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**Policy Brief on
Tax Credits for the Uninsured and Maternity Care**

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Any views expressed herein are solely those of the author and do not necessarily represent those of the March of Dimes.

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Tax Credits for the Uninsured and Maternity Care

Contents

Executive Summary	i
I. Introduction.....	1
II. Brief background on maternity coverage in private health insurance plans.....	2
A. Employer-group coverage.....	2
B. Coverage in the individual market.....	3
C. Coverage for pregnant women.....	3
III. Brief overview of approaches for subsidizing private health insurance coverage, and implications for availability of maternity benefits.....	4
A. Tax Incentives for Individual Taxpayers.....	4
B. Tax Incentives for Small Businesses	6
C. Likely Impact on Maternity Coverage.....	6
IV. Strategies for maximizing access to maternity benefits under tax credit approaches:	8
A. Assuring that tax-credit-eligible women and families can buy insurance that includes maternity benefits	8
B. Making coverage that includes maternity benefits affordable.....	10
C. Using purchasing pools for tax-credit recipients	16
D. Allowing tax credits to be used for employment-based coverage	17
E. Allowing tax credits to be used to “buy in” to public coverage, such as Medicaid or S-CHIP.....	19
F. Proposals to assist women who are already pregnant.....	20
V. Conclusion	22
Appendix A: State Maternity Coverage Mandates	24
NOTES.....	25

Tax Credits for the Uninsured and Maternity Care

Executive Summary

Some proposals aimed at reducing the number of uninsured Americans would use the tax system to subsidize the purchase of private health insurance. Lack of health insurance poses a particular problem for young families because of expenses associated with maternity care (i.e., prenatal care, delivery, and postpartum care).

This Policy Brief analyzes the extent to which alternative health insurance tax credit proposals would improve coverage of maternity care and, where they fall short, suggests modifications. It does not consider the broader question of which proposals would be most effective in covering the uninsured in general.

Summary of Key Points:

1. **Using tax credits to subsidize the purchase of individual (non-group) health insurance coverage would do little to expand access to maternity coverage.** Services related to normal pregnancy and childbirth are typically not covered under health insurance policies sold in the individual market—except in a few states where such coverage is mandated. Sometimes, maternity coverage for individuals is offered as a separate rider with an additional premium. Coverage under such riders is usually both expensive and quite limited, with separate and higher deductibles or low dollar caps on benefits, and special waiting periods. Private individual coverage for women who are already pregnant is simply not available, at any price. Even several state high-risk pools exclude coverage of maternity services or exclude pregnancy as a pre-existing condition.
2. **To the extent that a tax credit policy promotes a shift from employer-based coverage to individual coverage, as some researchers predict, it could increase the number of young families lacking coverage for maternity care.** In contrast to the individual market, maternity care is included in most employer plans. In fact, under the federal Pregnancy Discrimination Act, employers with 15 or more workers may not offer health insurance that excludes maternity care. Some researchers have estimated that, while providing tax credits for non-employment-based coverage would reduce the number of uninsured, there would be considerable shifting in sources of coverage. That is, the number of people with employment-based coverage and associated maternity benefits would decline, mostly due to employers dropping health coverage, with some switching to individual insurance and others becoming uninsured. Thus, the number of people with individual coverage (and, therefore, without maternity coverage in most cases) would increase significantly. None of the individual health insurance tax credit proposals introduced in the 108th Congress would specifically require qualifying health plans to cover maternity benefits.

3. **While several approaches to improve availability of maternity coverage might be considered in the context of designing a tax credit policy, there appears to be no easy way to assure that a policy of subsidizing individual health insurance plans will also expand coverage of maternity care.** Simply requiring health insurers to include maternity coverage in individual insurance policies could cause carriers to dramatically increase premiums or withdraw from the market altogether. In addition, by making health insurance more expensive, a maternity coverage mandate would reduce whatever effectiveness tax credits might have in helping the uninsured afford coverage, unless the credit amounts were also increased for those facing higher premiums due to maternity coverage.

Thus, if policy makers wish to provide maternity coverage for women who are eligible for tax credits but not eligible for Medicaid, it will probably be necessary for government to assume the additional costs directly. This could be done in one of several ways:

- Individual insurance policies could be required to cover the full range of maternity benefits in order to qualify for tax credits, and government could directly compensate carriers for the additional costs associated with offering maternity coverage through a “supplemental credit” per covered birth. If desired, the cost of the supplemental payment might be split between government and the covered woman on the same sliding scale as the underlying tax credit.
- Lower-income women who purchase individual insurance using a tax credit could be deemed eligible for Medicaid coverage of maternity-related services, whether or not they meet the normal Medicaid income-eligibility requirements, provided they keep their individual insurance in force during their pregnancy.
- The first two approaches could be combined by requiring individual insurance policies qualifying for the tax credit to cover prenatal care only, allowing women who become pregnant to access prenatal care promptly. At the same time, these women would also be made eligible for Medicaid coverage of delivery and postpartum care.

Each of these approaches would raise numerous implementation issues. For example, under the first approach, a system of paying insurers for providing maternity services to tax credit recipients would have to be created. And making tax credit recipients eligible for pregnancy-related services under Medicaid would raise the issue of how the cost should be shared between federal and state governments. In either case, additional resources would be required to fund the cost of covering maternity care for this group of women.

- 4. At a minimum, the design of a tax credit targeted at subsidizing individual health insurance coverage should address the overlap between eligibility for the credit and Medicaid coverage of pregnant women. If not addressed, the new tax credit could result in discontinuities of care for tax credit recipients who become eligible for Medicaid only when they are pregnant.**

Tax credit proposals introduced in Congress and proposed by the Bush Administration in 2003 deny credits to people enrolled in Medicaid. This provision, combined with the lack of meaningful, affordable maternity coverage in the individual insurance market, potentially forces low-income women either to forego prenatal coverage and enroll in Medicaid only to cover the cost of their delivery and postpartum care, or to potentially change established provider relationships and enroll in Medicaid for the duration of their pregnancy. The latter choice would then require them to re-apply for individual coverage—and face possible denial due to underwriting—once their postpartum period is over and they are no longer eligible for Medicaid. Such a result should be unacceptable, because it would erode the progress that has been made in extending access to maternity coverage and encouraging timely use of prenatal care. At the very least, pregnant women who become eligible for Medicaid only because of their pregnancy should be able to retain their tax credit for individual coverage if they enroll in Medicaid to obtain maternity care. The normal third-party liability provisions of Medicaid can assure that Medicaid does not pay for services that the woman’s private insurance ought to cover, thus avoiding any risk of duplicative federal costs.

- 5. Providing subsidies for employer-based coverage or other group insurance is an alternative way of using tax credits that would ensure that young families have coverage for maternity services.**

Because of the difficulties inherent in trying to integrate maternity benefits into individual insurance coverage, discussion of health insurance tax credits should include serious consideration of using the tax system to expand access to and participation by low-income workers in employment-based coverage or other group plans that cover maternity services. In addition, allowing tax credits to be used toward the purchase of COBRA continuation coverage through a former employer would protect some people from losing coverage that includes maternity care.

Tax Credits for the Uninsured and Maternity Care

I. Introduction

In 2001, about 40.9 million U.S. residents under age 65 were uninsured—about one of every six nonelderly Americans.¹ About 28 percent of the uninsured—11.5 million women—were women of childbearing age (15-44).² In 1999, approximately 428,000 women who were pregnant did not have (i.e., did not report having) health insurance.³

Lack of health insurance is particularly problematic for young families, because maternity care is expensive. On average, hospital charges alone for a normal vaginal delivery exceeded \$6,200 in 2002.⁴ Health insurance coverage is also important for women who may become pregnant and for their families because proper prenatal care is vital for positive birth outcomes. “[I]nfants born to mothers receiving late or no prenatal care are more likely to face complications which can result in hospitalization, expensive medical treatments, and increased costs to public programs.”⁵ But pregnant women are considerably less likely to get proper prenatal care if they are uninsured.

- In 1996, for example, 14.7 percent of uninsured pregnant women made no physician or medical provider visits during the year in which they gave birth, compared to 3.8 percent of privately insured women.⁶

Currently, particular attention is being paid to proposals that would use the tax system to help uninsured people buy private health insurance. Also under consideration are proposals that seek to encourage more employers (primarily small employers) to offer and contribute toward health benefits for their workers. Proposals to expand public program coverage for low-income people are also on the table but would affect pregnant women less than others, because Medicaid eligibility for pregnant women is relatively generous.⁷ (In fact, since at least 1993, Medicaid has paid for more than 35 percent of all births in the United States.⁸)

Channeling subsidies for the purchase of health insurance through the tax system would affect young families’ access to maternity care (i.e., prenatal care, delivery and postpartum care) in different ways, because—as discussed in the next section—maternity benefits are not always covered under private health insurance plans. In addition, for low-income women who would qualify for Medicaid only when pregnant, the design of most tax-credit proposals currently pending in Congress could lead to significant discontinuities in care.

This Policy Brief analyzes the extent to which alternative coverage-expansion proposals would improve coverage of maternity care and, where they fall short, suggests modifications. It does not consider the broader question of which proposals would be most effective in covering the uninsured in general. The first section provides brief background on the availability of maternity coverage in private group and individual health insurance plans. The second section outlines current proposals that aim to reduce the number of uninsured people by changing the tax treatment of health insurance premiums, and reviews their implications for availability of maternity benefits. The final section examines possible strategies for maximizing access to maternity benefits under various tax-subsidy approaches.

II. Brief background on maternity coverage in private health insurance plans

A. Employer-group coverage

Pursuant to the Pregnancy Discrimination Act of 1978, “health insurance plans offered in connection with employment must cover pregnancy, childbirth, and related medical conditions in the same way, and to the same extent, that they cover other medical conditions.” This means that employment-based health insurance plans may not exclude coverage for pregnancy or related medical conditions altogether, and must offer the same terms for coverage of pregnancy, childbirth, and related medical conditions as for other medical conditions.⁹ Like other provisions of title VII of the Civil Rights Act, however, these provisions apply only to employers with 15 or more employees.

As a result, essentially all but the smallest employer-sponsored health plans cover maternity benefits. In 2002, for example, 98 percent of covered workers in firms with 200 or more employees, and 97 percent of all covered workers, had coverage for prenatal care.¹⁰

Employers with fewer than 15 workers may choose whether or not to include maternity benefits in their health plans, except in the 12 states where state law directly or indirectly requires them to do so.¹¹ (See Appendix A for detailed information.) Most small employers that offer health benefits and have 10 or more workers have chosen to include maternity coverage. In 2000, only 7 percent of employers with 10 to 24 employees did not cover basic maternity care—doctor visits, hospital delivery and newborn care.¹² But information about maternity coverage among employers with fewer than 10 workers was not collected in that survey and is not readily available from other employer surveys.¹³

Even when maternity care is covered under an employer’s plan, a pregnant woman has to be enrolled in that plan to use the coverage. When the woman is the spouse of the worker, not the worker herself, she cannot enroll unless the employer’s plan is available to dependents at an affordable price. Essentially all larger firms that provide health benefits offer family coverage. Businesses with fewer than 50 workers are more likely not to offer family coverage, but only about six percent of workers in small firms that offer health benefits work for firms that do not offer family coverage.¹⁴

Affordability of family coverage is also an issue, however. Employers typically pay a larger share of the premium for coverage of their worker than for coverage of the worker’s dependents. In 2003, for example, the average worker with employer coverage paid \$42 per month, or 16 percent of the total premium, for worker-only coverage, but \$201 per month, or 27 percent of premium, for family coverage. Workers in firms with 3-199 workers paid a little less—\$37 per month—for single coverage but more—\$248 per month—for family coverage.¹⁵ Firms with 3-199 workers were much more likely than larger firms (200+ workers) to pay the entire cost of family coverage (15 percent v. 4 percent in 2003) but were also more likely to pay less than half the cost of family coverage (31 percent v. 6 percent).¹⁶

B. Coverage in the individual market

Families who have to purchase health insurance other than through an employment relationship, on the other hand, may have a difficult time obtaining maternity coverage. In most states, maternity care (other than complications of pregnancy) generally is not covered by health insurance policies sold to individuals. Only 13 states require all, or some forms of, health insurance to include maternity coverage.¹⁷ (See Appendix A for detailed information. These states account for about two-fifths of the total U.S. population.¹⁸) Elsewhere, where maternity coverage is available, it tends to be offered as a separate rider at a separate premium. Coverage under such riders can be strictly limited, with separate and higher deductibles or low dollar caps on benefits, and special waiting periods.¹⁹ Premiums are high because carriers must plan on recovering expected costs within a short period.

