates that most of the cost of a mandated benefit is shifted to employees in the form of lower wages (Klerman & Goldman, 1994).

A study conducted by Gruber (2002) to measure the extent to which health insurance costs are shifted to reductions in worker wages found that full shifting might not be possible, especially for workers near minimum wage. The study results suggest that a play-or-pay mandate may harm some employees more than benefit them, as the cost of labor may rise above the amount the employer is willing to pay and ultimately result in job loss for minimum wage

jobs. Based on evidence from employer reactions to increases in minimum wage, it is estimated that approximately 100,000 jobs nationwide would be lost as a result of a play-or-pay mandate (Klerman & Goldman, 1994).

Employer Buy-In to Public Programs

There are several states that use public funds to subsidize employers' health insurance. While Oregon operates a state-only program and does not receive federal matching funds to subsidize private health insurance, Massachusetts, Wisconsin, and Mississippi are three states approved by the Health Care Financing Administration (HCFA) to use Title XXI funds to help employers buy coverage for working families. The latter three states must abide by the following federal rules to receive funding:

- employer-sponsored insurance (ESI) plan must offer benefits equivalent to at least one of three federally designated benchmark plans
- subsidy may be no greater than the payment the state would make if the child was enrolled in a separate State Children's Health Insurance Program (SCHIP) plan
- prohibit subsidization of any child insured during the previous 6 months
- require a minimum employer contribution of 60% of the premium.

The Academy for Health Services Research and Health Policy (2001) evaluated the employer buy-in programs in Oregon, Massachusetts, Wisconsin and Mississippi.

Massachusetts' Division of Medical Assistance reported that approximately 62 children were insured through ESI as of January 2001 under Title XXI. An additional 4,749 were receiving premium assistance through the Section 1115 program. As of June 2000, Wisconsin Division of Health Care Financing reported seven families (11 parents and 16 children) covered through ESI

and 209 families awaiting eligibility determinations. As of September 2000, Oregon Insurance Pool Governing Board reported that 4,119 individuals were receiving either employer- or individual based subsidies through the program. Coverage information for Mississippi was not available.

A 50% minimum employer contribution is required in Massachusetts and Mississippi. In Wisconsin, there is a 60% minimum and an 80% maximum employer contribution, and in Oregon there is no minimum percentage. There were reportedly not many employers participating in the programs in Massachusetts and Wisconsin, Oregon reported 200 employers in the program, and Mississippi lacked a firm count. Despite low participation rates, Massachusetts, Wisconsin, and Oregon all reported non-existent or minimal employer resistance. Mississippi reported some employer resistance; employers were initially worried that they would be faced with high administrative costs. Based on the reported concerns of the employers, Mississippi attempted to create a program that would be administratively simple.

The California Small Business Association commissioned the Resource Group (1999) to conduct focus groups to examine the issues underlying employers' decisions to offer or not offer health insurance to their employees and explore possible solutions for the problem. The focus groups with employers revealed a negative view toward government subsidies and buy-in to Medi-Cal. Most felt that the issue of decreasing the number of uninsured would be best dealt with on a private sector basis.

Impact of Tax Credits on Employee Take-Up

Various studies have examined whether a price elastic association between premium costs and employee take-up exists. Price elasticity of demand (E_d) is determined by the following equation:

$$E_d = \% \text{ change in demand} / \% \text{ change in price}$$

An elasticity of 1 implies a unitary elastic relationship, where the quantity demanded changes by an equivalent change in price. An elasticity of 0 indicates that the relationship is perfectly inelastic and that the quantity demanded does not change at all as the price changes. A value between 0 and 1 indicates an inelastic relationship, which describes the case when the quantity demanded changes by a smaller percentage than price, and a value beyond 1 portrays an elastic relationship where the quantity demanded changes by a larger percentage than the price (Quick MBA Economics website).

Chernew, Frick, and McLaughlin (1997) used data from a sample of small firms to examine the degree of elasticity between premium costs and employee take-up. They found significant but modest effects, with an elasticity of 0.066. Blumberg, Nichols and Bantlin (2002) used a similar approach to analyze data from a nationally representative sample of firms and found an even smaller complementary effect of 0.04. These data call into question the potential effectiveness of employee tax credits on reducing the number of uninsured and suggest that premium subsidies for employers must be very large to elicit much change in worker take-up behavior. On the other hand, 90% of employees already take-up health coverage offered by their employer.

