Expanding Health Insurance Coverage: Are Tax Credits the Right Tack to Take?

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Abstract

Serious analysts agree that significant inroads into solving the problems of the uninsured will only occur through subsidization. The question is not whether coverage reforms should include subsidies, but how much subsidization is appropriate, who should receive the subsidies, and how they should be transferred, which remains at issue. This paper assesses the promise and shortcomings of tax credits as a health insurance subsidy in light of three objectives: increasing health insurance coverage, target efficiency, and horizontal equity.

Section 1. Introduction

Over the last few years, tax credit proposals have gained increasing attention as mechanisms for expanding health insurance coverage in the U.S. Proposals have been developed by both analysts[1] and members of Congress, including a number of bills that have been introduced in the current Congress (H.R. 539, H.R. 1136, and H.R. 1687). While tax credit approaches hold clear appeal in some respects, it is unclear whether they are the most effective tools for expanding health insurance coverage.

Tax credits for health insurance can be structured in an infinite number of ways. But at their core, these proposals consist of a specified dollar amount of additional purchasing power that is provided if health insurance is obtained. This dollar amount is received as a decrease in tax liability. Depending upon the credit's design, it may be refundable (i.e., available to those with no or only limited tax liability).

Serious analysts agree that significant inroads into solving the problems of the uninsured will only occur through subsidization.[2] The question is not whether coverage reforms should include subsidies, but how much subsidization is appropriate, who should receive the subsidies, and how they should be transferred, which remains at issue. This paper assesses the promise and shortcomings of tax credits as a health insurance subsidy in light of three objectives: increasing health insurance coverage, target efficiency, and horizontal equity.

Section 2 provides a background for the discussion, defining the three objectives, briefly summarizing current system tax inequities, and providing an overview of the

general structure of tax credits. Section 3 discusses each of the three stated objectives in the context of tax credits, and section 4 presents conclusions.

Section 2. Background

Objectives of Reforms to Expand Coverage

The first and most obvious objective of reforms of this nature ought to be that of **increasing coverage of the currently uninsured**, particularly the low-income uninsured, as much as possible. By current estimates, 18 percent of the nonelderly U.S. population is uninsured, including 35 percent of those with family incomes below the federal poverty level, 32 percent of those between 100 and 200 percent of the poverty level and 11 percent of those above 200 percent of the poverty level.[3] The lack of health insurance has well-known and potentially devastating effects upon the financial stability of families, access to care, and health status.[4] The high levels of uninsurance and their implications for the well-being of individuals and families is the greatest motivator for coverage reforms.

The second objective of reform is **target efficiency**: spending as high a percentage of new public program dollars on the target population as possible. Given that we are always operating under public budget constraints, policymakers want to get as much new coverage as possible with the resources that are available. Such budget constraints are the motivator for the pursuit of target efficiency. How the target population is defined will have important implications for costs, the particular way in which the program is designed, and, ultimately, the extent to which target efficiency is

achieved. An example of alternatively defined target populations is presented below in the context of the discussion of the third objective, **horizontal equity**.

A system that is horizontally equitable is one that treats those of similar economic situations in a similar manner.[5] This objective addresses issues related to both "fairness" and efficiency. A policy, for example, that attempts to exclude some individuals from subsidization (such as the currently insured) with a particular level of income while subsidizing other individuals (the currently uninsured) with similar income feels prima facie inequitable. While the excluded group already has insurance, they are likely making significant financial sacrifices[6] in order to try to "do the right thing," both by not imposing the external costs of their care on others through uncompensated care and by protecting themselves and/or their family members from the potential adverse health consequences of uninsurance.[7] In essence, programs should not be designed, if at all possible, in such a way that they seem to "punish" socially desirable behavior. Taking such an exclusionary approach is equivalent to choosing an extreme of the possible trade-offs of target efficiency over horizontal equity.

In addition, individuals who are low income and who have health insurance are economically vulnerable to losing that insurance. Job loss or other fluctuations in income, not uncommon among this population, could easily lead to the loss of coverage. Making these individuals and families eligible for a low-income subsidization program will improve the stability of their coverage.

