Who Gains and Who Loses under the American Health Care Act

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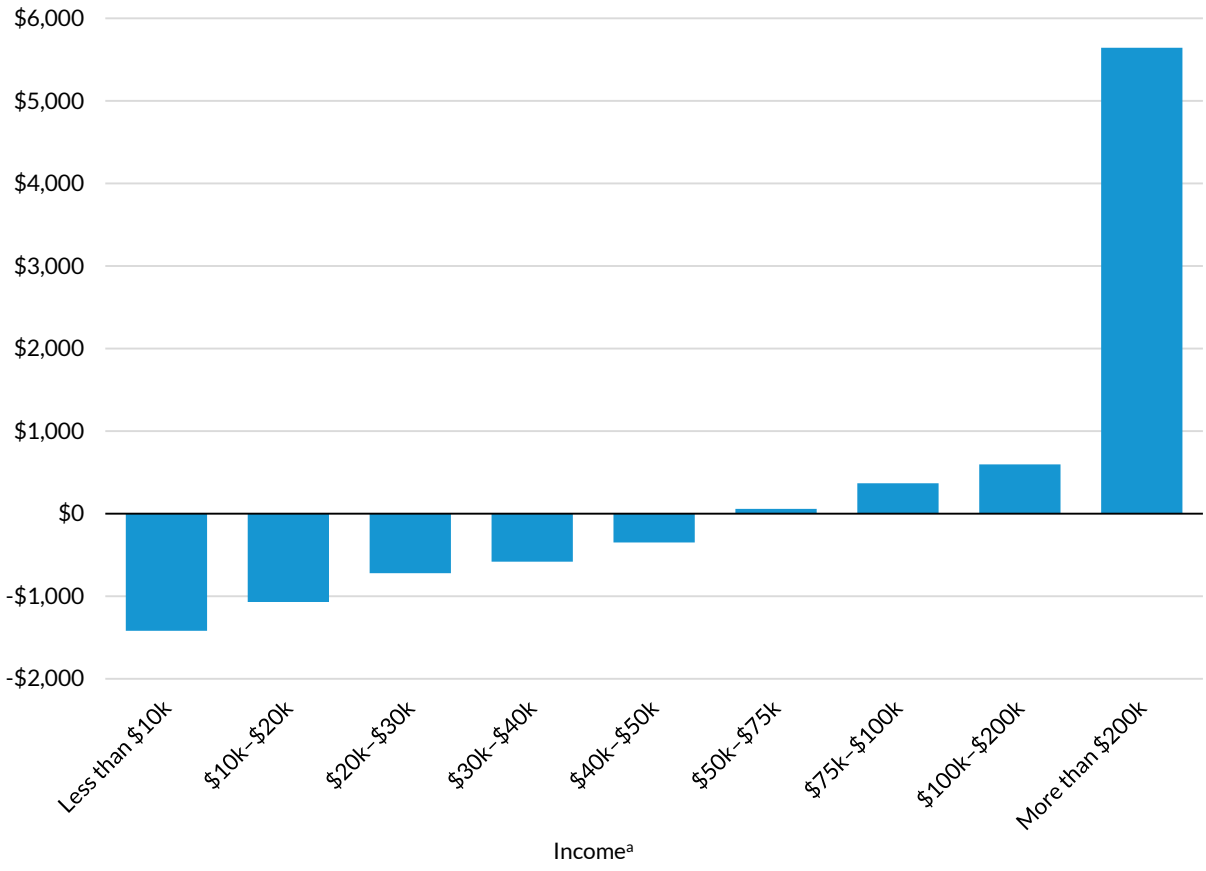
In Brief

Congress is currently considering passage of the American Health Care Act (AHCA). This bill would repeal large portions of the Affordable Care Act (ACA), including most of its sources of revenue, and it would introduce significant changes to the Medicaid program and the private nongroup insurance market. We use the Urban-Brookings Tax Policy Center Microsimulation Model and the Urban Institute Health Policy Center's Health Insurance Policy Simulation Model (HIPSM) to allocate changes in taxes and federal health benefits across families grouped by income.