Research results by Cooper et al (2003) suggest that reducing employee contribution to zero would yield an increase in employee take-up rates of approximately 6% in businesses that had previously required employee contributions. The results suggest that of the 13.8 million private sector workers who currently decline coverage from their employers, 2.5 million would potentially enroll in employer-sponsored coverage if their contribution fell to zero (Cooper, et al, 2003). A study by Thorpe et al (2000) found that most workers who refuse their employers'

offer of insurance are insured, either through a family member or by purchasing individual health insurance.

A potential drawback of subsidies to increase employee take-up is that lower premium shares may be associated with choosing more expensive plans, which may increase overall health care and government spending (Gruber & Washington, 2003). A solution for this potential problem would be to create a “fixed-subsidy” model, whereby employee subsidies would be limited to a percentage of the lowest cost health plan (Gruber & Washington, 2003).

Individual Tax Credits for Uninsured Workers

In analyzing the relationship between premium subsidies and individual participation rates, a clear pattern was detected. As low-income individuals’ premium shares in health care programs increase, their level of participation decreases dramatically (Ku, 1997). A study of the participation rates among low-income individuals from four states (Hawaii, Minnesota, Tennessee, and Washington) found that a premium of 1 percent of income corresponds to a participation rate of 57 percent. A premium of 3 percent of income correlates to a 35 percent participation rate. At 5 percent of a low wage individual’s income, only 18 percent are likely to participate (Ku, 1997). These data indicate that a premium subsidy for low-income individuals would need to cover a very high percentage of the cost of the premium in order to be effective. Furthermore, a sliding scale subsidy program may prove useful in reaching those most in need. Based on these data, a substantial tax credit (premium subsidy) for low-income individuals has the potential to broaden access to coverage.

An individual tax credit would be especially beneficial for uninsured individuals whose employers currently do not offer coverage but who would purchase coverage if the subsidy were

provided directly to them (Meyer & Wicks, 2000). Another advantage is that credits to individuals, unlike those to employers, can be targeted to family income as opposed to wages or earnings (Gruber, 2003). This would offset the equity problem of subsidizing coverage to low-wage workers with high-wage spouses.

A drawback of the individual tax credit is that it could promote an expansion of the individual market and reduce employer-sponsored coverage (Polzer & Gruber, 2003). For example, young workers with a low health risk may have a financial incentive to drop their employer-sponsored insurance and purchase non-group coverage (Williams, 2003). Zelenak (2000) estimates that about 8.1 million workers might leave employer-sponsored plans in favor of an individual health insurance tax credit. A reduction in employer-sponsored coverage could prove unfavorable since the workplace is the primary means by which most individuals receive health insurance.

Polzer and Gruber analyzed the possible impact of an individual tax credit option on the uninsured. The model proposed a tax credit option of \$1,000 per individual and \$2,500 per family for use in the individual market, which is lower than the proposed tax credit for employer-based coverage. The credit would be available for individuals with incomes up to \$20,000 and would phase out when income reaches \$40,000. The credit option would be available to families with incomes up to \$40,000 and would phase out when their incomes reach \$80,000. It was found that an individual tax credit of this amount would lower the number of uninsured by 640,000 or slightly more than 10 percent. The estimated average annual cost to the state would be approximately \$1.6 billion (Polzer & Gruber, 2003).

A study by the Lewin Group of the ITUP proposal for individual refundable tax credits revealed a very different potential impact of an individual tax credit on the uninsured. The study

found that the number of newly covered Californians by an individual tax credit would be about 1.8 million, with a program cost of about \$4.3 billion. If combined with other program expansions such as an employer tax credit and MediCal/Healthy Families expansions for adults, an individual tax credit would cover 1.2 million uninsured at a cost of \$3 billion (Sheils & Haught, 2003).

A study by the California Health Care Foundation and Field Research interviewed the moderate income (above 200% of the federal poverty level) uninsured about their willingness to buy individual health coverage. The study divided the respondents into four categories: prime prospects (26%), cost constrained (16%), tough sells (26%) and unworried well (31%). The prime prospects were somewhat older and more likely to have children. The tough sells and unworried well were younger, higher income and heavily male. The cost constrained were lower income, more likely to be female and have children.

Varying Premium Subsidies by Age and/or Gender

In the present non-group market, a \$2,000 premium for young workers is sufficient to purchase a fee for service policy with a benefit to premium ratio of approximately 75 percent. A study conducted by Zelenak (2000) proposed that a \$2,000 base credit amount might suffice to cover the entire cost of a basic individual health insurance package for young workers. An additional study conducted by Gabel, et al (2002) determined that a lower level tax credit, \$1,500, would be adequate to provide affordable health insurance for healthy 27-year-old uninsured males.