Attempting to exclude previously insured individuals from subsidization also introduces inefficiencies. Currently insured low-income persons could decide to forgo private coverage for the requisite time period in order to qualify for subsidization, with

the program thereby unintentionally resulting in more individuals with gaps in coverage. Other inefficiencies, such as labor market choices being made as a function of program eligibility rules, can result. These kinds of inefficiencies can also occur as a consequence of designing subsidy eligibility rules that are a function of firm characteristics (e.g., a person is only eligible if they work for a firm that does not offer coverage). Discrimination by firm characteristics can also lead to distortions of employer behavior.

Another well-known and highly criticized horizontal inequity that is present in the current system is that individuals purchasing health insurance through their employers receive a subsidy (exclusion of the employer contribution toward coverage from taxable income), while those purchasing coverage independently do not receive one (unless the individual purchaser is self-employed).

Subsidization is, by its nature, equivalent to an income transfer. The logic of horizontal equity is quite clear: If some individuals of a particular income class are considered "worthy" of subsidization, it is consistent to infer that all members of that income class are worthy of subsidization. One could think about a health insurance subsidization program as a transfer of funds to individuals in a given income group regardless of their insurance status. This income transfer allows some low-income persons to insure themselves and/or their families and it provides some financial relief to those individuals and families struggling to maintain the insurance that they have.

Defining the target population to include all low-income individuals ensures that the prioritization of target efficiency relative to horizontal equity is not a zero-sum game. But because target efficiency is usually an issue related to budget constraints, there will always be some tension between these objectives. Trade-offs between these two and

expansions of coverage will also be required. The policymaking process requires designing an initiative which places the relative emphasis on each of the three objectives at socially acceptable levels.

Current System Tax Inequities

Lack of coverage is not the only problem with the current system. There are, among other things, undisputed problems with the current tax subsidy for employer-sponsored insurance. The first of these was mentioned already, the inequitable treatment of nongroup coverage relative to employer-sponsored coverage. The current tax exclusion also reduces incentives to make efficient decisions about the amount of insurance purchased. Given that employer-sponsored coverage is tax preferred relative to wages and given that the subsidy is not capped, the value of this coverage is thus greater than the value of cash (for those with a tax liability), likely leading many to choose more insurance coverage than they would otherwise.[8] Examples of such possible "over-consumption" of health insurance are low-deductible policies and policies with very broad and rich benefits.

In addition, since individuals of all incomes are eligible and because the subsidy takes the form of an exclusion from tax liability, those with the highest marginal tax rates (the high income) gain the most from it. The lowest income families, those with no tax liability, receive no benefit from the subsidy.

At the root of many tax credit proposals is a desire to limit or eliminate the employer-sponsored coverage tax subsidy and use those funds to subsidize insurance coverage in a more efficient and equitable manner. Most analysts acknowledge the problems with this long-standing subsidy[9] and support efforts to correct for them.

However, it is not necessary to address these tax problems with the same tool that is used to expand coverage. Achieving more coverage and improving the equity of existing tax incentives are separable problems. To the extent that attempts are made to solve multiple problems with a single tool and with a single reform, the flexibility to correct each problem as effectively as possible may be compromised. The test of whether or not a tax credit is the appropriate mechanism for expanding coverage should be whether it best fills the objectives of reform. The savings from redesigning or eliminating the current employer-sponsored tax subsidy can be redirected for use in many different ways.

The General Structure of Tax Credits

The conceptual underpinnings of tax credits and their potential application for use in the health insurance context have been described in detail elsewhere;[10] consequently, the description here will be very brief. Tax credits are subsidies that take the form of reduced end-of-year tax liability for those deemed eligible. In the case of refundable tax credits, those eligible for the subsidy who do not have a tax liability receive a cash transfer. Tax credit policies must define the eligible population, the value of the credit (including whether the value varies across different groups of eligibles), how much insurance coverage is required to qualify (and if this varies by group of eligibles), and any offsets of existing tax subsidies that might apply.

For purposes of the discussion of health insurance-related tax credits, we can say that credits would be available to eligible families upon proof of qualifying insurance coverage. Tax credits can be structured in a number of ways. Credits can be set at a fixed amount that does not vary by income (e.g., every filing unit receives a $500 credit), or they can be structured to be more generous for some income groups than others. The

decision of whether or not to make a tax credit refundable, for example, is a decision as to whether the lowest-income families will be eligible for any subsidy at all, since nonrefundable credits exclude the lowest-income families. In addition, credits can be related to income, and any income group can be excluded from credits altogether. Credit amounts could also, theoretically, be related to the cost of an available premium.