We find that the AHCA's changes to federal taxes and health care benefits would be very regressive: taking both tax reductions and benefit reductions into account, the average high-income family would be significantly better off and the average low-income family would be significantly worse off under the AHCA. The average family with less than $10,000 of income in 2022 would be $1,420 worse off, a net reduction of more than 30 percent of the family's income. The average family with more than $200,000 of income in 2022 would be $5,640 better off, a net increase of 1.1 percent of the family's income. Using a measure of family income as a percentage of the federal poverty level (FPL), families with income below 200 percent of FPL would experience net tax and benefit losses and families with income above 300 percent of FPL would experience net gains under the AHCA. The greatest net gains would go to families with income exceeding 600 percent of the FPL.

FIGURE 1

Distribution of Change in Average Net Transfers (Benefits less Taxes) under the AHCA, 2022



Sources: Urban-Brookings Tax Policy Center Microsimulation Model (version 0217-1) and Urban Institute Health Policy Center's Health Insurance Policy Simulation Model (2017).

Notes: [a] Income is modified adjusted gross income (MAGI), defined as adjusted gross income plus nontaxable Social Security benefits and tax-exempt interest. Income includes both filing and non-filing units but excludes dependents of other tax units. Tax units with negative MAGI are excluded from the bottom income class but are included in the totals. Analysis includes AHCA provisions as amended on March 21, 2017.

Introduction

The version of the American Health Care Act[1] that was introduced in the House of Representatives on March 6, 2017, would repeal and replace substantial portions of the Affordable Care Act. We analyze the distributional effects of changes to federal taxes and health care spending that would result from this bill (including the changes made to it on March 21, 2017), estimating net changes by income level and by income relative to poverty categories.

The AHCA would eliminate almost all of the ACA's revenue provisions starting in 2017. It would eliminate the ACA's cost-sharing subsidies (in 2020), income-related premium tax credits (modified in 2018 and eliminated in 2020), individual and employer mandate penalties (as of 2016), nongroup and small-group insurance actuarial value standards (in 2020), 3:1 age rating limits (in 2020), funding for the Prevention and Public Health Fund (at the end of 2018), and enhanced matching rate for people in the Medicaid expansion population who do not maintain enrollment after 2019. Beginning in 2020, the bill would introduce age-related tax credits for those purchasing insurance in the nongroup market, permit states to adopt age rating at any ratios (with a presumption of 5:1 rating), impose late enrollment penalties of 30 percent of premiums for those who do not stay continuously covered, provide nine years of federal funding for a new State Innovation Grants and Stability Program that requires state matching funds, increase tax benefits associated with health savings accounts, and convert Medicaid funding from an open-ended federal matching entitlement to a program based on per capita allotments and limits on annual growth.

We use the Urban-Brookings Tax Policy Center Microsimulation Model and the Urban Institute Health Policy Center's Health Insurance Policy Simulation Model to allocate changes in taxes and federal health benefits across income groups.

Methods

Our estimates of federal Medicaid spending, AHCA tax credits, ACA premium tax credits, and ACA cost-sharing reductions were produced by the Urban Institute's Health Insurance Policy Simulation Model. Estimates of Medicaid spending in 2022 were derived using the same methods as our recent report on Medicaid per capita caps (Holahan et al. 2017). Estimates of ACA tax credits and cost-sharing reductions were done in the same manner as the ACA estimates from our recent report on the impact of ACA repeal (Buettgens et al. 2016).