In general, carriers writing individual coverage try to avoid offering more generous maternity coverage riders than their competitors. Because coverage for complications of pregnancy is (and, generally, must be) included whether or not maternity coverage is included, and because in most states newborns must be covered automatically for 30 days, a carrier that covers proportionately more pregnant women than its competitors will experience higher claims costs and be at a competitive disadvantage. For this reason, in the Fall of 2001, one large individual carrier revised its optional maternity rider in order to more closely match what was being offered by its competitors. The new rider imposed no deductible or coinsurance but paid a maximum maternity benefit of up to \$1,200 in the first policy year, rising to \$2,400 in the third policy year, for a normal childbirth occurring more than 10 months after the rider was issued.²⁰

C. Coverage for pregnant women

Another important issue is the extent to which health insurance coverage is available to women who are already pregnant at the time they seek to enroll. (About half of pregnancies in the U.S. are unintended, i.e., unwanted or mistimed.²¹) Federal law prohibits group health plans from considering pregnancy as a pre-existing condition and from denying coverage on the basis of health status (including pregnancy), but no such prohibitions apply in the individual insurance market.

In most states, insurers selling to individuals may deny coverage to a pregnant applicant. And, even where they are required to issue a policy, they will likely exclude coverage for the pregnancy as a pre-existing condition.²² Denying coverage for pre-existing conditions is essential in the present voluntary individual market in order to avoid “adverse selection,” which leads to higher premiums when people wait to buy insurance until they know they need and will use it.²³ For the same reason, even state high-risk pools exclude coverage for pre-existing conditions (most often for 6 months, but often for 12 months). Also, three high-risk pools do not offer routine maternity coverage at all; four offer it only as a separate rider; two impose longer waiting periods for maternity coverage; and one applies a higher deductible.²⁴

III. Brief overview of approaches for subsidizing private health insurance coverage, and implications for availability of maternity benefits

This section presents a brief overview of current proposals that seek to reduce the number of uninsured people by changing the tax treatment of health insurance premiums, and of their implications for availability of maternity benefits. The primary focus is on tax credits for non-employment-based individual health insurance, but approaches that would subsidize small employers with low-wage workers are also summarized.

A. Tax Incentives for Individual Taxpayers

Because workers who are not offered employer coverage and their dependents constitute the vast majority of the uninsured, many current proposals aim to help individuals and families buy coverage on their own by subsidizing the cost of their premiums through the income tax system.

Proposed tax benefits can take the form of deductions or credits. But deductions, whether itemized or “above-the-line,”²⁵ only reduce taxable income and thus are more valuable to those with higher incomes, while almost two-thirds of the uninsured (65%) have incomes below 200 percent of the federal poverty level (FPL).²⁶ Deductions also provide no benefit to taxpayers whose exemptions and other deductions have already reduced taxable income to zero. Therefore, expanding the deductibility of health insurance premiums is likely to have relatively little effect on health insurance coverage rates. “Deduction” proposals are generally intended to improve the horizontal equity of the tax code.²⁷

For these reasons, most current interest focuses on proposals that would provide a tax credit, rather than a deduction, for all or part of a taxpayer’s health insurance premiums. Credits can be refundable or nonrefundable and, if refundable, may or may not be payable “in advance.” The amount of premium that qualifies for the credit may be limited, either in dollar or percentage terms. And eligibility for the credit may be limited to taxpayers with incomes below a specified level and/or who are not enrolled in public programs like Medicaid or the State Children’s Health Insurance Program (S-CHIP).

A **nonrefundable credit** reduces the amount of tax paid, but cannot exceed total income tax liability. Thus, the maximum credit would be available only to taxpayers with a tax bill greater than the value of the credit.

A **refundable credit**, on the other hand, may exceed the taxpayer’s tax liability; the excess is refundable to the taxpayer. This approach would provide the greatest assistance to those with little or no tax liability.

All health insurance tax credit bills introduced in the 108th Congress through September 2003 provide for refundable credits, as does the Bush Administration’s plan described in the proposed 2004 budget.²⁸ One bill would limit the maximum refund to the amount of Social Security taxes the worker paid.²⁹ The health insurance tax credit enacted as part of the Trade Act of 2002³⁰ is also refundable. (Though available only to a very limited population,³¹ the Trade Act tax credit is being discussed as a possible model for a more broadly applicable credit.)

Advance payment. A tax credit that is received only when the taxpayer's return is filed may provide a benefit to higher-income taxpayers who have sufficient cash flow to pay their health insurance premiums up front through the year. But lower-income workers who cannot otherwise afford health insurance need to be able to access the value of the credit at the time premiums are due. Workers whose federal income tax withholding exceeds the amount of the credit could reduce that withholding to take account of the credit, but low-wage workers with no or minimal income-tax liability do not have this option. Therefore, the 2002 Trade Act and all but one of the current tax-credit bills provide a mechanism that would allow eligible taxpayers to access the value of the credit at the time health insurance premium payments are due.³²

Dollar or percentage limits. The credit would not exceed the amount actually spent on health insurance premiums, but in most proposals there would be stricter limits. As proposed, these generally take the form of a fixed dollar limit per capita, usually with a different amount for adults and children. Alternatively, the limit might be based on a percentage of premium costs: The Trade Act credit equals 65 percent of premiums. In the Bush Administration's proposal, both limits would be imposed: The credit would equal 90 percent of premiums paid up to a limit of \$1,000 per adult and \$500 per child per year, with a maximum of two adults and two children per family. Several Congressional proposals have adopted the Administration's proposed dollar limits.³³ Only one bill appears to have adopted the Administration's proposed percentage limit.³⁴ Another bill is open-ended, allowing a credit for the full amount of premiums paid.³⁵

Income limits. While proposed deductions tend to be available to people at all income levels, tax credit proposals vary widely on this dimension. Two would make credits available to all taxpayers, regardless of income,³⁶ and one sets relatively high limits.³⁷ The others are targeted at lower-income people. Where income limits are used, the proposals typically specify one limit for receipt of the maximum credit amount, with a phase-out that reduces the credit as income rises, up to a higher income level at which the credit is no longer available. For example, under the Administration's proposal, the full credit would be available to single taxpayers with adjusted gross incomes under \$15,000 (about 167% of the 2003 FPL), and the credit would be eliminated at \$30,000 (about 334% FPL). For parents with children, the full credit would be available to taxpayers with adjusted gross incomes under \$25,000 (163% FPL for a family of 3), and the credit would be eliminated at \$60,000 (393% FPL for a family of 3).³⁸

Applicability to employer-sponsored coverage and COBRA continuation coverage.

Because they seek to help working people who are not offered coverage by an employer, currently proposed tax incentives for individual taxpayers focus primarily on providing tax breaks for purchasing health insurance that is not employment-based. Several refundable credit proposals, including the Bush Administration's proposal, specifically prohibit people from claiming the credit if they have or are eligible for employer-subsidized health insurance. However, one proposal specifically provides a reduced credit for taxpayers with employer coverage,³⁹ and another allows the credit to be used for the worker's share of employer coverage.⁴⁰ A third allows a credit for any and all health insurance premiums paid, but limits the credit to the sum of income and social security taxes otherwise owed.⁴¹ All current bills permit the tax credit to be applied to COBRA continuation coverage purchased through a former employer, while the Bush Administration's proposal does not address the question.

Public program participation. All but one of the current proposals deny the credit for any month in which an individual is enrolled in a public program like Medicaid or S-CHIP. (As discussed below, because Medicaid income thresholds are higher for pregnant women than for other adults, this provision could interrupt continuity of care.)

“Certificates” instead of credits. One current proposal would use “health insurance certificates” instead of a refundable tax credit to provide subsidies for the purchase of private health insurance.⁴² Like most tax-credit proposals, eligibility for certificates would be means-tested on a sliding-scale basis. The certificates could also be applied toward the purchase of a group (employment-based) health plan, but in that case the value of the certificate would be lower.⁴³

B. Tax Incentives for Small Businesses

Because the majority of the uninsured have a worker in the family, and because most businesses that do not offer health insurance are small businesses, another approach reflected in current proposals is to provide tax incentives to encourage small businesses to sponsor and contribute toward health coverage for their workers.

The details of these proposals vary considerably, but they all provide a business-related tax credit for a portion of the health insurance premiums paid by small employers (generally, no more than 50 employees) on behalf of qualified workers.⁴⁴ The most generous proposed credit is 50 percent of premiums; this is generally reserved for the smallest (no more than 10 employees) and lowest-wage businesses. Lower credit percentages usually apply to firms with more and/or higher-wage employees; several proposals use sliding scales related to firm size and/or wage level of workers. To qualify for the credit, many of the proposals require employers to pay a specified minimum share of the total premium, ranging from 50 to 75 percent of the total premium. One proposal provides a more generous credit if the employer pays a larger share of the premium. In most of the proposals, no credit is allowed for employer contributions toward coverage of higher-wage workers; some proposals reduce the credit percentage as the average wage level of the employer’s workforce increases.

Finally, some of the proposals offer a credit only to employers who have not provided health coverage previously (usually for the past two years); others offer a credit to all small employers that offer and contribute toward coverage, adjusted to reflect the number of employees and wage levels.

C. Likely Impact on Maternity Coverage

As the discussion in section II above makes clear, maternity coverage is often not available in the individual (non-employment-based) insurance market and, when it is available, tends to cost extra. Therefore, simply subsidizing the purchase of individual health insurance would do little to make coverage of maternity care accessible to more families.⁴⁵

However, only one of the seven individual tax-credit/certificate proposals we identified includes provisions that would likely guarantee credit recipients access to coverage that includes maternity care.⁴⁶ The other proposals contain no provisions affecting the content of coverage for individually purchased health insurance, although several include mechanisms intended to

guarantee access to typical coverage for high-risk individuals. One proposal, offered identically in both the House and Senate, would allow “individual membership associations” to offer both coverage that meets and coverage that does not meet state benefit mandates.⁴⁷

These proposals could also have secondary effects on the prevalence of maternity coverage. Some researchers have estimated that, while providing tax credits (only) for individual coverage would increase the total number of people with coverage, there would also be considerable shifting in sources of coverage. In particular, the number of people with employment-based coverage and associated maternity benefits would decline, mostly due to employers dropping health coverage, with some switching to individual insurance and others becoming uninsured.⁴⁸ The number of people with individual coverage (and, therefore, without maternity coverage in most cases) would increase significantly.