Tax credits for health insurance can be made available to all individuals/families purchasing health insurance, or they can be available only to those purchasing a minimum amount of coverage (defined by a benefit package or dollar amount of premium), or for those purchasing coverage through a particular source (e.g., the nongroup market or the employer-sponsored market).

Another design issue is related to the timing of the credit. A credit could be made available only at the end of the tax year through the tax filing system. Another option would be to reduce the taxes paid throughout the year, by decreasing the amount of income taxes withheld by employers or by reducing estimated taxes for those who would ordinarily pay them. For those low-income persons who are not attached or only irregularly attached to the workforce it would be considerably more difficult to pay out credits during the course of a tax year, and an alternative mechanism for delivering subsidies to this group would be necessary if they were to be targeted for the credit.

The ways in which tax credits would interact with existing public insurance programs is also an important issue. Would those enrolled in Medicaid receive credits, for example? Would those insuring their children through the State Children's Health Insurance Program (S-CHIP) be eligible? Given that the S-CHIP program does require some family premium contribution in some states while the Medicaid program does not,

perhaps S-CHIP might be considered qualified coverage, whereas Medicaid might not. Depending upon the generosity of the credit relative to the public insurance, incentives for participation could vary significantly with design.

While there are theoretically an infinite number of ways to design a tax credit for health insurance coverage, the political appeal of these mechanisms is tied to the administrative efficiencies associated with the more simplistic approaches (such as fixed dollar amount credits) and the horizontal equity and accuracy of income verification associated with the tax system. In addition, fixed amount credits that do not vary by income do not increase marginal tax rates as income-related subsidies do. Undoubtedly, for those concerned with the inequities resulting from the current tax subsidy for employer-sponsored insurance coverage, it is also natural to look to the tax system as the mechanism for a policy redesign.

Section 3. Program Objectives in the Context of Tax Credits

The appropriate standard for judging any new policy proposal is how well it is expected to meet the three program objectives posited earlier.

Increasing Coverage

The effect of a reform on new coverage among the low-income population is complicated because it is a function of several factors.

First, what will the individual be able to buy with the subsidy? Subsidy amounts that are small relative to an available premium will lead to lower rates of new coverage. A number of current legislative proposals would provide a $500 credit for individuals of any income purchasing their insurance in the nongroup market.[11] Some analysts[12] have

made the argument that with a modest flat $500 credit, everyone could at least purchase a $500 policy and that would in and of itself be worthwhile. They have argued that universal coverage could be satisfied if everyone had a $500 health insurance policy. According to actuarial estimates by Actuarial Research Corporation (ARC), a $500 children's policy in the current nongroup market would be roughly equivalent to either a $10,000 deductible policy, or first-dollar coverage with a $1600 benefit maximum.[13] The options for adults are more extreme, with the potential $500 policy options being a $67,000 deductible policy or first dollar coverage with an $840 benefit maximum.

It is obvious that low-income people would not bother to purchase these very high deductible policies, since they would in all likelihood be unable to pay for the deductible. Even if they could, the policies would be mere substitutes for the uncompensated care that they would receive in the unlikely event that something catastrophic occurred to them, and so would not be considered of much value. And while first-dollar coverage policies might be more attractive, we should seriously question whether insuring people for predictable, essentially, noninsurable events warrants paying insurers administrative loads of 35 percent. If aggregate funds were limited to this amount it would be more worthwhile to subsidize the direct provision of services, saving the share of the subsidy that is passed to insurers in the form of a premium load.[14]

If one were to increase the amount of the credit somewhat, coverage would also increase somewhat. The maximum subsidy should be close to (if not equal to) the cost of an available policy if the main goal is expanding coverage as much as possible. This is an important consequence of the fact that requiring low-income individuals to make significant out-of-pocket premium contributions leads to sizable decreases in program

participation rates.[15] If the subsidy amount were tied to an available premium, then one could guarantee someone with a full subsidy, affordability of a comprehensive plan, and thereby boost the number of newly covered persons. Again, subsidization through the tax system does not cause a problem with accomplishing this; it is really a design issue.