The simulation of nongroup enrollment under the AHCA was new for this analysis. For each family, we computed the premium tax credit amount as defined in the bill and applied them to premiums for a 60 percent actuarial value plan, a plan consistent with bronze-level plans currently offered in the ACA-compliant nongroup markets. This plan level is appropriate for this analysis because the AHCA would maintain the current nongroup insurance out-of-pocket maximums and essential health benefit standards while eliminating the actuarial value standards. We accounted for other factors in addition to income that disqualify people for the credit: employer coverage, eligibility for public coverage, and

documentation status. Total premiums were computed for each coverage state. Instead of using the ACA's individual mandate, we modeled the AHCA's 30 percent premium surcharge for those who do not maintain insurance coverage as a reduction in the value of being uninsured. Based on this reduction, individuals and families in our model decided whether or not to enroll in private nongroup coverage, considering factors such as premiums, tax credits, health needs, risk of high health costs, and family income.

We assume that under the AHCA, states would eliminate Medicaid eligibility for the ACA expansion population unless the state had expanded eligibility for childless adults up to 100 percent of FPL at the traditional federal matching rate before the ACA. This differs from the assumption the Congressional Budget Office used in its analysis of the bill, and as a consequence, our estimates of the AHCA's impact on the federal deficit are smaller (CBO 2017).

Our analysis accounts for changes to Medicaid per capita cap growth rates made in manager's amendments to the bill on March 21, 2017.[2] Though the amendments also include a provision increasing subsidization of adults ages 50 to 64, the Senate will ultimately devise the structure of this additional subsidy; thus, we do not include it in this analysis.

We simulated the proposal's tax changes using the Urban-Brookings Tax Policy Center Microsimulation Model. We simulated repeal of the following ACA tax provisions:[3]

- 3.8 percent net investment income tax and 0.9 percent additional Medicare hospital insurance tax for individuals with incomes exceeding $200,000 and couples with incomes exceeding $250,000
- Individual and employer mandate penalties for inadequate health insurance
- Excise taxes on health insurance providers and pharmaceutical and medical device manufacturers and importers
- Additional limitations on the medical expense deduction
- Premium tax credits for health insurance purchased through ACA Marketplaces

Additionally we simulated delaying the "Cadillac" tax on high-cost health plans until 2026. We also simulated the new age-related health insurance credits, calibrating take-up to match projections from HIPSM. To make the analyses consistent, we distributed HIPSM projections of Medicaid benefits and cost-sharing subsidies to tax units in the TPC model in the same income groups.

Results

Table 1 shows the distribution of tax changes resulting from the AHCA in 2022 by tax unit income group; we refer to tax units as families for convenience.[4] The tax changes include repeal of almost all of the ACA's revenue provisions and the individual and employer mandate penalties, elimination of the ACA's income-related tax credits, and implementation of the AHCA's age-related tax credits. Table 2 shows the distribution of federal benefit changes that would result from the AHCA, including the new Medicaid per capita caps, federal matching rate changes, and elimination of the ACA's cost-sharing

subsidies. Table 3 combines the findings from tables 1 and 2 into net federal tax and benefit changes by income group. Comparable distributional findings by income relative to the poverty level are found in appendix tables A.1 through A.3. In each table, average tax changes and benefit changes are calculated over the total number of families in each income group, not only those families that would actually experience a change.

TABLE 1

Distribution of Federal Tax Change under the AHCA, 2022

Income[a]	Number of tax units (thousands)	Share of all tax units (%)	Average tax change per tax unit ($)	Average tax change as percentage of income (%)	Share of total tax change (%)
< $10,000	17,630	9.8	-210	-4.8	4.3
$10,000–$20,000	23,370	12.9	20	0.1	-0.5
$20,000–$30,000	25,600	14.2	200	0.8	-5.9
$30,000–$40,000	18,410	10.2	180	0.5	-3.8
$40,000–$50,000	13,310	7.4	40	0.1	-0.6
$50,000–$75,000	26,520	14.7	-240	-0.4	7.3
$75,000–$100,000	16,850	9.3	-470	-0.5	9.1
$100,000–$200,000	27,250	15.1	-650	-0.5	20.4
> $200,000	10,780	6.0	-5,680	-1.1	70.6
All	180,680	100.0	-480	-0.6	100.0
Addendum					
> $1,000,000	780	0.4	-51,410	-1.6	46.2

Sources: Urban-Brookings Tax Policy Center Microsimulation Model (version 0217-1) and Urban Institute Health Policy Center's Health Insurance Policy Simulation Model (2017).