Because employment-based insurance almost always covers maternity care, proposals that encourage more employers to offer coverage, and more workers to enroll in employer coverage, have at least the potential to expand coverage of maternity care. However, it is uncertain whether the credit levels for small businesses in current proposals would be sufficient to induce very many previously uninsured firms to begin offering coverage. A recent study suggests that “premium subsidies paid directly to small firms are unlikely to significantly reduce the number of uninsured,” in part because small employers have previously not been very responsive to premium subsidies. Targeting issues are also a consideration: “because subsidies are given to the employer—rather than directly to employees—it is difficult to target the subsidies to those most in need: low-income, uninsured persons.”⁴⁹ Current proposals for employer tax subsidies typically do attempt to target those subsidies on *low-wage* workers, but some low-wage workers are members of higher income families.⁵⁰

Finally, the individual tax-credit/certificate proposals currently on the table do not interface smoothly with Medicaid coverage for pregnant women. For example, consider a married couple with one child and an annual income of \$24,000 or about 157% of the 2003 FPL. This family would qualify for the maximum tax credit under most current proposals.⁵¹ A child in this family is eligible for public coverage under Medicaid or S-CHIP in almost all states, but the parents are not. If the woman becomes pregnant, however, she will qualify for pregnancy-related Medicaid coverage in most states. But, by enrolling in Medicaid, she would become ineligible for a tax credit. Therefore, the following scenario becomes likely:

The family enrolls their child in public S-CHIP or Medicaid coverage and the parents buy private individual insurance policies using their tax credit. Both parents select physicians based on their private coverage. When the woman subsequently becomes pregnant, she is faced with a dilemma: Her private policy will not cover costs associated with normal childbirth, and she cannot afford to pay those costs out of pocket. She is now eligible for Medicaid, but as soon as she enrolls, she will lose her tax credit and probably have to drop her private coverage and may also have to switch physicians. What should she do? Enroll in Medicaid immediately, drop her private coverage, and begin looking for an obstetrician (and a primary care physician) who participate in Medicaid? Or wait, maintain her current physician relationships for non-pregnancy-related care, defer prenatal care, and enroll in Medicaid at the time of delivery? Then, two to three months after delivery, she will lose her Medicaid eligibility and will have to go through the underwriting process to purchase a new individual policy using her tax credit.

Thus, as currently designed, tax-credit proposals could cause significant disruption in continuity of care for women who are income-eligible both for a tax credit and for Medicaid when they are pregnant.

IV. Strategies for maximizing access to maternity benefits under tax credit approaches

As we have seen, simply subsidizing access to coverage purchased in the individual health insurance market will not increase the number of women who have maternity coverage. This section examines ways in which tax credit/certificate approaches could be modified to improve access to maternity coverage.

For reasons discussed in section II, coverage for women who are already pregnant is difficult to accommodate in a voluntary insurance market. Therefore, this section focuses on ways to improve access to maternity coverage for women who are not currently pregnant. Thereafter, we discuss ideas about how to assist women who are already pregnant but are above the eligibility threshold for public program coverage.

If tax credits (or similar subsidies) for purchasing private health insurance are to improve access to maternity coverage, a woman of childbearing age must be able to purchase insurance that covers maternity benefits at a price she can afford. Whether or not she can afford the coverage will depend on the premium she is charged compared with the subsidy she is eligible to receive. In turn, her premium will depend on the rating rules that govern the market in which she is buying insurance and on whether maternity benefits are included in all policies or offered as a separate rider. All of these factors must be taken into account in developing appropriate strategies.

A. Assuring that tax-credit-eligible women and families can buy insurance that includes maternity benefits

There are two main ways to assure that tax-credit-eligible women and families can buy insurance that includes maternity benefits:

1. *Require all carriers to offer maternity-coverage riders or at least one policy form that includes maternity coverage on the same terms as other medical care (“mandatory offer”).* The same patient cost-sharing provisions applicable to other medical care under the policy would apply to maternity benefits, and the waiting period or pre-existing condition exclusion applicable to maternity coverage could not exceed 9 months for women without prior continuous coverage for maternity care.
2. *Mandate coverage of maternity benefits (“mandatory coverage”).* That is, require all health insurance policies to cover maternity benefits on the same terms as other medical care, subject to no more than a 9-month pre-existing condition exclusion for women without prior continuous coverage for maternity care.

These requirements could be made applicable to the entire individual health insurance market, including state high-risk pools, or they could be applied only to policies that qualify for tax credits.⁵²

As a practical matter, where maternity coverage is optional, it is very expensive, because only families who expect they may have a baby purchase it, and the cost of pregnancy-related services and delivery is therefore spread over many fewer policyholders. Also, whether or not normal childbirth is covered under the policy, policyholders who become pregnant increase their insurer's claims costs, because complications of pregnancy and care of newborns are typically (required to be) covered. Because optional maternity coverage attracts purchasers who expect to become pregnant, these additional claims costs must also be included in the price of the rider. One company, for example, typically charged an additional 80 percent to add maternity coverage on an optional basis and found that this was insufficient.⁵³ For these reasons, a "mandatory-offer" requirement (option 1 above) does not appear to be a reasonable approach, unless additional subsidies were made available specifically for maternity coverage.

Requiring that all health insurance policies or all tax-credit-qualifying policies cover maternity benefits (option 2 above), on the other hand, would increase premiums for other people who purchase those policies, including people who do not need or want maternity coverage, again unless additional subsidies were made available specifically for the cost of maternity coverage.

For employer groups, maternity costs typically represent roughly 4 or 5 percent of total costs or premium, on average.⁵⁴ But employer groups attain very high participation rates with very little adverse selection. For individual coverage, whether, and the extent to which, premiums would go up would depend in part on the rating rules that apply to the state's individual insurance market and in part on the generosity of the tax credit. (A generous credit would be more likely to keep average premiums low by inducing participation of low-risk individuals, as a generous employer contribution does for group coverage.)

Where carriers are allowed to vary rates by age and gender, significant increases could be expected for women of child-bearing age, while premiums for men and for older women would probably not increase. In a market without subsidies, even under relatively high-deductible (\$2,500) coverage, a maternity mandate could increase rates for women by about one-third, on average. The increase for married couples would presumably be about half as much.⁵⁵ At lower deductible levels, the increase would be even greater.

Where carriers' ability to vary rates by age and gender is restricted, premiums would be likely to increase for all individual policyholders. For example, if rates can vary by age but not by gender, a maternity mandate could increase the cost of a high-deductible policy for both men and women in the childbearing years by up to 20 percent. In community-rated states that allow no variation by age or gender, the increase would likely be on the order of 10 percent.⁵⁶

These higher prices, in turn, would mean that the tax credit would induce fewer currently uninsured people to purchase coverage. In addition, current individual policyholders who do not need maternity coverage might decide to drop coverage if the tax credit did not at least offset their premium increase.

Because insurance regulation is traditionally a state responsibility, the federal government would be unlikely to try to impose a mandate affecting the entire market. Instead, a federal requirement would most likely be imposed through the tax code, i.e., by specifying the conditions a policy must meet to qualify for a tax credit.⁵⁷

A mandate that applied only to tax-credit-qualifying policies would have generally the same effect as a broad maternity coverage mandate but might cause larger premium increases due to market segmentation. That is, policyholders and applicants with no need for maternity coverage who would have to pay more for a qualifying policy, even after applying the tax credit, could avoid the extra cost by simply passing up the tax credit and staying with their current policy (or, in the case of a new applicant, choosing a non-qualifying policy without maternity coverage). The extent to which this occurred would depend on several variables. But, to the extent it did occur, the premium increase for qualifying policies would likely be higher than under a broad mandate that applied to all individual policies, because the maternity costs for women receiving tax credits would be spread across fewer policies.

There is also a risk that making maternity coverage a condition for tax-credit qualifying policies would cause carriers to refuse to sell tax-credit qualifying policies. The extent of this risk is difficult to assess, but there is no doubt that the individual market is already under severe stress. Early in 2003, for example, one prominent carrier exited the individual market entirely, nationwide. In this environment, the risk and pricing uncertainties associated with a maternity-coverage mandate would very likely cause other carriers to withdraw as well. And those that did not withdraw might well revise their underwriting standards to make it harder for women who are likely to become pregnant to obtain coverage.

B. Making coverage that includes maternity benefits affordable

Most, though not all, current individual income tax credit/certificate proposals set a dollar limit on the credit amount, generally \$1,000 per adult. Because premiums in the individual insurance market usually vary by age and by health status, this kind of credit structure would subsidize a much larger share of premium for younger and healthier taxpayers than for those who are older and less healthy. Policy makers may intend this effect, because young, healthy adults are more likely to be uninsured and are expected to need a strong incentive to get them to purchase insurance. Older and/or less healthy adults are thought to be more aware of their need for health insurance and therefore not to need as strong an incentive to purchase it.⁵⁸

A 2002 Council of Economic Advisors (CEA) analysis of the Bush Administration's tax-credit proposal, which incorporates a \$1,000-per-adult cap, found that 25-year-old males would have had little trouble buying PPO coverage with a \$1,000 deductible for a premium of \$1,000 per year. But premiums for older (55-year-old) males averaged about three times as much.⁵⁹ (For comparison, in 2002, the average cost of single coverage through employer plans, which are not age-rated but typically have lower patient cost sharing, was \$3,060 per year.⁶⁰)

Most states permit carriers in the individual insurance market to establish separate premium rates by gender as well as by age. Where gender rating is permitted, women of childbearing age will generally pay higher premiums than men of the same age. The 2002 CEA study found that premiums for young women were only "slightly higher on average than premiums for young

men,” but the policies analyzed typically did not include maternity coverage. Example premiums for a similar policy (\$1,000 deductible, 20% coinsurance, PPO) from one large individual carrier show that, in a state which allows gender rating, premiums for women aged 25-45 averaged about one-third higher than premiums for men of the same ages.⁶¹

Therefore, in most states, a tax credit with a relatively low maximum, such as \$1,000 per year, would cover a larger share of the premium for men than for women, other circumstances being equal, and this differential would be greater for policies that include coverage of maternity benefits. This gender differential also means that, among the young married couples for whom maternity coverage is likely to be of greatest interest, the tax credit would probably cover a smaller share of the combined premium for the couple than it would have if only the man bought coverage, but a larger share than if only the woman bought coverage.⁶²

Possible approaches for improving affordability for young families and women of childbearing age include:

1. *Structuring the tax credit as a percentage of the premium paid, with no cap or maximum amount. (Presumably, as in most current proposals, the credit percentage would decline with income over a range determined to be appropriate.)*

This approach could be used with either a “mandatory offer” or a “mandatory coverage” requirement for maternity care. The 2002 Trade Act, for example, uses a flat 65 percent credit with no upper limit.

The advantage of this approach is that it would subsidize the same percentage of premium for everyone, regardless of age, gender, or geographic residence. Still, where premiums vary by age, gender, or health status, it would not make coverage equally affordable for everyone with the same income. Moreover, a sliding-scale percentage credit would be either very much more expensive than a capped credit (if the credit percentage is high) or very much less effective in inducing currently uninsured people to buy coverage (if the credit percentage is kept low in order to reduce total costs). Therefore, it may not be feasible due to budget constraints.

2. *Adjusting the maximum credit amount for age and gender in states where age and/or gender rating are permitted*

This approach could be used where all policies qualifying for tax credits are required to include maternity coverage. It would probably not provide a sufficient adjustment where carriers are required only to offer maternity coverage riders to tax-credit-eligible women and families.

Adjusting maximum credit amounts to fully reflect expected premium variation by age and gender would be more equitable than not doing so, but it would not address differences in premiums arising from geographic differences in health care costs and, where premiums vary by age, gender, or health status, would not make coverage equally affordable for everyone with the same income. Moreover, leaving the cap at \$1,000 for young males and increasing it for more expensive age/gender categories would both cost considerably more and create stronger incentives for low-income workers and their employers to choose individual insurance over employment-based coverage. The alternative, reducing the basic credit amount below \$1,000, would make the credit less effective at encouraging young males to purchase coverage.

Full age/gender rating can create premium ratios of as much as 4 to 1 or more, depending on the applicable deductible. Elsewhere, a partial age-adjustment of the tax-credit cap has been suggested.⁶³ A ratio of 1.75 to 1 between the highest and lowest cap, by age, was illustrated. Such partial age adjustment, rather than full age adjustment, would partly address the inequities resulting from age rating of premiums and could reduce the incentive for young, healthy workers to leave employer coverage in favor of tax-credit-subsidized individual insurance. It would be less expensive than full age adjustment.