Because of budget constraints, it would not be politically feasible to promise a credit sufficient to cover high-cost plans but, as noted previously, it is appropriate to be concerned with the type of plan that will be available at the level of the subsidy. Consequently, the credit would have to be tied to a premium available in a broad-based risk pool, something akin to a low-cost plan of acceptable quality.[16] This does, however, make the administration of the credit more difficult, as the IRS would be required to coordinate information about insurance options in a given area with individuals' tax returns.

Second, the goal of high rates of coverage for low-income individuals requires careful attention to who wins and who loses under a redistribution of subsidy dollars. An important test is whether members of the target population are worse off under the reform than under the current subsidization system. While the current employer-based tax subsidy has its problems, it is likely inducing some low-income workers in firms offering coverage to insure themselves and their families. One could easily conceive of a situation where a redistribution of the current subsidy to a new credit would lead to these low-income workers receiving a smaller tax credit post-reform, with the consequence that they drop coverage.

Third, can those eligible for a subsidy be provided with the liquidity that they need as their premiums come due, while reconciling the amount of their subsidy with

their income as determined through their tax returns at the end of the year? If low-income people are to buy health insurance they must have the liquidity they need — prepayment of the tax credit or subsidy must be offered throughout the insurance year. Clearly, tax credits can be designed to do just that — the Earned Income Tax Credit (EITC) is an example. The trouble comes in, however, when attempting to reconcile the prepayment of the subsidy with the actual subsidy owed to a taxpayer as a function of the year's actual income.[17]

The first problem is that low-income persons who need the added liquidity in order to purchase coverage will be less likely to take advantage of a credit because the actual size of the subsidy at the end of the year is uncertain. The U.S. General Accounting Office (GAO) determined that fears of owing the IRS money at the end of the year were important in explaining the extremely low take-up rate of advanced payments under the EITC.[18] Second, what the EITC has taught us is that for those who do participate, it is extremely difficult to reconcile prepayment of subsidies at the end of the year, and the costs of correcting the errors may substantially exceed the benefits of doing so.

According to the same GAO study, of those individuals receiving advanced payment of the EITC, a significant proportion do not file tax returns at the end of the year, making it impossible to determine if they have been over- or underpaid with respect to the credit owed them.[19] In addition, a significant percentage who do file returns do not report their advance payments.[20] While many of these errors may be attributable to lack of understanding rather than intentional fraud, the costs associated with accurately reconciling these returns are large. Given that the size of errors in the credits are small by

IRS standards, these errors may be dwarfed by the costs associated with rectifying them. Because of their low incomes, however, the size of any errors could be very meaningful to the credit's recipients, and many may find it extraordinarily difficult to repay amounts owed to the Treasury.

If reconciliation is not worth doing, then one could design subsidy eligibility criteria using any of an infinite number of different measures of income, such as past three months or last year's income. But if we are not going to reconcile, use of a tax credit to subsidize coverage loses a lot of its appeal. The tax system is attractive in large part because of its ability to accurately determine income. Without reconciliation, direct subsidization to individuals becomes more attractive, since it allows us to avoid relying upon employers and the IRS for eligibility determination and delivery of the subsidy.

Target Efficiency

A tax credit approach to subsidization is not inherently more or less target efficient than subsidization via vouchers. Target efficiency is determined by the eligibility criteria for the subsidy, the size of the subsidy, and, tautologically, how the target population is defined. These comments assume that the target is the general low-income population.

There is no reason why a tax credit could not be structured that was progressive and that was not available to higher-income persons. However, many actual tax credit proposals are less target efficient than voucher type proposals, because they subsidize individuals in higher-income categories who already have the highest rates of insurance

coverage and the highest likelihood of continued coverage, and they tend not to increase credit amounts with declining income.

Fixed tax credit approaches (those that provide a fixed amount tax credit to all tax payers) are attractive from the standpoint of simplicity of administration, but proposals that extend credits to high-income families are at least in part an outgrowth of the way that these credits tend to be financed. Because many tax credit proposals are at least partially financed by redistributing current subsidies, such as the employer-sponsored coverage tax exemption, their proponents feel it is important to give at least some type of subsidy back to high-income persons, even if it is small relative to their current subsidy. One might also argue that even a redistribution that subsidizes individuals up to 500 percent of the poverty level is more target efficient than the current system. While that might be true, it is not necessarily the best standard to use in designing a new system.

