A Health Insurance Tax Credit for Uninsured Workers

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EXECUTIVE SUMMARY

A new system of tax credits could help low-income workers pay for health insurance. The scheme would aim to extend health insurance coverage to workers who are uninsured or who pay high premiums for non-group insurance. Anyone age 19 or over, and not covered by Medicaid, Medicare or employer-sponsored health insurance would be eligible for a Health Insurance Tax Credit, or HITC. Like the Earned Income Tax Credit, the HITC would be administered through the Internal Revenue Service.

Under the HITC scheme, uninsured workers with incomes below 200 percent of the Federal Poverty Level (FPL) would receive a tax credit to cover the cost of the non-group health insurance package of their choice, up to $2,000 per year for a single patient, or $4,000 for a family of four. For those with higher incomes the base amount of the credit would be reduced by $150 for every $1,000 earned above 200 percent of the FPL. At the current FPL, single workers with no children earning up to $16,900 and married couples with three children earning up to $39,300 would qualify for the full basic tax credit. Those earning above 200 percent of the FPL would be subject to phaseout, but a single, childless worker would receive some portion of the tax credit, as long as his earnings fell below $30,000. For a family of five, the HITC would phase out completely if earnings surpassed $66,000 per year. The phaseout would be adjusted annually for inflation, based on the Consumer Price Index (CPI), and the base amount of the credit would be adjusted for the health care component of the CPI.

The average basic HITC would differ, just as insurance premiums do, depending upon the worker's age and sex. For example, premiums tend to be higher for women of childbearing age and above than they are for young men between the ages of 25 and 34. So, if the HITC were $2,000 for the average low-income single worker, a 50-year-old woman earning less than 200 percent of the FPL would receive a tax credit of $3,524, whereas a 30-year-old man with similar earnings would receive $1,148.

Eligibility would be based on the worker's income for the entire year, but the tax credit would only be granted for those months that the worker was not actually participating in another insurance scheme. Zelenak envisions that the HITC would be granted in advance, in order to encourage the participation of those who may not be able to pay for insurance up front. The taxpayer would submit a form to the IRS at the beginning of the year, indicating her age, sex, and Modified Adjusted Gross Income (MAGI). The IRS would notify the taxpayer of her eligibility and she in turn would inform the IRS of her choice of insurer. The IRS would then pay the insurer directly. If

at the end of the year the taxpayer actually earned more or less than she had estimated, she would either pay the balance due the IRS or receive a refund.

For those workers whose circumstances change during the year, the financial burden of reconciling the amount due to the IRS might be quite severe. For this reason, Zelenak suggests that the IRS pay only 60 percent of HITC to insurers in advance. Participants would then be responsible for the balance, which might be deducted out of payroll. Most participants would therefore receive a refund at the end of the year. However such a scheme might discourage those for whom even 40 percent of the cost of insurance poses a heavy financial burden, even if it is reimbursed at the end of the year.

The HITC has many advantages. It would expand health insurance coverage to include nearly all Americans in a politically feasible way. It would be managed by the IRS like the Earned Income Tax Credit, and so would not require significant administrative innovations. By bringing a large number of healthy workers into the health insurance market, it might increase competition among health insurance companies, and thus lower premiums.

However, the HITC has at least three significant drawbacks. First, even with age and sex adjustments, the HITC would not be sufficient to cover the full cost of insurance for those subject to the highest premiums, such as patients with preexisting conditions. These patients would have to cover the remainder of their insurance costs themselves. Secondly, a marriage penalty is inevitable because the HITC would be based on the FPL, which is lower for a married couple than for two single people. Nevertheless, many health insurance plans also offer discounts for couples and families.