A partial gender adjustment could be added to allow women of childbearing age to receive a somewhat larger credit to offset the higher cost of health insurance that includes maternity coverage.

It would not seem appropriate to use age- and gender-adjusted credit caps in states that do not permit health insurance premiums to vary by age and/or gender, but implementing a tax code provision that varied by state could present problems. While there is precedent for age adjustment in the tax code,⁶⁴ there seems to be no precedent for applying different upper limits on tax preference items in different states. And administrative complexity would be a concern.

If the credit cap was adjusted only for age, and if only a partial adjustment was made, it might be possible to make age-rated caps the default and require the few states that do not permit age rating at all to certify that fact to the Treasury Department. There would then be only two options, and the Internal Revenue Service could provide clear guidance about which option applied in which states.

Adding an adjustment for gender would complicate the situation, because several states permit age rating while prohibiting gender rating.⁶⁵ In this situation, three schedules of credit caps would be needed: one for states that allowed both age and gender rating, one for states that allowed age rating but not gender rating, and one for states that prohibit both age rating and gender rating.

Allowing full age-adjustment of the credit caps would be more unworkable, because some states allow age rating but limit the degree to which premiums can vary based on age, while others do not limit how much premiums can vary by age. Also, a few states limit gender rating without prohibiting it entirely. If a state limited premium variation to a range narrower than that recognized by the federal tax credit, without prohibiting premium variation by age or gender entirely, determining what credit caps to apply could become entirely too complex.

3. Adjusting the cap or maximum credit amount for women of childbearing age only in states where gender rating is permitted.

This approach would recognize that requiring maternity coverage would make individual insurance policies more expensive and that, in states that allow age and gender rating, those higher premiums would be paid only by families that include women of childbearing age.

In states that permit gender rating, separate caps would be determined for women of childbearing age and for all other adults. The differential between the two caps would reflect the expected difference in premiums between the two groups due to the inclusion of maternity coverage, and

the absolute amounts would be set so that the expected average credit amount in gender-rating states equaled the expected average credit amount in states that do not permit gender rating.

This approach would give families with women of childbearing age the same “tax-credit purchasing power” as other families when maternity coverage is required. As noted earlier, requiring the inclusion of maternity benefits would increase the cost of individual insurance and therefore reduce the incentive effect of a capped credit unless the basic credit cap was also increased. This effect would be more obvious in states that allow gender rating, because the credit cap would actually be reduced for tax-credit recipients other than women of childbearing age.

Implementing this adjustment would be more feasible than implementing a combined age and gender adjustment (as discussed in the previous section), though still more difficult than if there were no adjustment. There would be only three possible credit limits: one for women of childbearing age in states that permit gender rating, one for all other tax-credit recipients in states that permit gender rating, and one for all tax-credit recipients in states that do not permit gender rating. State insurance regulators could certify to the Treasury Department whether gender rating was permitted or not in their state. Alternatively, health insurance issuers could be required to report whether or not each policy was gender-rated.⁶⁶

4. *Allow an additional credit for health insurance that includes maternity coverage in states that do not already require all individual policies to include maternity benefits.*

This approach would be most applicable if carriers were only required to offer maternity coverage as an option (“mandatory offer”).

Under this approach, the additional credit would be available to any otherwise eligible woman or couple who purchased tax-credit-qualifying health insurance that included maternity coverage, either directly or through a rider. The limit for the maternity coverage credit would be set based on an actuarial assessment of the additional cost of coverage when such coverage is optional. The limit would represent approximately the same percentage of the average premium for coverage with and without maternity benefits.⁶⁷

This approach could be combined with the previous approach, for states that allow gender rating but require individual insurance policies to include maternity coverage.

This approach faces a by-now-familiar dilemma: Unless additional funds can be made available to finance the added costs of maternity coverage, the value of the basic credit will have to be reduced. And a reduction in the basic credit will reduce its effectiveness in helping uninsured people afford to buy coverage.

However, by focusing narrowly on the issue of maternity coverage, this approach would likely require less additional funding (or a smaller decrease in the basic credit cap) than the other approaches discussed in this section.

5. *Provide a supplemental “credit” for maternity coverage in the form of a payment to the insurer when a tax-credit recipient gives birth.*

Under this approach, all policies qualifying for tax credits would be required to include maternity coverage with no (or minimal) patient cost-sharing and no dollar limitations. The amount of the supplemental payment could be determined in a variety of ways, but the intent would be to cover the full cost of providing prenatal care, delivery and postpartum care associated with normal childbirth and, possibly, costs associated with complications of pregnancy and care of newborns.

By paying the costs associated with childbirth, this approach attempts to maintain a functioning individual insurance market and preserve the possibility that tax credits might be effective in reducing the number of uninsured, while also assuring that all tax-credit recipients have maternity coverage. By making *all* tax-credit recipients eligible for fully subsidized maternity coverage, the approach would complement prior efforts to guarantee maternity coverage for low-income women by making them eligible for Medicaid while they are pregnant.⁶⁸

Because all insurers offering tax-credit-qualifying policies would have to include maternity coverage meeting specified requirements, there should be no particular reason why any one carrier would receive more than its fair share of women likely to become pregnant. That being the case, the supplemental payment might be limited to costs associated with normal childbirth only, and insurers might be expected to price their underlying policies to include the costs associated with complications of pregnancy and care of newborns. Taking this tack, however, would not reduce incentives for insurers to use marketing or underwriting practices aimed at avoiding women likely to become pregnant, because insurers that were successful at doing so could offer lower rates. Therefore, it might be sensible to design the supplemental payment to include costs for complications of pregnancy and care of newborns.

Alternative approaches to setting the amount of the supplemental payment might include:

- A fixed-dollar amount, which might vary by geographic area, based on the estimated average full cost of providing prenatal care, delivery and postpartum care associated with childbirth.
- A “reinsurance” approach, which would simply reimburse carriers for claims related to maternity care, perhaps including necessary claims processing costs.*

Payment would be made upon presentation of documentation that a tax-credit recipient covered by the carrier had delivered a baby.[†]

A fixed-dollar approach would be more consistent with the tax-credit construct, would be simpler to administer (once the appropriate dollar amount was determined), would better protect the public fisc, and would maintain incentives for carriers to negotiate favorable rates with maternity-care providers. It would also, inevitably, over-compensate some carriers and under-compensate others, thus affecting those carriers’ premiums and competitive positions.

* In this case, the term “reinsurance” would be something of a misnomer, because carriers would not be required to pay a premium to obtain the “reinsurance.”

† Consideration would have to be given to how to cover prenatal costs for women who suffered a miscarriage after receiving prenatal care.

If paying for pregnancy-related costs beyond those associated with normal pregnancy and delivery was determined to be necessary, a “reinsurance” approach might be required due to uncertainty about those costs. But such an open-ended approach would create incentives for inefficiency.

Overall, in addition to the advantages already mentioned, this approach would permit women receiving tax credits to maintain continuity of care and provider relationships when they become pregnant.

If the cost of fully funding maternity coverage for all tax-credit recipients is viewed as prohibitive, two variants of this basic approach could be considered.

a. Mandate (and pay for) prenatal care only.

One lower-cost variant would require policies to include only prenatal care and would base the supplemental payment only on the cost of that care. Hospitals would be expected to enroll eligible women in Medicaid to cover the cost of delivery and postpartum care, but having prenatal care covered under their private policy could help to assure that they begin prenatal care promptly. This variant might solve a good deal of the problem, since fewer than 6 percent of newborn discharges are uninsured.⁶⁹ In addition, continuity of care could be maintained during the prenatal period if Medicaid covered only labor, delivery, and postpartum services and if the woman were allowed to retain her tax credit and her private coverage (for non-pregnancy-related care) despite having enrolled in Medicaid. Otherwise, she would have to re-apply for individual coverage—and be subject once again to underwriting and possible denial of her application.

b. Provide a “shared-cost” supplement on a sliding-scale.

Another variant would require insurers to cover all maternity care, pay the insurer a percentage of the estimated full cost of that coverage, and allow the insurer to charge the policyholder for the remainder. The percentage paid by the government would equal the percentage credit the policyholder was receiving toward their regular individual coverage.

This variant would be applicable primarily under tax-credit approaches that phase-down the tax credit as the taxpayer’s income increases and would work most simply with the “fixed-dollar” approach for the supplemental payment. Use of a sliding-scale of this sort would limit public costs while still providing access to maternity coverage and some degree of financial protection to taxpayers with incomes too high to qualify for the full tax credit or for Medicaid coverage of maternity care.

Finally, this approach could potentially be used to compensate insurers even for the maternity-related costs of women who are already pregnant when they apply for coverage. Doing so, however, would certainly increase the number of pregnant women covered and, therefore, premiums in the individual market due to increased costs associated with complications of pregnancy and care of newborns.⁷⁰ Therefore, the supplemental payment would have to recognize those costs in addition to the costs of normal maternity care.

C. Using purchasing pools for tax-credit recipients

Some observers believe that the individual health insurance market is, to a considerable extent, dysfunctional. They note that it is characterized by high turnover and high average medical costs, risk segmentation, aggressive underwriting, and competition among carriers based on risk selection. Overhead costs are high and premiums vary widely based on health status in many states. In this view, it is highly unlikely that using tax credits to purchase coverage through the individual insurance market would be a cost-effective means of covering uninsured workers and their dependents.⁷¹ Others disagree.⁷²

For such reasons, some analysts have proposed that tax-credit recipients should be permitted to buy coverage through existing employment-based pools that offer enrollees a choice of health plans, such as the Federal Employees Health Benefits Program (FEHBP), similar programs for state government employees, or purchasing pools that serve small employers. But current participants in these plans most often oppose allowing other groups or individuals to become part of the same pool, due to fears of adverse selection and resulting higher premiums. Thus, the proposition usually shifts quickly to building on the same administrative apparatus and somehow using the same health plans, but keeping the new enrollees separate from the original group for rating purposes.

A broader application of the concept is that purchasing pools should be set up to provide tax-credit recipients a choice among multiple participating health plans and carriers, and that only insurance purchased through such pools should qualify for tax credits.⁷³ Coverage offered through such pools could be designed to meet a number of desirable public policy goals such as inclusion of maternity coverage, guaranteed acceptance of all applicants, and elimination of health status as a rating factor.⁷⁴

Purchasing pools for tax-credit recipients could be established at the state level, with some kind of federal fallback mechanism if states failed to act. (E.g., one tax-credit bill tasks the Office of Personnel Management—the administrator of the FEHBP—with setting up a pool in any state that fails to arrange for one on its own.⁷⁵) If too few health plans agree to participate in a separate tax-credit pool voluntarily, health plans might be required to serve the tax-credit pool if they want to continue covering government employees. As noted, pools serving small employers already exist in a few states. One current Congressional tax-credit proposal specifically provides for purchasing pools to be established by states for this purpose, but it does not make such pools the only venue through which tax credits can be applied.⁷⁶ Under the Bush Administration's proposal, at state option, "certain individuals not otherwise eligible for public health insurance programs" would be allowed to use tax credits "to buy into privately contracted state sponsored purchasing groups (such as Medicaid or S-CHIP purchasing pools for private insurance or state government employee programs for states in which Medicaid or S-CHIP does not contract with private plans.)"⁷⁷ However, the Administration would not permit states to require credit recipients to use such pools. Also, the Trade Act of 2002 permits states to provide coverage through a "private sector purchasing pool" for the health insurance tax credit made available by that Act, but eligible individuals could also apply their credit toward other coverage.