The most effective use of new dollars would be to subsidize those who need it most and the ones that are most likely to change their behavior as a consequence (i.e., begin to purchase insurance), meaning the low-income population. It is difficult to justify spending a large amount of money in aggregate on higher-income persons who will buy insurance regardless of the presence of a subsidy. As contrasted with the case of low-income workers, a very small percentage of higher-income workers lack private insurance, and the insurance premium as a share of income is much lower for the higher income, making the unsubsidized purchase of coverage far less burdensome. Eliminating a large subsidy, such as the employer-sponsored coverage tax exclusion will be unpopular with high-income persons whether it is replaced with a new small subsidy or with no new subsidy at all. Consequently, the political capital gained from extending a

new subsidy to high-income persons is likely to be very small, but the cost would not be, since virtually all of them are insured and would thus qualify for the credit. Thus concerns about target efficiency argue for income-relating subsidies, directing them to the low-income population where the bulk of the coverage problem exists.

Target efficiency also raises the question of whether or not there are particular subpopulations among the low-income population that the program is intended to reach. This gets to the point that the size of the subsidy matters for target efficiency. We know that a large majority of uninsured persons are in families with at least one worker. It turns out that the majority of uninsured workers (approximately 76 percent) are employed in firms that do not offer health insurance to their workers.[21] A small subsidy might be effective at inducing some share of currently uninsured low-income people who work in firms that do offer them insurance coverage to begin to take it up. But in order to target the nearly 80 percent of uninsured workers and their dependents who are in firms that *do not* offer coverage, policymakers must recognize that these individuals will be shopping for insurance in the nongroup market. Since we know that low-income individuals are unlikely to purchase coverage in the open nongroup market with the inducement of only a small subsidy, we have to acknowledge that target effectiveness is going to be highly related to the size of the subsidy relative to the size of an available insurance premium.[22]

This point was also in evidence in the experience of a previous (now discontinued) health insurance tax credit that was associated with the Earned Income Tax Credit. This credit, legislated through the Omnibus Budget Reconciliation Act (OBRA) of 1990 and legislated out of existence in 1993, provided a modest health insurance tax credit for those who qualified for the EITC and contributed toward the purchase of health

insurance for their child. The maximum amount of the credit available in 1991 was $428. A rough estimate of the participation rate in the program (number receiving the credit divided by the number within the income and family eligibility criteria) was only about 19 percent.[23] There was no evidence as to how many of the participants had been previously uninsured.[24]

It is also important to recognize that the workers and nonworkers who do not have employer offers of coverage are unlikely to be well served by an unreformed individual insurance market.[25] This is particularly true for those with current or past health problems. Only 13 states currently have guaranteed issue of health insurance of any kind in the nongroup market and only 19 have some type of rating bands in effect in this market.[26] Consequently, risk pool issues can become dominant, with individuals potentially unable to access this market at all and others potentially unable to access an affordable premium. In addition, large administrative loads (on the order of 35 to 40 percent of benefits or more) can consume a significant portion of an available credit. Consequently, effectively targeting workers in firms that do not offer insurance coverage may require consideration of market reforms that would make policies of an acceptable quality more accessible to these workers. Otherwise, this population of interest may be effectively excluded from using the new credit. Such reforms could include more effective regulation of the nongroup market, or perhaps the development of alternative sources for purchasing coverage with the credit (e.g., Medicaid or other state-organized insurance pools).

Horizontal Equity

In terms of horizontal equity, tax credits are very effective tools. Because the tax system is the most effective way to verify income over a particular year, it is probably the most effective way to ensure that individuals or families in particular income categories are treated the same way for subsidization purposes. In addition, it is possible, and fairly easy, to design a tax credit system that makes public subsidization equitable across those purchasing coverage in groups and those purchasing alone in the nongroup market.

In general, tax credits do not discriminate by previous health insurance status. Low-income individuals who currently struggle financially to purchase health insurance for themselves and/or their family members are not penalized vis-a-vis a credit relative to low-income persons who do not currently purchase coverage. This treatment is not only fair, but prevents undesirable distortions of behavior that might result from possible incentives to remain uninsured. Some recent tax credit proposals, however, would exclude from eligibility those workers in firms that offer health insurance coverage. This type of modification introduces some of the inequities and inefficiencies discussed previously.