Finally, some low-paid workers whose employers already provide health insurance might switch to HITC, in order to gain a more substantial tax deduction. This might in turn cause some employer-sponsored plans to unravel, and would not serve to expand coverage. Zelenak estimates that about 8.1 million workers might leave employer-sponsored plans in favor of the HITC. Such "crowd-out" would be limited because employer-sponsored group plans cost, on average, 30 percent less than the non-group plans that would be financed with HITC, and this would reduce the tax advantage of switching. The phaseout for workers with incomes above 200 percent of the FPL and the age and sex adjustment of the HITC would also reduce the advantage of switching from employer-sponsored plans to HITC-financed insurance.

Medicaid patients would be eligible to switch to HITC, but few would be expected to do so, since Medicaid currently provides more comprehensive coverage than the non-group plans that would be paid for by HITC. Because states pay a proportion of Medicaid but would not contribute to the federally funded HITC, some states might encourage patients on Medicaid to switch to HITC. In order to prevent this, the HITC scheme might include a mandate that states maintain their current level of Medicaid funding.

A HEALTH INSURANCE TAX CREDIT FOR UNINSURED WORKERS

I. SUMMARY

This paper describes a proposal for a health insurance tax credit (HITC) for uninsured low-income working adults, in order to fill the coverage gap between Medicaid and employer-sponsored health insurance. The base amount of the proposed credit is $2,000 for each individual covered, but this will vary with age and sex, just as non-group premiums do. The base amount would be multiplied by an index number reflecting the relationship between the cost of non-group health insurance for people of the age and sex of the covered individual, and the average cost of non-group health insurance for all adults. The index number will be less than 1 for people in low-cost age and sex categories, and greater than 1 for people in high-cost categories. With this adjustment, the credit amount should be sufficient to cover the entire cost of a basic insurance package in most cases. The base amount of the credit is reduced by $150 for every $1,000 by which the person's income exceeds 200 percent of the federal poverty level (FPL), resulting in eventual elimination of the credit. Because the FPL is a function of family size, the income level at which the credit is eliminated varies according to family size. For an unmarried person with no children, the credit would be eliminated at approximately $30,000. For a married couple with three children, the phaseout would be completed at an annual income of approximately $66,000, if both spouses claim the credit. The credit would be available for any adult not covered by employer-sponsored health insurance, by Medicare, or by Medicaid, except where it is reduced or eliminated by the phaseout. Children of low-income working parents are generally already eligible for coverage under the Children's Health Insurance Program (CHIP), and so are not considered in this proposal. In order to encourage participation in the program, most of the credit would be available through an advance payment system, with final reconciliation (payment of additional credit or repayment of excessive advance payments) after the end of the year.

II. BACKGROUND

The tax credit proposed here bears slight resemblance to the supplemental health insurance credit, which was briefly a part of the earned income tax credit (EIC) in the early 1990s. That credit was available to low-income workers who provided health insurance coverage for their children. The credit was 6 percent of the first $7,750 of earned income, resulting in a maximum credit of $465, but the credit could not exceed the out-of-pocket cost of insurance. The credit was phased out at the rate of 4.285 percent as income increased above $12,200. A study by the Government Accounting Office estimated the participation rate for the credit at only 26 percent.[1] The GAO blamed low participation on failure to publicize the program effectively, and on the fact that the credit typically covered only a small portion of the cost of insurance. In the

population studied, the GAO found an average credit of $233 and an average out-of-pocket insurance premium of $1,029.

With this experience in mind, the proposed credit should be accompanied by an aggressive publicity campaign. In addition—and perhaps even more significantly—the tax credit is designed so that it will cover the *entire* cost of insurance for many participants with incomes below 200 percent of the FPL.[2] With no permanent out-of-pocket cost, participation rates should be much higher than under the earlier credit. In addition, the advance payment system means participants' *temporary* out-of-pocket costs will be modest.