Denying tax credits for coverage purchased outside the designated pools is arguably anti-competitive and would be certain to meet with strong opposition. Nevertheless, unless they were

the only venue in which tax credits could be used, separate pools simply would not be viable. Experience over the past decade with purchasing pools for small employers shows that, if pools attempt to offer coverage on more generous terms than their competitors, the pools will attract a larger share of high-risk people, and their premiums will become more expensive than their competitors. Over time, as higher risks are referred to the pools and as more and more lower-risk people leave the pools, premiums become ever higher, and eventually the pools fail.⁷⁸ Thus, if pools were required to compete for tax-credit recipients against aggressively underwritten and selectively marketed individual health insurance, the pools would almost certainly suffer severe adverse selection, associated costs, and ultimate failure.

Even with an exclusive franchise for tax-credit recipients, pools could face some degree of adverse selection related to elimination of health underwriting. Ideally, the tax credit would be large enough, relative to the premium charged, to induce many low-risk people to join the pool. But, under most proposals, tax-credit recipients would have to put up some of their own funds to buy coverage, and all but young adults with access to age- and health-adjusted rates would have to pay considerable amounts. People who know they need health care would be more likely than healthy individuals to find a way to come up with their share of the premium. In addition, some low-risk people, especially those whose credit amount is smaller because their income is in the “phase-out” range, may find that they can obtain traditional, underwritten insurance outside the pool for a lower net premium, even though the tax credit would not be available for non-pool coverage. For these reasons, whether a “pool” strategy is realistically feasible may depend on the specific parameters of the particular tax-credit proposal and on whether purchase of health insurance remains voluntary.⁷⁹

D. Allowing tax credits to be used for employment-based coverage

All seven individual tax-credit/certificate proposals we identified appear to permit the tax credit to be used toward an individual’s purchase of COBRA continuation coverage through a former employer. By making COBRA coverage more affordable, this provision should be of particular benefit to women who are already pregnant when their regular employer coverage ends, since it could allow them to retain insurance that includes maternity coverage. Also, since most people experience relatively short spells without insurance—less than 8 months in most cases—being able to afford COBRA continuation coverage (which is available for up to 18 months in most cases) would aid a significant portion of the uninsured population, although not everyone who loses health insurance is eligible for COBRA continuation coverage.⁸⁰

But current proposals differ with respect to whether tax credits could be used toward employer-sponsored coverage for current employees and their dependents. This section discusses some possible approaches on that topic.

1. Where employment-based coverage is already available

Although tax credits are intended primarily to help people who do not have access to employer coverage, a considerable number of uninsured people actually are offered employer coverage but decline to enroll in it, most often because they view their share of the premium as too expensive.⁸¹ Among uninsured people under age 65 in working families,⁸² about one-third declined an employer’s offer of coverage.⁸³

As noted in section II, virtually all employer plans provide coverage of maternity benefits. No eligible worker or dependent can be denied coverage if they enroll in a timely manner, and under federal law no waiting period can be imposed for pregnancy-related services (other than a general waiting period to become eligible for the plan).

Where workers have access to but have not enrolled in employer coverage, or have enrolled themselves but not their spouse, allowing the tax credit to be applied toward the worker's share of the premium could make it financially feasible for the worker and spouse to enroll in the employment-based coverage. Allowing tax credits to be used toward employment-based coverage would also reduce the risk that, if tax credits were available only for non-work-based health insurance, some employers would drop coverage they now offer. As noted earlier, this could actually lead to a decline in the total number of people with access to maternity benefits.

One disadvantage of allowing tax credits to be used toward already available employer coverage is that a significant part of the total cost of the credit would go toward providing tax relief for the already insured, rather than toward helping uninsured people afford coverage. However, if the credit is focused on relatively low-income people, this may be appropriate for equity reasons.

Another disadvantage is the possibility that employers might reduce the amount they contribute toward health coverage for their workers, in order to maximize the federal tax contribution toward the total premium. To the extent this occurred, the total cost of the credit could increase.

Several current proposals permit the tax credit/certificate to be used toward employment-based coverage.⁸⁴ One way they attempt to deal with the potential disadvantages is by reducing the maximum credit when the qualifying coverage is employment-based, in order to adjust for a typical level of employer contributions. But, since employer contribution policies vary, a lower credit amount could leave some workers still unable to afford their employer's coverage.

2. *Where employment-based coverage is not already available*

Although some of the uninsured declined coverage that was offered by an employer, many more work for (or their spouses work for) employers who simply do not offer coverage. If large tax credits could be applied toward employment-based coverage, some businesses that now do not offer health benefits to their workers might be induced to do so. Often, businesses refrain from offering health insurance not because they are unwilling to contribute toward its cost but because they cannot afford to pay the entire cost and their workers cannot afford to contribute much, if anything, toward the cost. In this situation, if subsidies like tax credits enabled workers to afford a substantial contribution, businesses that now do not offer coverage might well be willing to sponsor a plan and contribute some portion of the cost.

In order to make workers in such businesses eligible for the full tax credit, rather than a reduced credit as discussed in the previous section, an employer would be required to opt out of the current system of income-tax preferences for employer coverage. Instead, the employer could contribute a modest amount, which would be exempt from FICA taxes—though counted as part of the worker's pay for income tax purposes—and which would be available only toward a worker's health plan premium. The worker would pay the remainder of the premium out of his or her paycheck, and would receive a refundable income-tax credit based on the entire amount of the premium. The employer's contribution would only have to be sufficiently large, when

combined with the tax credit, to induce enough workers to participate so that the business could meet a carrier's requirements for group coverage.⁸⁵

While the actual pay-off from allowing this use of tax credits for employment-based coverage is difficult to predict, there is considerable potential for favorable results and little downside risk. Some uninsured workers who would not otherwise have used tax credits to become insured might do so, and their coverage would generally include maternity benefits (though the smallest firms are not required to provide it). Group-participation requirements would help to assure that the costs of maternity coverage are broadly spread, and HIPAA rules protect workers from having to pay more based on their health status. Additional costs related to simply refinancing existing coverage would likely be modest, because the all-or-none requirement would assure that currently insured employers would elect this option only when a substantial majority of their employees would qualify for a substantial tax credit.⁸⁶ The same requirement would also reduce the possibility of confusion or lack of clarity about what is required.⁸⁷

E. Allowing tax credits to be used to “buy in” to public coverage, such as Medicaid or S-CHIP

Several, though not all, current tax-credit proposals are aimed at lower-income workers and families who do not qualify for current public programs such as Medicaid or State Children's Health Insurance Programs (S-CHIP). Both of those programs provide broader coverage and much lower out-of-pocket costs than are available in the individual health insurance market or even in the group market. Allowing tax-credit recipients to “buy in” to Medicaid coverage or S-CHIP coverage (expanded to include adults), at an appropriate premium, would give tax-credit eligible individuals the option to purchase a relatively comprehensive benefit package, including maternity coverage, at an affordable price.⁸⁸

Due to the special eligibility thresholds that public programs like Medicaid apply to pregnant women, a considerable number of women eligible for tax credits to buy private coverage would not qualify for public coverage until they became pregnant. Then, however, they would be eligible for Medicaid (or, in a few states, S-CHIP) coverage.

Current proposals typically would deny health insurance tax credits for any month in which the beneficiary was enrolled in a public program. Thus, a tax-credit recipient who became pregnant would have to choose between continuing her private health insurance coverage entirely at her own expense, or dropping that coverage to enroll in Medicaid. Medicaid provides all necessary maternity care with essentially no out-of-pocket costs, while private health insurance requires a premium and would likely impose copayments and deductibles. Moreover, if the woman already had an obstetrician under her private health plan, switching to Medicaid might require her to choose a new one. Allowing women to use tax credits to enroll in Medicaid (or S-CHIP) at the outset would avoid such a disruption of provider relationships.

Many supporters of tax credits oppose expansion of public programs. Perhaps for this reason, the Bush Administration's proposal allows the option only when the public program provides coverage by contracting with private health plans, and describes it as “buy[ing] into privately contracted state sponsored purchasing groups.”⁸⁹

The purchasing pool analogy is apt, because allowing tax-credit recipients to buy into public programs would raise many of the same issues purchasing pools would face if tax-credit recipients had the option to purchase coverage either through a pool or in the regular individual insurance market. Private health plans that now contract to serve Medicaid- and/or S-CHIP-eligible parents and children generally have not experienced adverse selection, because the state negotiates and pays the premium on behalf of low-income enrollees. But plans would be wary of selection issues in a new population that would most likely be required to pay a significant portion of the premium out of their own pocket. As a result, plans might insist on imposing waiting periods for coverage of pre-existing conditions, to prevent people from waiting to enroll until they need coverage and then dropping out when the need has been met.*

If tax credits were available to people above traditional public-program income levels, provider groups might also oppose allowing tax-credit recipients to enroll in public coverage because doing so would increase the number of people for whom providers are asked to accept below-market payment rates.

Thus, allowing tax-credit recipients to buy into public coverage *per se* would likely not be acceptable to policy makers, but letting states organize purchasing pools for tax-credit recipients using the same health plans that serve public program recipients might be.⁹⁰ However, as discussed earlier, such pools would likely have high costs due to adverse selection unless they were the only coverage vehicle tax-credit recipients were permitted to use.

Alternatively, women who have used tax credits to purchase private insurance for at least 9 months might be given access to Medicaid or S-CHIP for coverage of maternity care services, whether or not they otherwise met the eligibility requirements for the public program. This option would be available only to women who qualify for the tax credit and who use it to purchase private insurance in the individual market in states that do not mandate maternity coverage. Women who do not otherwise meet the state's Medicaid or S-CHIP eligibility requirements for pregnant women would be required to maintain their private coverage in order to be eligible to enroll in public coverage for maternity care.

This approach would provide access to maternity coverage for women who cannot access it in the private market at an affordable price. To be fully effective, states would have to include this group of women under their Medicaid or S-CHIP programs.

F. Proposals to assist women who are already pregnant

As has been discussed, individual private insurance could not remain fiscally viable if it were required to provide maternity coverage to women who are already pregnant when they apply. Pregnant women who meet the income standards can enroll in public programs like Medicaid and receive immediate coverage with no exclusions. But with few exceptions uninsured pregnant women with higher incomes are not able to obtain maternity coverage unless they are able to qualify somehow for employer coverage. Instead, they pay for maternity care directly.

* To avoid a double subsidy, the federal government might well insist that tax-credit recipients not be pooled with current program eligibles in determining premium rates. Otherwise, some of the costs of tax-credit recipients would be paid not by the recipients themselves (as the tax-credit construct intends) but by the federal and state governments through the public program.

Can anything be done to make maternity coverage available to these pregnant women in order to encourage receipt of proper care? Some observers believe that it is unrealistic to expect uninsured women to purchase insurance before they become pregnant. In this view, if the problem is to be addressed effectively, arrangements must be made to provide maternity coverage to women who are already pregnant.

1. Require State high-risk pools to offer maternity coverage with no exclusions as a condition of qualifying for tax credits.

In 29 states, high-risk pools already guarantee coverage to individuals who have been denied coverage by regular insurance carriers or who have a specified medical condition.⁹¹ Most, though not all, provide maternity coverage,⁹² but except for “HIPAA continuity” eligibles, coverage is subject to the usual waiting period for any pre-existing condition.⁹³

Thus, simply requiring high-risk pools to provide maternity benefits would extend maternity coverage only to women who were already participating in the high-risk pool due to some other medical condition (or who came to the pool with sufficient “creditable coverage”). It would provide little benefit to other women uninsured for their pregnancy, since the pools’ waiting periods for coverage of pre-existing conditions in most cases excludes coverage for the current pregnancy.

To help women who are already pregnant, high-risk pools could be required, as a condition of qualifying for tax credits, to waive waiting periods for pregnancy-related conditions and to accept for enrollment any pregnant woman. This approach would be less harmful than requiring all carriers in the individual market to do so, because the losses of risk pools are usually funded from a somewhat broader base than the individual insurance market.