Notes: The AHCA would repeal the following ACA taxes: 3.8 percent net investment income tax; 0.9 percent additional Medicare hospital insurance tax; excise tax on employers offering inadequate health insurance coverage; excise tax on individuals without adequate health insurance; increase in the threshold for medical expense deductions; excise taxes on health insurance providers, pharmaceutical manufacturers and importers, and medical device manufacturers and importers; and the premium tax credit. The bill would delay the Cadillac tax until 2026 and enact a new health insurance tax credit. Analysis excludes changes to health savings accounts and medical flexible spending accounts. Analysis captures change in taxes and credits but does not include the impact of changes in premiums or the welfare impact of changes in health insurance coverage or coverage generosity.

[a] Income is modified adjusted gross income (MAGI), defined as adjusted gross income plus nontaxable Social Security benefits and tax-exempt interest. Income includes both filing and non-filing units but excludes dependents of other tax units. Tax units with negative MAGI are excluded from the bottom income class but are included in the totals.

Taxes would decrease for families with incomes of $50,000 or more and, in general, increase for families with lower incomes (table 1). Those with incomes below $10,000 would experience a tax decrease on average because they would become eligible for age-related premium tax credits; however, as shown in table 2, simultaneous Medicaid benefit losses for this income group would be much larger than the decrease in taxes. For families with incomes above $50,000 per year, the average tax reduction increases markedly as income increases. The average family with more than $200,000 of income would receive a $5,680 tax reduction, and this high-income group would account for 70.6 percent of the net tax decrease under the AHCA. Families with income exceeding $1,000,000 would see a tax decrease of

$51,410 on average, accounting for 46.2 percent of the net tax decrease for the whole population. This decrease would amount to 1.6 percent of their income on average.

TABLE 2

Distribution of Change in Federal Medicaid and Cost-Sharing Benefits under the AHCA, 2022

Income[a]	Number of tax units (thousands)	Share of all tax units (%)	Average benefit change per tax unit ($)	Average benefit change as percentage of income (%)	Share of total benefit change (%)
< $10,000	17,630	9.8	-1,630	-37.4	33.1
$10,000–$20,000	23,370	12.9	-1,050	-6.9	28.3
$20,000–$30,000	25,600	14.2	-520	-2.1	15.3
$30,000–$40,000	18,410	10.2	-400	-1.2	8.5
$40,000–$50,000	13,310	7.4	-310	-0.7	4.8
$50,000–$75,000	26,520	14.7	-180	-0.3	5.5
$75,000–$100,000	16,850	9.3	-100	-0.1	1.9
$100,000–$200,000	27,250	15.1	-50	0.0	1.6
> $200,000	10,780	6.0	-40	0.0	0.5
All	180,680	100.0	-480	-0.6	100.0

Sources: Urban-Brookings Tax Policy Center Microsimulation Model (version 0217-1) and Urban Institute Health Policy Center's Health Insurance Policy Simulation Model (2017).
Notes: [a] Income is modified adjusted gross income (MAGI), defined as adjusted gross income plus nontaxable Social Security benefits and tax-exempt interest. Income includes both filing and non-filing units but excludes dependents of other tax units. Tax units with negative MAGI are excluded from the bottom income class but are included in the totals.

Table 2 shows the change in federal health care spending resulting from Medicaid funding reductions and elimination of the ACA's federal cost-sharing reductions. The average reduction in federal health care benefits would increase quickly as income decreases, reflecting the fact that these benefits accrue largely to low-and middle-income populations under the ACA. Almost 77 percent of the federal funding losses under the AHCA would come from families earning less than $30,000 per year. Most of the rest of the funding reductions would come from families with incomes between $30,000 and $50,000 per year. The federal benefit losses to families with incomes below $10,000 would amount to 37.4 percent of their income on average. As table 2 shows, federal funding losses as a share of income decrease dramatically as income increases.