III. TARGET POPULATION

The core target population is uninsured workers with incomes below 200 percent of the FPL. To be eligible, a person must be at least 19 years old, and thus too old to be eligible under CHIP. If a person satisfies the age requirement, he is eligible even if he is a dependent.[3] Because the phaseout of the credit does not *begin* until 200 percent of the FPL, uninsured workers with incomes moderately above that level are also targeted. Those with incomes below 200 percent of the FPL should participate at high rates, because they will receive a 100 percent credit, most of it paid in advance. Workers with higher incomes may participate at a lower rate because they will be eligible only for a reduced credit, and therefore will have to make a permanent cash outlay.

IV. ADMINISTRATIVE STRUCTURE—MACRO

Eligibility for the proposed HITC is based on income (more precisely, modified adjusted gross income, or MAGI). The system would be administered by the Internal Revenue Service. Because the HITC takes advantage of existing tax rules (the definition of MAGI) and administrative structures (the 1040 filing requirement), administrative costs should be relatively low. On the other hand, the advance payment system will impose significant new costs on the IRS—in processing advance payment forms filed by taxpayers, in issuing payments to insurers, and in administering the reconciliation rules. The IRS will need a budget increase sufficient to cover the expected costs.

V. ADMINISTRATIVE STRUCTURE—MICRO

A. Basic Credit

The credit can be used only to obtain non-group health insurance; it cannot be used to pay the employee's cost of participating in an employer-sponsored group. The credit is designed to be sufficient to cover the entire cost of a basic individual health insurance package for most participants. The base credit amount is $2,000. In the current non-group market a $2,000 premium would be sufficient, on average, to buy a fee-for-service policy

with a benefit ratio of about 75 percent. An example of such a policy would be a plan with a deductible of $375, a coinsurance rate of 20 percent, and an out-of-pocket maximum of $7,500.[4] Alternatively, $2,000 would purchase, on average, HMO coverage with a $20 copayment on physician visits and prescription drugs, and 15 percent coinsurance on hospital and other services.

This is adequate basic insurance coverage. Not everyone, however, will be able to buy such coverage for $2,000. If they were entitled to only a $2,000 credit, individuals with above average age/sex insurance cost indices either would have to pay for a substantial part of the insurance themselves, or would have to buy policies providing poor coverage. Faced with those unattractive options, some might decide not to obtain any health insurance. A person with an index of 1.5 percent,[5] for example, would have to pay a total of $3,000 ($2,000 from the credit and $1,000 of her own money) for the standard $375/20 percent/$7,500 policy. Alternatively, for $2,000 she could buy a policy with a $3,500 deductible, 25 percent coinsurance, and a $10,000 out-of-pocket maximum. This is little more than catastrophic-care coverage.

This proposed legislation addresses this problem by varying the credit amount according to age/sex health insurance cost indices.[6] The individual credit amount would be $2,000 multiplied by the taxpayer's index number.[7] For example, the credit for a 30-year-old man (index 0.574) would be $1,148; the credit for a 50-year-old woman (index 1.762) would be $3,524.

These adjustments may add a modest amount of complexity to the credit, but they will target the subsidy more effectively than a fixed credit amount. There is substantial precedent for age-sensitive provisions in the income tax.[8] The most closely analogous rule is the age-sensitive ceiling on the deductible cost of long-term care insurance premiums, ranging from a low of $200 (per year) for a covered individual age 40 or younger, to a high of $2,500 for a covered individual older than 70.[9]

However, there is no precedent in current federal tax laws for adjusting the credit amount according to the sex of the insured. The tax laws consistently do *not* make sex-based adjustments, even where it might be reasonable to do so. Prominent examples of the unisex approach include the long-term care deduction provision mentioned above, and the actuarial tables used to determine the values of annuities, life estates, and remainders.[10] There is even a risk of a constitutional challenge to a sex-based adjustment.[11] On the other hand, the sex-based difference in index numbers are so great during women's childbearing

years,[12] that a credit that does not take those differences into account will not be very accurate or fair.