One important concern related to horizontal equity that should be considered in the design of a tax credit for health insurance coverage is the variation in health care costs across geographic areas. A credit amount that does not vary by region will buy an individual in a high-cost area less insurance than a similarly situated individual in a low-cost area. Because of the considerable geographic price variations that exist, extending credits without geographic adjustments could lead to horizontal equity that is more illusion than reality. Public programs designed as defined contributions (tax credits are

one example) do not tend to address issues of geographic variation, whereas those designed as contributions of a defined benefit do tend to account for them.[27]

Section 4. Maximizing New Coverage through Use of a Health Insurance Tax Credit

It is important to remember that all three objectives—expanding coverage, target efficiency, and horizontal equity—cannot all be perfectly satisfied simultaneously. Prioritizing one or two objectives will be necessary, leading to compromise in the degree of success in meeting the other objective(s). If we were to make the expansion of health insurance our first priority among the three objectives, which design issues would we want to keep in mind? Obviously, the desire for coverage ought to be balanced with other considerations, not the least of which is budget constraints. As a way of summarizing the previous discussion, the following points provide some guidelines for pursuing coverage expansions within a general tax credit framework, while being mindful of issues related to target efficiency and horizontal equity.

(a) **The credit should be refundable**. Nonrefundable credits provide no benefit to low-income persons who do not have tax liabilities and limit the benefit to those who have small tax liabilities. Excluding these individuals from a new benefit significantly inhibits a policy's ability to target the uninsured. More than half of the uninsured would have their credits limited to at least some extent by a nonrefundable credit.

(b) **The amount of the full tax credit should approximate the cost of an available plan of acceptable quality**. The smaller the amount of the tax subsidy relative to the cost of an available plan, the lower the participation rate of previously uninsured persons will be.

(c) **Tax credit dollars should be made available at the time at which premium payments are due**. Without the liquidity to purchase coverage, a tax credit will have limited value to low-income individuals and families. Those most in need of the benefit would be significantly less likely to be able to take advantage of it without advance payments.

(d) **Eligibility for the credit should be limited to those of low and moderate income.** With resources scarce and assuming a priority to expand insurance coverage, spending tax dollars on the high-income population — those who are most likely to continuously purchase coverage in the absence of any subsidy — is not target efficient. Given a fixed amount of resources devoted to a credit, including high-income persons will decrease the amount of a credit available to each eligible family. And, as the amount of a credit declines, so will participation among the low-income population.

(e) **Eligibility for a tax credit should not be a function of employer behavior**, otherwise incentives will be distorted. If, for example, only those working for employers not currently offering employer-sponsored insurance were eligible for the credit, workers would have an incentive to seek out employers who do not offer coverage. This could lead to employers dropping coverage and/or to workers choosing jobs that are not the best fit for their particular skills.

(f) **Likewise, eligibility for a credit should not be conditioned upon past insurance status**, in order to avoid horizontal inequities and distorted incentives. If, for example, only previously uninsured persons are eligible for a credit, a financial incentive to become uninsured would have been created. Public policies should not encourage individuals to create gaps in insurance coverage. In addition, such a policy effectively punishes low-income individuals who have tried to "do the right thing" by sacrificing wages and other disposable income in order to purchase coverage.

(g) **Advance payments of the tax credit should not (and cannot be) perfectly reconciled at the end of the tax year**. Uncertainty about the final annual credit amount is likely to dissuade low-income persons from using the credit to purchase coverage throughout the year. In addition, while the size of the errors in payments (due to unexpected fluctuations in income throughout the year) can be substantial from the individual's perspective, they are small from the perspective of the IRS, making the costs of collection likely to outweigh the benefits of doing so. Credits can be paid out throughout the year based upon wages, with a "loose" reconciliation through the tax system at the end of the year that is intended to recoup only very large differences between wages and family income.

(h) **The income range over which the full credit begins to phaseout should be rather short**. As the amount of the credit declines, so does participation among the low-income population — a continuing theme among the design issues highlighted in this list. Consequently, if the full credit is only available to those up to say 100 percent of the federal poverty level, and phases down to zero between 100 and 200 percent of the poverty level, one should not expect much participation among the previously uninsured between 100 and 200 percent of the poverty level. In order to maximize participation by the previously uninsured, maintain full (or near full) subsidization for as long as possible along the income scale and then keep phase-out schedules very steep. The clear trade-off of steep phase-out schedules is that they create high marginal tax rates for those with incomes at the top of the phase-out range. If

attaining a high participation rate is a higher priority than work disincentives at the margin, one would be willing to accept this downside.