But, in many cases risk-pool losses are funded by assessments on health insurance sold in the state, so additional losses by the high-risk pool tend to increase health insurance premiums for individual and (primarily small) group purchasers in the state generally. Where risk-pool losses are funded by state revenue, total enrollment in the pool might have to be limited. Thus, coverage for pregnant women could limit a pool’s ability to accept other applicants. In 1999, an estimated 84,000 pregnant women were uninsured and did not appear to be eligible for Medicaid or S-CHIP.⁹⁴ Perhaps 60 percent, or about 50,000 of these women, lived in states with operating risk pools.⁹⁵ At approximately the same time, about 112,700 people were enrolled in state high-risk pools.⁹⁶ Thus, allowing pregnant women to buy risk-pool coverage using tax credits could have a significant impact on risk-pool operations.

Finally, this approach would not help pregnant women in the many states that have not established a high-risk pool.

2. A maternity-care “stored value” and discount card for tax-credit-eligible women.⁹⁷

To provide some assistance to already-pregnant women who do not qualify for Medicaid and do not have other insurance that covers maternity care, carriers might make available “stored value” smart cards that could be used toward payment for routine prenatal, delivery and postpartum care and that would give access to the carriers’ negotiated provider discounts. Tax-credit-eligible pregnant women could obtain a card from the carrier of their choice. The value of the card

would equal a percentage of the estimated full cost of providing prenatal care, delivery and postpartum care associated with normal childbirth through the carriers' network. This percentage would equal the percentage credit for which the woman would be eligible. The dollar value of the card would be fixed upon issuance, and the carrier would bill the advance-tax-credit issuing agency for that amount. Limiting the card's "stored value" to less than the expected full cost of maternity care would help avoid creating perverse incentives for women to drop other—presumably less generous—maternity coverage they might have.

All care used would be deducted from the card's value at the carrier's negotiated provider rates. To encourage use of prenatal care, only minimal copayments might be required. The amount remaining after prenatal care was complete (or after paying the provider's global fee for prenatal care, delivery and postpartum care) would be available toward hospital charges for delivery (again, at the carrier's negotiated rates). This construct would encourage women to shop around for the best prices. Ideally, the carrier would have a system that would enable women to compare prices of providers in their area.

This approach is similar in some ways to the "supplemental payment for maternity coverage" discussed earlier, but it puts the risk that maternity costs will exceed the value of the card on the woman and her family, rather than on the carrier or the government. As with other approaches discussed in this paper, it would require additional funds. However, it is intended to be an efficient way of providing subsidies for otherwise uninsured tax-credit-eligible women in need of maternity care. Note that the card itself would not provide "insurance" of any sort; it would simply be a private-sector mechanism for distributing a maternity-care subsidy and making available insurers' negotiated provider rates.

V. Conclusion

While several approaches to improve availability of maternity coverage might be considered in the context of designing a tax credit policy, there appears to be no easy way to assure that a policy of subsidizing individual health insurance plans will also expand coverage of maternity care. Simply requiring health insurers to include maternity coverage in individual insurance policies could cause carriers to dramatically increase premiums or withdraw from the market altogether. In addition, by making health insurance more expensive, a maternity-coverage mandate would reduce whatever effectiveness tax credits might have in helping the uninsured afford coverage, unless the credit amounts were also increased for those facing higher premiums due to maternity coverage.

Thus, if policy makers wish to provide maternity coverage for women who are eligible for tax credits but not eligible for Medicaid, it will probably be necessary for government to assume the additional costs directly. This could be done in one of several ways:

- Individual insurance policies could be required to cover the full range of maternity benefits in order to qualify for tax credits, and government could directly compensate carriers for the additional costs associated with offering maternity coverage through a "supplemental credit" per covered birth. If desired, the cost of the supplemental payment might be split between government and the covered woman on the same sliding scale as the underlying tax credit.

- Lower-income women who purchase individual insurance using a tax credit could be deemed eligible for Medicaid coverage of maternity-related services, whether or not they meet the normal Medicaid income-eligibility requirements, provided they keep their individual insurance in force during their pregnancy.
- The first two approaches could be combined by requiring individual insurance policies qualifying for the tax credit to cover prenatal care only, allowing women who become pregnant to access prenatal care promptly. At the same time, these women would also be made eligible for Medicaid coverage of delivery and postpartum care.

Each of these approaches would raise numerous implementation issues. For example, under the first approach, a system of paying insurers for providing maternity services to tax credit recipients would have to be created. And making tax credit recipients eligible for pregnancy-related services under Medicaid would raise the issue of how the cost should be shared between federal and state governments. In either case, additional resources would be required to fund the cost of covering maternity care for this group of women.

Whether or not any of these approaches is adopted, the design of a tax credit targeted at subsidizing individual health insurance coverage should, at a minimum, address the overlap between eligibility for the credit and Medicaid coverage of pregnant women. If not addressed, the new tax credit could result in discontinuities of care for tax-credit recipients who become eligible for Medicaid only when they are pregnant.

- Tax-credit proposals introduced in Congress and proposed by the Bush Administration in 2003 deny credits to people enrolled in Medicaid. This provision, combined with the lack of meaningful, affordable maternity coverage in the individual insurance market, potentially forces pregnant tax-credit recipients either to forego prenatal coverage and enroll in Medicaid only to cover the cost of their delivery and postpartum care, or to potentially change established provider relationships and enroll in Medicaid for the duration of their pregnancy. The latter choice would then require them to re-apply for individual coverage—and face possible denial due to underwriting—once their postpartum period is over and they are no longer eligible for Medicaid. Such a result should be unacceptable, because it would erode the progress that has been made in extending access to maternity coverage and encouraging timely use of prenatal care. At the very least, pregnant women who become eligible for Medicaid only because of their pregnancy should be able to retain their tax credit for individual coverage if they enroll in Medicaid to obtain maternity care. The normal third-party liability provisions of Medicaid can assure that Medicaid does not pay for services that the woman's private insurance ought to cover, thus avoiding any risk of duplicative federal costs.

Finally, because of the difficulties inherent in trying to integrate maternity benefits into individual insurance coverage, discussion of health insurance tax credits should include serious consideration of using the tax system to expand access to and participation by low-income workers in employment-based coverage or other group plans that cover maternity services. In addition, allowing tax credits to be used toward the purchase of COBRA continuation coverage through a former employer would protect some people from losing coverage that includes maternity care.

Appendix A: State Maternity Coverage Mandates

According to the Health Insurance Resource Guide prepared by Georgetown University for the March of Dimes in August 2002, the following states require coverage of basic maternity-related services in insurance policies sold in the individual or small group markets, as noted.⁹⁸ Laws that require the inclusion of maternity coverage in all policies are shown first, followed by laws that require only some forms of insurance to include maternity coverage. Laws that only require that maternity coverage be offered are not included in this table. Note that, in the small group market, some requirements derive from state civil rights law, rather than from state insurance law.

State	Individual Market	Small Group (Employer) Market
Colorado		*
Hawaii		✓
Idaho		✓ [Ers w/ 5+ Ees, per civil rights law]
Maryland	Hospitalization for delivery	✓
Massachusetts	✓	✓
Michigan		✓ [Ers w/ 1+ Ees, per civil rights law]
Minnesota	✓	✓
Montana	✓	✓
New Jersey	✓	✓
New York	✓	✓
Oregon	✓	✓
Vermont	✓	✓
Washington	✓	✓
California	✓ [MCOs]	✓ [MCOs]
Georgia	✓ [MCOs]	✓ [MCOs]
Illinois	✓ [MCOs]	
Maine	✓ [HMOs]	✓ [HMOs]
All Carriers	9	12
HMOs/MCOs only	4	3

* Colorado's maternity coverage mandate only applies to groups of 15 or more. Because it provides no additional protection beyond the federal Pregnancy Discrimination Act, we have chosen not to include it for purposes of this discussion.

"MCO" = managed care organization, "HMO" = health maintenance organization.

NOTES

- ¹ Paul Fronstin, “Sources of Health Insurance and Characteristics of the Uninsured: Analysis of the March 2002 Current Population Survey,” *EBRI Issue Brief* No. 252, December 2002.
- ² Unpublished analysis of the Census Bureau’s March 2002 Current Population Survey, as reported in the March of Dimes Data Book for Policy Makers, *Maternal, Infant, and Child Health in the United States: 2003*.
- ³ Kenneth E. Thorpe, Jennifer Flome and Peter Joski, “The Distribution of Health Insurance Coverage Among Pregnant Women, 1999,” Emory University, April 2001. Prepared for the March of Dimes.
- ⁴ Mutual of Omaha Insurance Company, *Current Trends in Health Care and Dental Costs Utilization*, 2003 Edition (based on 2002 data). Accessed August 8, 2003, from <http://www.mutualofomaha.com/acrodocs/mugc6794.pdf>.
- ⁵ Report 107-233. “Mothers and Newborns Health Insurance Act of 2002.” Committee on Finance, United States Senate. August 1, 2002.
- ⁶ Bernstein, A. “Insurance Status and Use of Health Services by Pregnant Women.” March of Dimes. December 1999.
- ⁷ As of October 1, 2002, pregnant women are eligible for Medicaid coverage up to 133% of the poverty level in every state and to 185% of poverty or higher under Medicaid or S-CHIP in 35 states. National Governors’ Association Center for Best Practices *Issue Brief*, “MCH Update 2002: State Health Coverage for Low-Income Pregnant Women, Children, and Parents,” June 9, 2003.
- ⁸ National Governors’ Association Center for Best Practices, *MCH Update 2002: State Health Coverage for Low-Income Pregnant Women, Children and Parents*, June 9, 2003 (Issue Brief).
- ⁹ U.S. Equal Employment Opportunity Commission, Directives Transmittal Number 915.003, October 3, 2000, Chapter 3: Employee Benefits. Accessed July 22, 2003, at <http://www.eeoc.gov/docs/benefits.html>.
- ¹⁰ Kaiser Family Foundation and Health Research and Educational Trust, *Employer Health Benefits: 2002 Annual Survey*. Exhibit 8.3.
- ¹¹ Federal regulations at 45 CFR 146.150, issued pursuant to section 2711(a)(1)(A) of the Public Health Service Act [42 U.S. C. 300gg-11(a)(1)(A)], as added by Title I, section 102(a), of Pub. L. 104-191, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), require health plans and health insurance issuers to offer to all small employers (i.e., those with two to 50 workers) every policy they offer to any small employer. Therefore, employers with fewer than 15 workers must be offered policies that include maternity coverage, because the Pregnancy Discrimination Act in effect requires carriers to offer such policies to employers with 15 or more workers.
- ¹² In 2000, only 7 percent of employers with 10 to 24 employees did not cover basic maternity care—doctor visits, hospital delivery and newborn care—but information on employers with fewer than 10 workers was not collected. March of Dimes, 2001. Questions included as part of the Mercer/Foster Higgins National Survey of Employer-sponsored Health Plans 2000, conducted by William M. Mercer, Inc.