However, even with a \$1,500 or \$2,000 tax credit, healthy 55-year-old low-income individuals and young females are still likely to find health insurance out of reach (Gabel, et al,

2002). It was found that after a \$1,500 tax credit in the least expensive market, individual insurance would still consume almost 10 percent of a 55-year-old's income (Gabel, et al, 2002). Furthermore, it is generally recognized that women, on average, experience greater healthcare use over a lifetime compared to men, including preventive services, care during pregnancies and childbirth. A healthy young woman receiving a tax credit of \$1,500 would have a more difficult time finding a plan with an affordable price, assuming that the woman has an annual income of \$15,000 or less (Collins, et al, 2002). Furthermore, even an affordable plan would most likely buy less coverage for women than men. Women in poor health face still higher premiums and fewer options (Collins, et al, 2002).

Since insurance costs can vary with age and/or gender, researchers suggest that the credit amount of \$2,000 be multiplied by an index number specific to the taxpayer's age and gender (Zelenak, 2000). For example, the credit for a man of 30 years (index 0.574) would be \$1,148; the credit for a 50-year-old woman (index 1.762) would be \$3,524 (Zelenak, 2000).

Pilot Premium Assistance Programs

A presentation by Amerish Bera at the Insure the Uninsured Project (ITUP) 2004 Conference discussed a pilot program, Sacramento (SAC) Advantage, which aims to increase health insurance options for small businesses. Health coverage is provided through a Pac Advantage purchasing pool for small employers. Employees with an income of 251-300% FPL receive a 40% subsidy; employees with income of 200-250% FPL receive a 50% subsidy and those with income less than 200% FPL receive a 60% subsidy. Employer eligibility is determined by the following criteria:

- between 2 and 50 employees

- in operation for at least 12 months
- not offered coverage in the past 6 months
- agree to pay 50% of the unsubsidized portion of the selected coverage.

The model was implemented in January 2003 and has since received positive feedback and financial support from the federal and county government. However, enrollment to date is relatively low as there are presently only 22 companies enrolled. The typical enrollee is under 35 years of age, works 40 hours per week and is around 200% of the FPL (Bera, 2004).

The Financially Obtainable Coverage for Uninsured San Diegans (FOCUS) program is an example of a premium assistance program that began in April 1999, and aimed to increase health coverage among small businesses. The program was funded by a \$1.2 million grant from the Alliance Healthcare Foundation, and later expanded by a \$400,000 grant from the California Endowment. FOCUS provided a premium assistance averaging 50% for those meeting the following eligibility criteria: small businesses with fewer than 50 workers that have not provided coverage in the last year and/or whose full-time workers all make less than 300% of FPL and have been uninsured for the past year (Cubanski & Schaffler, 2001). Participating employers were required to make fixed contributions toward employees' health coverage while employee contributions were based on an income-related sliding scale.

As of August 2000, a reported 1,766 employees and 232 businesses participated in the program (Cubanski & Schaffler, 2001). Following 3 years of program operation, the foundation funding for the FOCUS premium subsidy was discontinued. According to Kathryn Mead, Executive Director of Sharp Health Plan, over 75% of the participating employers continued coverage in the absence of an ongoing subsidy. Professor Rick Kronick of the University of California at San Diego suggests that employers purchasing coverage through

FOCUS may have been easy to reach early adopters and that the pilot program would have experienced greater difficulty reaching other more cost adverse employers.

Health Choice is a premium assistance program that began in May 1, 1994 in Wayne County, Michigan. Health Choice is a managed care program that provides coverage to businesses with three or more employees. Employer eligibility criteria are as follows:

- 90% of the business is in Wayne County
- the business is comprised of at least 3 employees who qualify for coverage (i.e. employees must work at least 20 hours/week and must be without health insurance)
- the business must not have offered health insurance in the last 12 months
- 50% or more of all employees qualifying for coverage must average a wage of \$10/hour or less

The premium subsidy provides an assistance amount totaling 1/3 the cost of the premium. The employer and employee must then pay 1/3 each of the remaining cost. The initial target for the program was 9,000 businesses and 20,000 employees in the county. As of June 2000, the program included 1,977 businesses and 19,019 employees and an estimated 80-90 new businesses join per month (Silow-Carroll, et al, 2000).