(i) **Those without access to an employer-sponsored insurance policy must be given a source for purchasing insurance coverage**. Without an affordable, stable policy of acceptable quality to purchase, a tax credit loses its value. The individual insurance market is, in most states, extremely difficult to navigate and does not generally well serve those who have the highest health risks. There are a number of options that can be considered in this regard. Some of these are:

- public contracting with private plans (as is the case in many states under S-CHIP);
- reform of individual insurance market rules, including guaranteed issue and premium rating restrictions, and perhaps including the development of purchasing cooperatives for individual products;
- allowing individuals to purchase actuarially fair coverage through public programs such as Medicaid, state or federal employee systems (individual purchasers would face a premium independent of the currently eligible risk pool and would not receive subsidization through the public program — they would use their tax credit to purchase coverage through the program);
- allowing individuals to purchase individual insurance products guaranteed accessible to HIPAA-eligible persons, including high-risk pools in those states that have them. Non-HIPAA eligibles could be risk rated separately from HIPAA eligibles and the high-risk population.

It is unclear whether addressing these important design issues will leave the original supporters of tax credit approaches feeling satisfied or feeling as though the final product does not fit their conceptualization of a tax credit. However, if these features were to be ignored, the resulting policy could not be one honestly touted as a program to significantly expand the number of insured.

Endnotes

[1] Some examples are: Mark V. Pauly, "Extending Health Insurance through Insurance Credits," *in Expert Proposals to Expand Health Insurance Coverage for Children and Families*, Henry J. Kaiser Family Foundation Project on Incremental Health Reform, draft, February 1999; Mark V. Pauly and John C. Goodman, "Tax Credits for Health Insurance and Medical Savings Accounts," *Health Affairs*, 14(1), pp. 126-139, 1995; C. Eugene Steuerle, "The Search for Adaptable Health Policy through Finance-Based Reform," in R. Helms, ed. *American Health Policy: Critical Issues for Reform* (Washington, D.C.: AEI Press), pp. 334-361, 1993; Sue A. Blevins, "Restoring Health Freedom: The Case for a Universal Tax Credit for Health Insurance," *Policy Analysis*, no. 290, Cato Institute, December 1997; Grace-Marie Arnett, "The Top Eight Reasons Why Employment-Based Health Insurance Is Trouble," Galen Institute Policy Paper, 1998.

[2] Subsidies can take the form of support for the purchase of health insurance or for the direct provision of medical services. In this paper, the focus is on the subsidization of health insurance.

[3] Paul Fronstin, "Sources of Health Insurance and Characteristics of the Uninsured: Analysis of the March 1998 Current Population Survey," Employee Benefit Research Institute Issue Brief, December 1998.

[4] Linda J. Blumberg and David W. Liska, "The Uninsured in the United States: A Status Report," paper prepared for the American College of Physicians, April 1996 (http://www.urban.org/pubs/hinsure/uninsure.htm).

[5] While income is probably the most commonly used metric for comparing relative economic welfare, one could also choose to include other factors, such as employer-provided benefits.

[6] Either by forgoing higher wages in order to take a job that offers employer-sponsored coverage or by forgoing resources for other purposes in order to purchase nongroup coverage.

[7] It is also possible that some adverse selection issues are at play here. Those that anticipate larger health expenditures may be more likely to purchase insurance through their employers or independently. Irregardless, for low-income persons, uncompensated care is an alternative to health insurance, and the purchase of insurance coverage is likely to be a financial burden.

[8] In other words, the tax subsidy for employer-sponsored insurance lowers the marginal price of health insurance, and the marginal price is lowered the most for those in the highest tax brackets.

[9] The tax excludability of employer-sponsored insurance was confirmed in the 1954 Internal Revenue Code.

[10] Mark V. Pauly, "Extending Health Insurance through Insurance Credits," in *Expert Proposals to Expand Health Insurance Coverage for Children and Families*, Henry J. Kaiser Family Foundation Project on Incremental Health Reform, draft, February 1999; Mark V. Pauly, "How Can We Get Responsible National Health Insurance: What Constitutes A Good Plan? What Present Proposals Lack," *The American Enterprise*, 3(4): 60-70, July/August 1992.