Notes (cont'd)

- ¹³ Note, however, that only about 40 percent of firms with fewer than 10 workers offer any health benefits, only about 35 percent of all workers in such firms are covered through those firms, and those workers account for less than 8 percent of workers covered through their own employer. U.S. Agency for Healthcare Research and Quality, Employer-Sponsored Health Insurance Data. Private-Sector Data by Firm Size, Industry Group, Ownership, Age of Firm, and Other Characteristics (various years), Rockville, MD: September 2002. Tables I.A.2., I.B.2. and I.B.2.b. (http://www.meps.ahrq.gov/data_pub/ic_tables.htm).
- ¹⁴ According to unpublished tabulations of Private-Sector Employer-Sponsored Health Insurance Data for 2000, provided to the author by the U.S. Agency for Healthcare Research and Quality on June 20, 2003, 99.5% of businesses with 50 or more workers that offer any health insurance offer family coverage; these businesses employ 99.8% of all workers in large businesses that offer health insurance. Among businesses with fewer than 50 workers that offer any health insurance, 88.9% offer family coverage; these businesses employ 94.4% of all workers in small business that offer health insurance.
- ¹⁵ Kaiser Family Foundation and Health Research and Educational Trust, *Employer Health Benefits: 2003 Annual Survey*. Exhibits 6.1, 6.2 and 6.4.
- ¹⁶ *Ibid.* Exhibit 6.9.
- ¹⁷ In some situations, whether required maternity coverage applies to teenaged dependents is unclear. This seems to be the case especially where the requirement is applied to health maintenance organizations through a defined basic benefit package.
- ¹⁸ These 13 states account for 39.3 percent of the total U.S. population, based on 2000 Census figures (http://eire.census.gov/popest/estimates_dataset.php, accessed July 25, 2003).
- ¹⁹ Health Insurance Resource Guide prepared by Georgetown University for the March of Dimes, August 2002.
- ²⁰ Personal communication. The carrier prefers not to be identified.
- ²¹ “Excluding miscarriages, 49% of the pregnancies concluding in 1994 were unintended.... Forty-eight percent of women aged 15-44 in 1994 had had at least one unplanned pregnancy sometime in their lives.” Stanley K. Henshaw. “Unintended Pregnancy in the United States.” *Family Planning Perspectives*, vol. 30, no. 1 (January/February 1998):24-29.
- ²² Only four states (MA, MI, NM, OR) limit pre-existing condition exclusions to a maximum of 6 months from the date of issuance. BlueCross BlueShield Association, *State Legislative Health care and Insurance Issue: 2001 Survey of Plans*, December 2001.
- ²³ The individual market is much more subject to adverse selection than the group market, because in the individual market people have to pay the entire premium out of their own pocket. Therefore, those who do not think they “need” insurance right now are more likely to put off purchasing it, especially if they believe they will be able to purchase it when they do need it.
- ²⁴ Communicating for Agriculture and the Self-Employed, Inc., *Comprehensive Health Insurance for High-Risk Individuals*, Seventeenth Edition 2003/2004.
- ²⁵ An “above-the-line” deduction can be taken even by taxpayers who do not itemize deductions.
- ²⁶ Kaiser Commission on Medicaid and the Uninsured, *Health Insurance Coverage in America: 2001 Data Update*, January 2003. Table 8.

Notes (cont'd)

- ²⁷ Bills introduced in the 1st session of the 108th Congress that would make health insurance premiums deductible for income-tax purposes include: H.R. 1117 (Cox), the “Health Care Freedom of Choice Act,” which would remove the current 7.5%-of-AGI limitation on deductibility of medical expenses (including insurance premiums paid); H.R. 198 (Stearns), the “Health Care Tax Deduction Act of 2003,” which would make health insurance premiums and prescription drug expenses fully deductible, whether or not a taxpayer itemizes other deductions; and S. 637 (Boxer), the “Health Insurance Tax Relief Act,” which would allow taxpayers to deduct up to \$2,000 of health insurance premiums paid, whether or not they itemize other deductions.
- ²⁸ Health insurance tax credit proposals introduced in the 1st session of the 108th Congress through August 1, 2003, include: S. 100 (Collins-Landrieu), the “Access to Affordable Health Care Act;” H.R. 583 (Kennedy of Minnesota) and S. 1570 (Santorum), the “Fair Care for the Uninsured Act of 2003” [the House and Senate versions are largely similar but not completely identical]; H.R. 1236 (Granger), the “Securing Access, Value, and Equality in (SAVE) Health Care Act,” H.R. 1287 (Paul), the “Comprehensive Health Care Reform Act of 2003;” and S. 1030 (Bingaman), the “Health Coverage, Affordability, Responsibility, and Equity Act of 2003” or the “HealthCARE Act of 2003,” which has also been introduced in the House as H.R. 2402 (Kaptur). The Bush Administration’s proposal *per se* has not been introduced, although the tax-credit provisions in S.100 (Collins-Landrieu) appear to reflect several major parameters of the Administration’s proposal.
- ²⁹ H.R. 1287 (Paul).
- ³⁰ Public Law 107-210.
- ³¹ The credit is available only to certain workers who lose their jobs due to the effects of international trade and certain beneficiaries of the Pension Benefit Guaranty Corp.
- ³² The exception is H.R. 1287 (Paul).
- ³³ S. 100 (Collins-Landrieu), H.R. 583 (Kennedy of Minnesota) and S. 1570 (Santorum). In addition, H.R. 1236 (Granger) uses \$1,000 per adult and \$500 per child as the “base amounts” for the credit, but also gives the taxpayer credit for half of any premium payments in excess of those amounts.
- ³⁴ S. 100 (Collins-Landrieu).
- ³⁵ H.R. 1287 (Paul).
- ³⁶ H.R. 583 (Kennedy of Minnesota) and the very similar S. 1570 (Santorum), and H.R. 1287 (Paul). The 2002 Trade Act credit is also available without regard to income, but the eligible population is very narrowly defined.
- ³⁷ H.R. 1236 (Granger).
- ³⁸ Department of the Treasury, “General Explanations of the Administration’s Fiscal Year 2004 Revenue Proposals,” February 2003. As of July 2003, the Administration’s proposal had not been put into legislative language.
- ³⁹ H.R. 1236 (Granger).
- ⁴⁰ S. 1030 / H.R. 2402 (Bingaman-Kaptur).
- ⁴¹ H.R. 1287 (Paul).

Notes (cont'd)

- ⁴² H.R. 2698 (Bilirakis-Towns), the “Health Insurance Certificate Act of 2003.” Mr. Bilirakis chairs the Subcommittee on Health of the House Committee on Energy and Commerce, which does not have jurisdiction over tax issues.
- ⁴³ When applied toward employer coverage, the value of the certificate would be 40 percent of its value when applied toward individual coverage.
- ⁴⁴ Bills introduced in the first session of the 108th Congress (2003) that include a small-employer health-insurance tax-credit provision include: S. 10 (Daschle), the “Health Care Coverage Expansion and Quality Improvement Act of 2003,” S. 53 (Durbin-Clinton), [no short title], S. 86 (Clinton-Durbin), the “Small Employer Tax Assistance for Health Coverage Act of 2003,” S. 100 (Collins-Landrieu), the “Access to Affordable Health Care Act,” H.R. 450 (Dunn-Neal), the “Small Business Health Insurance Affordability Act of 2003, and H.R. 1936/1937 (Moore), the “Small Business Health Insurance Expansion Act of 2003.” As of July 17, 2003, no committee action had been taken on any of these bills.
- ⁴⁵ An unlimited credit would pay for maternity riders where they are available, but enactment of such a credit seems highly unlikely.
- ⁴⁶ S. 1030 / H.R. 2402 (Bingaman-Kaptur) requires the establishment of purchasing pools for individuals eligible for tax credits. Health plans available through purchasing pools would be required to offer coverage that met certain benchmarks based on coverage available to government workers or public programs. It appears that these standards would require the inclusion of maternity coverage.
- ⁴⁷ H.R. 583 (Kennedy of Minnesota) and S. 1570 (Santorum).
- ⁴⁸ See, for example, Jonathan Gruber’s estimate of the effects of the Bush Administration’s health insurance tax credit proposal in his [written] testimony submitted to the House Ways and Means Subcommittee on Health, Hearing on Health Insurance Tax Credits, February 13, 2002. (Electronic copy provided by Dr. Gruber.) Dr. Gruber estimates that 5.6 million people would lose employer-sponsored insurance, with 3.6 million of those (about 65 percent) due to the firm dropping coverage and the remainder resulting from individual decisions.
- ⁴⁹ James D. Reschovsky and Jack Hadley, “Employer Health Insurance Premium Subsidies Unlikely to Enhance Coverage Significantly,” Issue Brief No. 46, Center for Studying Health System Change, December 2001.
- ⁵⁰ In 1999, almost 30 percent of full-time, full-year workers who earned less than \$20,000 (about \$10 per hour) from their work were members of families with incomes equal to 250 percent of poverty or higher, based on unpublished tabulations of the March 2000 Supplement to the Current Population Survey by the Institute for Health Policy Solutions. Among *uninsured* full-time, full-year workers, the figure was lower—12.6 percent or about one in eight—but current proposals of this type typically do not require that low-wage workers be previously uninsured in order for their employer to qualify for a tax credit.
- ⁵¹ Under S. 1030 / H.R. 2402 (Bingaman-Kaptur), families below 150% FPL qualify for a larger credit.
- ⁵² Implementing a “mandatory coverage” requirement (option 2) for tax-credit-qualifying policies would be straightforward. Implementing a “mandatory offer” requirement (option 1) through the tax code would be more indirect, since policies that did not cover maternity care could still qualify for credits. Presumably, as a condition of qualifying for tax credits, carriers could be required to offer maternity-coverage riders or at least one policy form that includes maternity coverage to tax-credit-eligible women and families. If they did not do so, none of their policies would qualify for tax credits.

Notes (cont'd)

- ⁵³ For the estimates in this section, except as otherwise noted, the author consulted senior actuaries with an insurance company that sold individual health insurance for many years but wishes to remain anonymous. They graciously provided these rough figures based on their general sense of their company's experience over the years. However, these rough, order-of-magnitude estimates are not based on a formal actuarial analysis.
- ⁵⁴ Mutual of Omaha reports that, in its group health insurance products in 2002, the diagnosis category "pregnancy, childbirth, puerperium" represented 5.6 percent of total charges. Mutual of Omaha Insurance Company, *Current Trends in Health Care and Dental Costs Utilization*, 2003 Edition (based on 2002 data). Accessed August 8, 2003, from <http://www.mutualofomaha.com/acrodocs/mugc6794.pdf>. Because actual payments may be lower than billed charges, and because premiums include administrative overhead and profit in addition to claims paid, maternity costs probably represent a somewhat lower percentage of total premiums. A study of mandated benefits for the Business Council of New York State found that the maternity care mandate in New York State cost 3.6 percent of premium for group insurance. Donna Novak, FCA, ASA, MAAA, MBA, of NovaRest Consulting, "New York State Mandated Benefits," May 2003. Accessed August 8, 2003, from www.bcnys.org/inside/gac/2003/mandate0530.pdf.
- ⁵⁵ While different carriers no doubt take different approaches to setting premiums, it is believed that applicants for individual insurance are generally rated as individuals, even if they apply as a married couple. That is, the premium for the couple equals the sum of the premiums for each of the individual members of the couple.
- ⁵⁶ All of these estimates pertain to a voluntary market without subsidies.
- ⁵⁷ Whether states could, without specific federal authorization, impose requirements applicable only to policies qualifying for tax credits is uncertain. But the Trade Act of 2002 provides an interesting precedent. Under it, certain forms of insurance are specified by Congress as qualifying for the credit. These include continuation of coverage through a former employer under COBRA, coverage through a spouse's employer under certain limited conditions, and continued coverage under an individual policy that was in effect 30 days prior to job loss. But Congress also allowed other forms of insurance to qualify if a state so elects. States have some degree of control over the content and conditions of those other forms of insurance, but not over the forms specified by Congress.
- ⁵⁸ Council of Economic Advisers, "Health Insurance Credits," February 14, 2002.
- ⁵⁹ Council of Economic Advisers, "Health Insurance Credits," February 14, 2002.
- ⁶⁰ Kaiser Family Foundation and Health Research and Educational Trust, *Employer Health Benefits: 2002 Annual Survey*. Exhibits A and 1.13.
- ⁶¹ Personal communication from Mutual of Omaha. Example rates provided were for Omaha, Nebraska, for April 2002, for non-tobacco users in the "preferred class." (In February 2003, Mutual of Omaha announced that it would no longer sell individual major medical policies.)
- ⁶² While different carriers no doubt take different approaches to setting premiums, it is believed that applicants for individual insurance are generally rated as individuals, even if they apply as a married couple. That is, the premium for the couple equals the sum of the premiums for each of the individual members of the couple.
- ⁶³ Rick Curtis and Ed Neuschler, *Tax Credits for Individual Health Insurance: Effects on Employment-Based Coverage and Refinements to Improve Overall Coverage Rates*. Occasional Paper for the "Covering America" project of the Economic and Social Research Institute, August 2002.