Lansing, Michigan also implemented a premium assistance program. The Ingham Health Plan is a health coverage program for uninsured residents of Ingham County below 250% of the FPL who are currently ineligible for any other insurance (Silow-Carroll, et al, 2000). Individuals below 100% of FPL receive free care and those ranging from 100% to 250% of FPL have cost-sharing requirements. The intended target beneficiaries are 14,000 uninsured residents of Ingham County and 1,400 former State Medical Plan enrollees. As of June 2000, there are over

10,000 enrollees including 1,400 former State Medical Plan enrollees, which is representative of roughly one-third of the uninsured population in the county (Silow-Carroll, et al, 2000).

The New Mexico Health Insurance Alliance was created to increase health insurance access to small businesses, self-employed individuals, and individuals who lose group coverage. The program does not offer direct premium subsidies, but rather aims to guarantee that health insurance is available to groups too small to obtain coverage in the private market and to individuals who¹ have lost group coverage. Employer eligibility to purchase an Alliance health plan is as follows:

- firm has 2 to 50 eligible (working at least 20 hours per week) employees or self-employed and purchasing insurance for self and at least one family member
- at least half of eligible workers enroll in an Alliance plan
- employer does not offer group coverage other than Alliance plans to eligible workers

Individuals are eligible to purchase an Alliance health plan if they have lost group coverage and have exhausted COBRA. All eligible groups and individuals may obtain coverage regardless of medical history or risk (Silow-Carroll, et al, 2000).

The Alliance health plans¹ have a lifetime maximum of \$2 million. As of August 2000, there are approximately 7,800 individuals in 3000 “accounts” insured through the Health Insurance Alliance. The accounts represent about 2,400 small businesses that offer Alliance health plans and about 600 individual policyholders. The overall portion of the state’s uninsured population dropped from 28 percent in 1998 to between 21 and 25 percent in 2000; however, 500,000 state residents remain uninsured. It is clear that coverage remain unaffordable for many

¹ Alliance health plans include hospital services, physician services, wellness benefits, and limited prescription coverage. The plans offer a choice of deductibles (\$100 to \$2,500), coinsurance (plan pays from 50% to 70%), and out-of-pocket maximums.

since the premiums—although indirectly subsidized through community rating and risk sharing—are not directly subsidized.

The New York State Health Insurance Partnership Program (NYSHIP), begun in August of 1997, was established to assist eligible employers and self-employed individuals in purchasing small group health insurance policies for themselves, their employees, and dependents. Businesses are eligible to receive the subsidy if they:

- are located in New York State;
- have 1 to 50 employees (eligible employees must work at least 20 hours per week);
- have not provided group health benefits to any employee during the 12 months prior to application.

If the above criteria are met, NYSHIP will subsidize health insurance premiums up to 45%. As of the end of 1999, NYSHIP was subsidizing health insurance for about 1,100 small businesses (Silow-Carroll, et al, 2000).

Conclusion

Premium subsidies or tax credits have the potential to address the affordability problems that hinder employers from offering and individuals from purchasing health insurance. An evaluation of employer buy-in programs, suggests that buying into public programs may not be the most useful means for maximizing widespread employer participation due possibly to employers' distrust of government programs. In order for employer buy-in programs to be somewhat effective, they need to be administratively simple for the employers. On the other hand, tax credits or premium subsidies may be a useful means for somewhat decreasing the number of uninsured through the workplace. It appears that in order to be effective the tax credit

or premium subsidy must be set at an adequate price point, take into account differences in age and gender, and target businesses and individuals least likely to already offer or purchase insurance and most likely to purchase in response to the subsidy. Furthermore, research suggests the occurrence of different outcomes depending on the type of tax credit provided (i.e. individual vs. employer) produce very different results. A refundable tax credit offered to small or low-wage employers may be the most efficient means to promote long-term sustainability of employment based coverage, but it is far less efficient at reaching uninsured individuals than a properly designed and financed individual premium subsidy. The advantages of employment-based coverage are: tax advantages for employers and employees and lower risk profile for health plans. Based on evaluation of pilot tax credit subsidy programs, a credit or premium subsidy of 50% for employment based coverage seems likely to prove most useful in maximizing employer and employee participation. To encourage strong participation for low-income individuals, a premium subsidy should not require them to contribute more than 1-2% of their income. The need for subsidy would decline as an individual's income increases. Those most responsive to individual premium subsidies are likely to be those individuals described by the California HealthCare Foundation research as "prime prospects" and "cost constrained".

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