[11] One example is The Patient's Health Care Choice Act (H.R. 1687), sponsored by Rep. John Shadegg (R-AZ), which would provide an annual credit of $500 for individuals and $1000 for families. Others have proposed credits in the amount of $800 per adult/$400 per child, or 30 percent to 60 percent of the cost of a premium capped at a specified dollar level.

[12] Mark V. Pauly, "Extending Health Insurance through Insurance Credits," in *Expert Proposals to Expand Health Insurance Coverage for Children and Families*, Henry J. Kaiser Family Foundation Project on Incremental Health Reform, draft, February 1999; C. Eugene Steuerle, "The Search for Adaptable Health Policy through Finance-Based Reform," in R. Helms, ed. *American Health Policy: Critical Issues for Reform* (Washington, D.C.: AEI Press), pp. 334-361, 1993.

[13] Actuarial estimates assume nongroup purchase of insurance with administrative loads of 35 percent. Estimates are based upon proprietary actuarial data. These estimates were compared with those based upon expenditure distributions in the National Medical Expenditure Survey and found not to be substantively different.

[14] Of course, with a fixed amount of subsidy dollars, a policy could be designed such that higher income people are made ineligible for the credit and each low-income person is made eligible for a much more sizable credit.

[15] M. Susan Marquis and Stephen H. Long, "Worker Demand for Health Insurance in the Non-Group Market," *Journal of Health Economics*, vol. 14, pp. 47-63, 1995.
[16] While such a pool does not currently exist in most states, one could be created by the states or by other entities. A state purchasing pool open to individuals is one possible example.
[17] Of course, reconciliation is not an issue if the subsidy is not income related, but as I will argue below, a desire for target efficiency would by necessity take policymakers to an income-related design.
[18] U.S. General Accounting Office, "Earned Income Tax Credit: Advance Payment Option Is Not Widely Known or Understood by the Public," GAO/GGD-92-26, February 1992.
[19] "GAO estimated that about 45 percent of those who, according to IRS records, might have received the advance payment never filed a tax return." This figure is based upon 1989 returns, and reforms implemented since that time may have improved that rate somewhat.
[20] "GAO estimated that about 49 percent of the workers who clearly received advance payments in 1989 and filed a tax return did not report receiving the credit." Again, reforms since 1989 may have improved this rate to some extent.
[21]Philip F. Cooper and Barbara Steinberg Schone, "More Offers, Fewer Takers for Employment-Based Health Insurance: 1987 and 1996," *Health Affairs*, November/December 1997, vol. 16, no. 6, pp. 142-149.
[22] While a small number of firms might begin to offer coverage as a result of the new credit, we cannot expect this increase in offers to be very big. There are many different reasons why firms do not offer health insurance coverage (see Len M. Nichols, Linda J. Blumberg et al., "Small Employers: Their Diversity and Health Insurance," Urban Institute Monograph, 1997, http://www.urban.org/health/smemployers.htm), only one of which is the low wage level of the workers and the consequent inability to pass health insurance costs back through lower wages. In addition, a subsidy for employer-sponsored coverage currently exists, and these firms do not take advantage of it; any change will result from the marginal difference between the current system subsidy and the new system credit.
[23] U.S. GAO, "Tax Policy: Health Insurance Tax Credit Participation Rate Was Low," Letter Report, May 2, 1994, GAO/GGD-94-99.
[24] In addition, there was anecdotal evidence of abuses by insurers pursuing sales of policies to those eligible for the health insurance tax credit.
[25] Linda J. Blumberg and Len M. Nichols, "Health Insurance Market Reforms: What they Can and Cannot Do," Urban Institute Monograph, 1995 (http://www.urban.org/pubs/hinsure/insure.htm).
[26] "State Legislative Health Care and Insurance Issues: 1998 Survey of Plans," Blue Cross Blue Shield Association, 1998.
[27] Another complicating issue is the extent to which such geographic variations in price are related to variations in income. The important question here is whether individuals with somewhat higher incomes in particular areas have higher standards of living or if the higher area costs associated with medical care and other goods and services leave them with buying power that is equivalent to that of lower-income persons in areas with lower prices. Again, achieving true horizontal equity will require an assessment of these interactions and construction of adjustment factors that will compensate for them.