TABLE 3

Distribution of Change in Net Transfers (Benefits less Taxes) under the AHCA, 2022

Income[a]	Number of tax units (thousands)	Share of all tax units (%)	Average net transfer change per tax unit ($)	Average net transfer change as percentage of income (%)
< $10,000	17,630	9.8	-1,420	-32.6
$10,000–$20,000	23,370	12.9	-1,070	-7.1
$20,000–$30,000	25,600	14.2	-720	-2.9
$30,000–$40,000	18,410	10.2	-580	-1.7
$40,000–$50,000	13,310	7.4	-350	-0.8
$50,000–$75,000	26,520	14.7	60	0.1
$75,000–$100,000	16,850	9.3	370	0.4
$100,000–$200,000	27,250	15.1	600	0.4
> $200,000	10,780	6.0	5,640	1.1
All	180,680	100.0	0	0.0

Sources: Urban-Brookings Tax Policy Center Microsimulation Model (version 0217-1) and Urban Institute Health Policy Center's Health Insurance Policy Simulation Model (2017).
Notes: [a] Income is modified adjusted gross income (MAGI), defined as adjusted gross income plus nontaxable Social Security benefits and tax-exempt interest. Income includes both filing and non-filing units but excludes dependents of other tax units. Tax units with negative MAGI are excluded from the bottom income class but are included in the totals.

Table 3 shows the net effect of the AHCA's federal tax and health benefit changes. On average, families with incomes below $50,000 would be worse off, and the average amount of the loss in both absolute dollars and as a share of income would increase as income falls. For example, the average net loss for those with incomes below $10,000 would amount to 32.6 percent of income, but the net loss for families with income between $30,000 and $40,000 would amount to 1.7 percent of income. Families with incomes over $50,000 in 2022 would see net gains under the AHCA, but the gains would constitute a small percentage of income (less than 0.5 percent) for those with incomes below $200,000. Families with incomes above $200,000 would receive the largest net gains in absolute dollars ($5,640 on average) and as a share of income (1.1 percent). Similarly, appendix table A.3 shows that families with incomes below 200 percent of FPL would experience measurable net losses, but those with incomes exceeding 600 percent of FPL would gain the most, $2,250 on average.

Conclusion

Upper-income families would receive net benefits from the tax and spending changes proposed in the AHCA, and lower-income families would experience net losses. Higher-income families benefit the most from the tax cut, with 70.6 percent of the tax reductions in 2022 received by those with incomes over $200,000 and 46.2 percent of the tax reductions received by those with incomes over $1,000,000. Reductions in federal funding for health benefits would hurt lower-income families the most; families with incomes below $30,000 would sustain more than three-quarters of the losses in benefits. Taking both tax and benefit changes into account, the largest average gains under the AHCA would go to those with the highest incomes ($5,640 on average for those with incomes over $200,000), and the largest average losses from the AHCA would go those with the lowest incomes.

APPENDIX TABLE A.1

Distribution of Federal Tax Change under the AHCA, 2022

Income relative to FPL[a]	Number of tax units (thousands)	Share of all tax units (%)	Average tax change per tax unit ($)	Average tax change as percentage of income (%)	Share of total tax change (%)
< 50% of FPL	13,470	7.5	-210	-6.4	3.3
50–100% of FPL	18,730	10.4	-250	-1.8	5.4
100–138% of FPL	15,180	8.4	510	2.4	-8.9
138–200% of FPL	24,320	13.5	540	1.9	-15.1
200–300% of FPL	28,350	15.7	-190	-0.4	6.2
300–400% of FPL	20,330	11.3	-440	-0.7	10.3
400–500% of FPL	16,000	8.9	-470	-0.6	8.7
500–600% of FPL	11,530	6.4	-540	-0.5	7.2
> 600% of FPL	31,780	17.6	-2,280	-0.8	83.5
All	180,680	100.0	-480	-0.6	100.0

Sources: Urban-Brookings Tax Policy Center Microsimulation Model (version 0217-1) and Urban Institute Health Policy Center's Health Insurance Policy Simulation Model (2017).