Age and sex adjustments will not only reflect insurance costs more accurately; they will also help protect existing employer-sponsored insurance groups from being undermined. If low-risk members of an employer group, such as healthy young men, were entitled to an unadjusted $2,000 credit, they might leave the group in favor of credit-financed individual coverage. Their motivation would be to avoid having to pay part of the cost of employer-sponsored insurance, to get insurance with very low deductibles and coinsurance,[13] or both. As the lowest-cost people left the group, the cost of coverage for remaining members would rise. In the worst case, the group could totally unravel. The age/sex adjustments greatly decrease the credit's impact on existing employer-sponsored groups; young men will be much less likely to leave a group for a credit of about $1,100 than for a credit of $2,000.

A person considered by insurers to be a poor risk compared to other members of her age/sex group may be unable to find a reasonable health insurance package for the amount of the tax credit, even with the age and sex adjustments. Short of requiring the Internal Revenue Service to investigate the health status of millions of credit recipients, the only solution to this problem would be to provide credits for the full amount of whatever a particular recipient actually pays for health insurance. However, the potential for abuse of such a system is apparent.

B. Eligibility

Subject to the income phaseout, the credit is available for non-group health insurance for any person who is at least 19 years old and not actually covered by employer-sponsored health insurance, Medicare, or Medicaid.[14] People who are eligible to participate in an employer-sponsored plan but who elect not to do so are eligible for the credit. Ineligibility because of other health insurance coverage is determined on a *month-by-month* basis. Thus a taxpayer might be credit-eligible for some months of the year and ineligible for others. This contrasts with the phaseout rules, described below, which are based on *annual* income.

An alternative would be to make anyone who is *eligible* to participate in an employer-sponsored plan ineligible for the credit, regardless of actual participation. However, it might be very difficult for the IRS to gather the information on eligibility necessary to enforce such a rule. Aside from that practical concern, whether such a rule would be a good idea depends both on empirical questions and on value judgments.

Consider, as an example, an employee who is currently eligible to participate in an employer plan, but who elects not to, because he would need to pay $1,000 of the premium himself. When the new credit is introduced, he becomes eligible for the $2,000 base credit amount, which covers the full cost of insurance. Making him ineligible for the credit because he is eligible under the employer plan would defeat the credit's purpose of expanding health insurance coverage to those currently uninsured. On the other hand, imagine another employee, faced with the same option to participate in an employer plan at a cost of $1,000, who currently chooses to participate. After the credit is introduced, he will save $1,000 by switching to credit-eligible insurance, and the government will have spent a substantial sum on the credit without having expanded health insurance coverage. It is an empirical question which type of error would be more common: failure to expand coverage if those eligible for employer plans are not eligible for the credit, or wasted money and some unraveling of employer groups if those eligible for employer plans are eligible for the credit. It is a value judgment which type of error is worse. This proposal treats expanding coverage as the primary concern, and so extends credit eligibility to those who are eligible to participate in employer plans, as long as they do not actually do so.

Another way to limit eligibility would be to impose a waiting period of six months, a year, or some other period of time between the end of participation in an employer-sponsored plan and the beginning of eligibility for the credit. The waiting period would discourage currently insured workers from moving from employer plans to the credit system in cases where the credit provides a larger subsidy than the favorable tax treatment of employer plans.[15] A waiting period might dissuade employers from dropping insurance coverage for current employees and telling them to buy their own credit-eligible insurance instead, but employers would still be discouraged from providing insurance for employees entering the workforce for the first time or reentering after an absence of more than, for example, six months. The fundamental problem with the waiting period, however, is that it will create unintended—but inevitable—victims. It would decrease the opportunity to game the system, but only at the cost of denying the credit to those who have lost their employer-sponsored coverage and are not trying to game the system. In addition, it would be difficult for the IRS to obtain and manage the information necessary to enforce a waiting-period requirement.