Notes (cont'd)

- ⁶⁴ The maximum allowable deduction for premiums for long-term care insurance varies according to the age of the covered person. See Department of the Treasury, Internal Revenue Service, Publication 502, "Medical and Dental Expenses" (for use in preparing 2001 Returns), page 8. For this purpose, 5 age categories are used.
- ⁶⁵ No state permits gender rating while prohibiting age rating.
- ⁶⁶ Most tax-credit proposals already contain provisions requiring issuers of qualifying health insurance to file informational returns with the Internal Revenue Service annually and to provide a copy of that information to affected taxpayers.
- ⁶⁷ Alternatively, the cap could be set so that the expected net cost of insurance with and without maternity coverage would be the same for individuals (couples) with the same income. However, none of the current tax credit proposals use a construct anything like this approach.
- ⁶⁸ Because policy makers might not want to provide free maternity coverage to women in high-income families, this approach might not be appropriate for use in conjunction with a health insurance tax credit that is available to high-income families, as in H.R. 583/S. 1570, H.R. 1287, and H.R. 1236.
- ⁶⁹ HCUPnet, Healthcare Cost and Utilization Project. Agency for Healthcare Research and Quality, Rockville, MD. <http://www.ahrq.gov/data/hcup/hcupnet.htm>. Accessed November 17, 2003. In this database, only 5.5 percent of hospital discharges for "newborns and other neonates with condition originating in the perinatal period" are uninsured.
- ⁷⁰ As noted earlier, in the current individual market, women who are already pregnant cannot buy individual coverage in most states, and carriers also use product design, underwriting and marketing to avoid covering women who are likely to become pregnant.
- ⁷¹ See, for example, Richard E. Curtis, Edward Neuschler, and Rafe Forland, "Private Purchasing Pools to Harness Individual Tax Credits for Consumers." *Inquiry* 38(2):159-176. See also Katherine Swartz, "Markets for Individual Health Insurance: Can We Make Them Work with Incentives to Purchase Coverage?" *Inquiry* 38(2):133-145.
- ⁷² See, for example, Mark Pauly, Allison Percy, and Bradley Herring, "Individual versus Job-Based Health Insurance: Weighing the Pros and Cons." *Health Affairs* 18(6):28-44 [November/December 1999].
- ⁷³ Curtis, Neuschler, and Forland, *op.cit.*
- ⁷⁴ Elimination of waiting periods for coverage of pre-existing conditions is not recommended, to discourage people from buying coverage only when they perceive they need it. Whether age rating should be retained or eliminated would depend on a number of factors, such as whether the tax credit was also age-rated (or open-ended), how much of the average premium the tax credit covered, and whether tax credits could or could not be used outside the pool.
- ⁷⁵ S.1030 / H.R. 2402 (Bingaman-Kaptur).
- ⁷⁶ S.1030 / H.R. 2402 (Bingaman-Kaptur).
- ⁷⁷ Department of the Treasury, "General Explanations of the Administration's Fiscal Year 2004 Revenue Proposals," February 2003. As of July 2003, the Administration's proposal had not been put into legislative language.

Notes (cont'd)

- ⁷⁸ For a discussion of small-employer purchasing pool experience, see Elliot K. Wicks, Mark A. Hall and Jack A. Meyer, *Barriers to Small-Group Purchasing Cooperatives: Purchasing Health Coverage for Small Employers*, Washington, D.C.: Economic and Social Research Institute, March 2000. Available at <http://www.esresearch.org/Documents/HPC.pdf>. On the potential importance of public subsidies for individual purchasers to the future success of consumer-choice purchasing pools, see Richard E. Curtis, Edward Neuschler, and Rafe Forland. Consumer-Choice Purchasing Pools: Past Tense, Future Perfect? *Health Affairs* 20(1):164-168.
- ⁷⁹ This paper discusses tax credits as an incremental addition to the current voluntary health insurance system. However, the idea of making health insurance mandatory for everyone is beginning to be discussed. Senator John Breaux has developed a plan, not yet put into legislative language, that includes such a requirement (see http://breaux.senate.gov/issue_health_care.html), and Presidential candidate Senator John Edwards has proposed that parents be required to provide health coverage for their children.
- ⁸⁰ Over the four-year period from 1996 through 1999, about one-third (32.1 percent) of the U.S. population (including those over age 64) experienced at least one month without health insurance. But the median duration of a spell without health insurance was only 5.6 months, overall. For people in the child-bearing years, the median duration of such spells was somewhat longer: 7.2 months for ages 18-24, 6.8 months for ages 25-34, and 7.6 months for ages 35-44. (Statistics presented by age group were not also broken out by gender, but the median spell duration for men and women without respect to age was virtually identical.) Shailesh Bhandari and Robert Mills, "Dynamics of Economic Well-Being: Health Insurance 1996-1999," *Current Population Reports* No. P70-92, U.S. Census Bureau, August 2003.
- ⁸¹ A 1996-97 survey found that, "... when asked in the Household Survey why they did not enroll in an employer-sponsored plan that was offered, two-thirds of all uninsured workers and three-fourths of low-income uninsured workers cited cost as the main reason for declining coverage." Peter J. Cunningham, Elizabeth Schaefer and Christopher Hogan, "Who Declines Employer-Sponsored Health Insurance And Is Uninsured?" *Issue Brief* Number 22, Center for Studying Health System Change, October 1999.
- ⁸² In this study (see next note), a working family was defined as one in which the total number of hours worked by all adult members of a family was 20 or more per week. Families in which all adult members were self-employed without paid employees, as well as people who obtained health insurance from someone outside the family, were excluded.
- ⁸³ See Bradley C. Strunk and James D. Reschovsky, "Working Families' Health Insurance Coverage, 1997-2001," *Tracking Report* No. 4, Washington, D.C.: Center for Studying Health System Change, August 2002. The one-third figure is not reported directly in the published document (although it is consistent with Figure 1 in the published document). It was calculated by the Institute for Health Policy Solutions from supporting tabulations provided by Dr. Reschovsky.
- ⁸⁴ H.R. 1236 (Granger), S. 1030 / H.R. 2402 (Bingaman-Kaptur), and H.R. 2698 (Bilirakis-Towns).

Notes (cont'd)

- ⁸⁵ This proposal has been put forward elsewhere (Curtis and Neuschler, *op.cit.*) primarily as a way to encourage continued coverage and contributions by those businesses most likely to be induced to drop coverage by a tax credit limited to non-employment-based coverage. By allowing continued exclusion of any employer contribution from FICA taxes (for both employer and worker), it aims to provide an incentive for the employer to maintain contributions for the group plan, thereby lessening the risk that some currently covered workers would become uninsured. However, this approach could also provide a financially feasible way to offer health insurance for employers who previously have not offered coverage but have a high proportion of tax-credit-eligible workers who want to obtain it.
- ⁸⁶ There would be some additional cost because employers would not choose this option unless it afforded their workers greater tax savings than the current tax system does. Note, however, that higher-income workers (though not a self-employed proprietor/owner) would lose all tax advantages with respect to employer-sponsored health coverage except the exclusion of the employer's contribution from FICA taxes. The employer's contribution would be taxable for income-tax purposes, and such workers would not be able to use section 125 flexible spending accounts to tax shelter any portion of their premium. Thus, firms with any covered higher-income workers (presumably, non-owner managers) would be unlikely to elect this option. The proposal could be modified further to allow some tax preferences for such workers, but doing so would increase the cost of the proposal by greatly increasing the number of firms likely to take advantage of the option.
- ⁸⁷ By contrast, if individual workers were allowed to choose whether to take the tax credit or use the current tax preferences, the potential for confusion among employers and workers would be very high.
- ⁸⁸ In the case of S-CHIP, while "benchmark" requirements under title XXI of the Social Security Act assure that maternity care is covered in virtually all states, there might be some question as to whether child-oriented S-CHIP provider networks include sufficient OB/GYNs, etc. However, three states—Illinois, Michigan and Rhode Island—have already expanded S-CHIP coverage to include pregnant women [HHS Press Releases, April 17, 2003, and June 11, 2003], after the Bush Administration revised S-CHIP regulations to permit them to do so [*Federal Register*, Vol. 67, No. 191 (Wednesday, October 2, 2002), pp. 61956-61974].
- ⁸⁹ Department of the Treasury, "General Explanations of the Administration's Fiscal Year 2004 Revenue Proposals," February 2003. As of July 2003, the Administration's proposal had not been put into legislative language.
- ⁹⁰ New Mexico has received federal waiver approval for, but has not yet implemented, a project to provide subsidized coverage to low-income workers through what might be called a state pool. Under the project, the state will solicit health plans willing to offer a state-specified benefit package to employers participating in the project. Employers and income-eligible workers will each pay modest amounts toward the premium, and state program subsidies will pay the balance. While not required, it is expected that several health plans that already participate in the state's Medicaid program will offer to provide coverage under this project.
- ⁹¹ Thirty-one states currently operate high-risk pools, but one (AL) is available only to people eligible for HIPAA-guaranteed continuity coverage and one (FL) has been closed to new entrants for many years. *Communicating for Agriculture and the Self-Employed, op.cit.*
- ⁹² As of 2003, one (MS) specifically did not cover maternity services, and two (AK, LA) only covered major complications of pregnancy. Four (IL, IA, NE, NM) provided maternity coverage only as a rider. *Communicating for Agriculture and the Self-Employed, op.cit.*

Notes (cont'd)

- ⁹³ As of 2003, eight of the 29 pools then operating imposed a 12-month waiting period for pre-existing conditions, one imposed a 9-month period, and sixteen imposed a 6-month waiting period. Of the latter group, two (ND, UT) specifically imposed a longer waiting period for maternity benefits (9 months and 10 months, respectively). Communicating for Agriculture and the Self-Employed, *op.cit.* Of course, no waiting period for coverage of pre-existing conditions can be imposed on new enrollees who meet HIPAA requirements for continuous coverage.
- ⁹⁴ Kenneth E. Thorpe, Jennifer Flome and Peter Joski, “The Distribution of Health Insurance Coverage Among Pregnant Women, 1999,” Emory University, April 2001. Prepared for the March of Dimes.
- ⁹⁵ The 29 states with operating risk pools in 1999 represented about 59.6 percent of the total U.S. population in 2000, based on 2000 Census figures (http://eire.census.gov/popest/estimates_dataset.php, accessed July 25, 2003). Uninsured pregnant women are probably not distributed across states in the same proportion as total population, but that assumption will serve to provide a very rough order of magnitude.
- ⁹⁶ Lori Achman and Deborah Chollet, *Insuring the Uninsurable: An Overview of State High-Risk Health Insurance Pools*, The Commonwealth Fund, August 2001, Table 3. Enrollment figures were available only for 27 state high-risk pools, primarily as of December 31, 1999, but as of early 2000 for a few states.
- ⁹⁷ The concept for this approach was suggested by John Bertko.
- ⁹⁸ This information was checked against similar information available from the BlueCross BlueShield Association State Services Department (personal communications, July 25 through September 3, 2003), which led to some updating of Georgetown’s August 2002 report. Where discrepancies remained, the information obtained from Georgetown is shown.