Notes: FPL = federal poverty level. The AHCA would repeal the following ACA taxes: 3.8 percent net investment income tax; 0.9 percent additional Medicare hospital insurance tax; excise tax on employers offering inadequate health insurance coverage; excise tax on individuals without adequate health insurance; increase in the threshold for medical expense deductions; excise taxes on health insurance providers, pharmaceutical manufacturers and importers, and medical device manufacturers and importers; and the premium tax credit. The bill would delay the Cadillac tax until 2026 and enact a new health insurance tax credit. Analysis excludes changes to health savings accounts and medical flexible spending accounts. Simulation of health insurance credits calibrated to match HIPSM. Analysis captures change in taxes and credits but does not include the impact of changes in premiums or the welfare impact of changes in health insurance coverage or coverage generosity.

[a] Income is modified adjusted gross income (MAGI), defined as adjusted gross income plus nontaxable Social Security benefits and tax-exempt interest. Income includes both filing and non-filing units but excludes dependents of other tax units. Tax units with negative MAGI are excluded from the bottom income class but are included in the totals.

APPENDIX TABLE A.2

Distribution of Change in Federal Medicaid and Cost-Sharing Benefits under the AHCA, 2022

Income relative to FPL[a]	Number of tax units (thousands)	Share of all tax units (%)	Average benefit change per tax unit ($)	Average benefit change as percentage of income (%)	Share of total benefit change (%)
< 50% of FPL	13,470	7.5	-1,770	-53.8	27.5
50–100% of FPL	18,730	10.4	-1,160	-8.4	25.1
100–138% of FPL	15,180	8.4	-1,240	-5.8	21.7
138–200% of FPL	24,320	13.5	-470	-1.6	13.2
200–300% of FPL	28,350	15.7	-200	-0.5	6.5
300–400% of FPL	20,330	11.3	-110	-0.2	2.6
400–500% of FPL	16,000	8.9	-70	-0.1	1.3
500–600% of FPL	11,530	6.4	-50	0.0	0.7
> 600% of FPL	31,780	17.6	-30	0.0	1.1
All	180,680	100.0	-480	-0.6	100.0

Sources: Urban-Brookings Tax Policy Center Microsimulation Model (version 0217-1) and Urban Institute Health Policy Center's Health Insurance Policy Simulation Model (2017).

Notes: FPL = federal poverty level.

[a] Income is modified adjusted gross income (MAGI), defined as adjusted gross income plus nontaxable Social Security benefits and tax-exempt interest. Income includes both filing and non-filing units but excludes dependents of other tax units. Tax units with negative MAGI are excluded from the bottom income class but are included in the totals.

APPENDIX TABLE A.3

Distribution of Change in Net Transfers (Benefits less Taxes) under the AHCA, 2022

Income relative to FPL[a]	Number of tax units (thousands)	Share of all tax units (%)	Average net transfer change per tax unit ($)	Average net transfer change as percentage of income (%)
< 50% of FPL	13,470	7.5	-1,770	-53.8
50–100% of FPL	18,730	10.4	-1,160	-8.4
100–138% of FPL	15,180	8.4	-1,240	-5.8
138–200% of FPL	24,320	13.5	-470	-1.6
200–300% of FPL	28,350	15.7	-200	-0.5
300–400% of FPL	20,330	11.3	-110	-0.2
400–500% of FPL	16,000	8.9	-70	-0.1
500–600% of FPL	11,530	6.4	-50	0.0
> 600% of FPL	31,780	17.6	-30	0.0
All	180,680	100.0	-480	-0.6

Sources: Urban-Brookings Tax Policy Center Microsimulation Model (version 0217-1) and Urban Institute Health Policy Center's Health Insurance Policy Simulation Model (2017).

Notes: FPL = federal poverty level.

[a] Income is modified adjusted gross income (MAGI), defined as adjusted gross income plus nontaxable Social Security benefits and tax-exempt interest. Income includes both filing and non-filing units but excludes dependents of other tax units. Tax units with negative MAGI are excluded from the bottom income class but are included in the totals.

Notes

1. The AHCA consists of two separate bills, one from the House Ways and Means Committee (https://waysandmeans.house.gov/wp-content/uploads/2017/03/AmericanHealthCareAct_WM.pdf) and one from the House Energy and Commerce Committee (http://energycommerce.house.gov/sites/republicans.energycommerce.house.gov/files/documents/AmericanHealthCareAct.pdf).
2. American Health Care Act of 2017, H.R. 1628, 115th Cong. (2017).
3. For description and analysis of the distribution of ACA taxes, see Mermin (2017). We exclude AHCA provisions that enhance health savings accounts and reduce limits on medical flexible spending accounts.
4. A tax unit is an individual or a married couple who files a tax return or would file a tax return if their income were high enough, along with all dependents of that individual or married couple. A tax unit can differ from a family in certain situations.

References

Buettgens, Matthew, Linda J. Blumberg, John Holahan, and Siyabonga Ndwandwe. 2016. *The Cost of ACA Repeal*. Washington, DC: Urban Institute.

CBO (Congressional Budget Office). 2017. *Cost Estimate: American Health Care Act*. Washington, DC: CBO.

Holahan, John, Matthew Buettgens, Clare Wang Pan, and Linda J. Blumberg. 2017. *The Impact of Per Capita Caps on Federal and State Medicaid Spending*. Washington, DC: Urban Institute.

Mermin, Gordon. 2017. *Affordable Care Act Taxes*. Washington, DC: Urban Institute.

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Matthew Buettgens is a senior research analyst in the Health Policy Center at the Urban Institute, where he is the mathematician leading the development of Urban's Health Insurance Policy Simulation Model (HIPSM). The model is currently being used to provide technical assistance for health reform implementation in Massachusetts, Missouri, New York, Virginia, and Washington as well as to the federal government. His recent work includes a number of research papers analyzing various aspects of national health insurance reform, both nationally and state-by-state. Research topics have included the costs and coverage implications of Medicaid expansion for both federal and state governments; small firm self-insurance under the Affordable Care Act and its effect on the fully insured market; state-by-state analysis of changes in health insurance coverage and the remaining uninsured; the effect of reform on employers; the affordability of coverage under health insurance exchanges; and the implications of age rating for the affordability of coverage.

John Holahan is an Institute fellow in the Health Policy Center at Urban, where he previously served as center director for over 30 years. His recent work focuses on health reform, the uninsured, and health expenditure growth. He has developed proposals for health system reform, most recently in Massachusetts. He has examined the coverage, costs, and economic impact of the Affordable Care Act (ACA), including the costs of Medicaid expansion as well as the macroeconomic effects of the law. He has also analyzed the health status of Medicaid and exchange enrollees, and the implications for costs and exchange premiums. Holahan has written on competition in insurer and provider markets and implications for premiums and government subsidy costs as well as on the cost-containment provisions of the ACA.

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Frank Sammartino is a senior fellow at the Urban-Brookings Tax Policy Center and an affiliate of Urban's State and Local Finance Initiative. His current work focuses on the interaction among federal, state, and local tax policies and on the influence of tax and transfer policies on income inequality. Sammartino has written extensively about federal tax and retirement policy issues. In an earlier stint at Urban, he designed and developed the initial version of the Tax Policy Center microsimulation model, which researchers use to analyze how federal tax policies affect federal revenues and families at different income levels. He also led a team of researchers in developing a new version of the Dynamic Simulation of Income Model, which Urban researchers use to analyze how public policies and economic and demographic forces shape retirement income security.

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