C. Phaseout of the Credit

The phaseout is based on modified adjusted gross income (MAGI), according to the definition used for the earned income credit (EIC). If a person is claimed or is eligible to be claimed as a dependent on another's tax return, the phaseout is based on the MAGI of the supporting person. MAGI expands AGI to resemble economic income more closely

by disallowing certain business and investment tax losses, and by including certain non-taxable receipts. In the case of taxpayers without children, the phaseout begins at $16,900 for unmarried taxpayers, and $22,500 for a couple filing a joint return. These amounts approximate 200 percent of the FPL for a one-person family and for a two-person family, respectively. The base credit amount is reduced by $150 for every $1,000 of MAGI above $16,900 or $22,500. For a single person claiming one credit, the phaseout would be complete at approximately $30,200 MAGI. If more than one credit is claimed on one tax return (e.g., for both spouses on a joint return, or for the taxpayer and an adult dependent) the credits are phased out consecutively rather than concurrently. In other words, if there are two credits the phaseout *range* is doubled, rather than the phaseout *rate*. For a childless couple claiming two credits, the phaseout would be complete at approximately $49,200.

The income level at which the phaseout begins increases by $5,600 (200% of the $2,800 income tax dependency exemption for 2000) for every dependent in the family, so that the phaseout always begins at approximately 200 percent of the FPL, regardless of family size. For a couple with three children, for example, the phaseout does not begin until $39,300 and is not complete (if both spouses claim the credit) until almost $66,000.

After the base amount of the credit is reduced by the phaseout, it is multiplied by the taxpayer's age- and sex-index number to determine the amount of the allowable credit. Suppose, for example, the phaseout reduces the base credit amount to $1,200. If the taxpayer's index number is 1.5, she is entitled to a credit of $1,800.

The following example illustrates the interaction of the phaseout rule (based on income for the entire year) and the eligibility rule (based on month-by-month determinations). Suppose that, after application of the phaseout and multiplication by the index number, an individual would be entitled to a $1,500 credit if she were credit-eligible for the entire year, but in fact she is credit-eligible for only eight months, because she has employer-sponsored insurance for the other four months. Then for each of the eight months of eligibility she is entitled to a credit of $1,500 x 1/12 = $125, for a total credit for the year of $1,000.[16]

It would be possible to include an excessive investment income test, similar or identical to the test used for purposes of the EIC. Under the EIC version of the test, the earned income credit is denied to any person with investment income (as specially defined) in excess of $2,400. The rule serves as a surrogate for an asset test. Because health insurance is most valuable precisely to those low-income workers who have some assets to protect, an asset test is not included in this proposal.

D. Inflation Adjustments

Both the base credit amount and the starting point of the MAGI-based phaseout will be adjusted annually for inflation. Like other income-tax inflation adjustments, the phaseout starting point would be adjusted in line with the Consumer Price Index (CPI). The adjustment in the maximum credit amount could also be tied to the overall CPI, but it would be more accurate to base it on the medical care component of the CPI. It is appropriate to use different indices because the phaseout is conceptually related to the poverty level, which changes in line with the overall CPI, whereas the maximum credit amount is conceptually related to the cost of health insurance, which changes with the cost of medical care.

E. Advance Payment

If the credit could be used only to reimburse amounts the taxpayer had spent for health insurance, the delay between payment and reimbursement, which could be a year or more, could significantly depress participation levels. Therefore, an advance payment system is proposed. The IRS would determine whether a taxpayer is expected to qualify for the credit for the year, based on information the taxpayer supplies. The required information would include the taxpayer's age and sex, and expected MAGI for the upcoming year. The IRS would then notify the person that he appears to be eligible for a credit, and of the expected amount of the credit. The eligible person would notify the IRS of his choice of insurer, and the insurer would receive payments at regular intervals (probably monthly) from the government. Because the recapture of excessive advance payments could impose hardships on both taxpayers and the IRS, the advance payment would be limited to a specified percentage (e.g., 60%) of the estimated amount of the taxpayer's credit.[17]

The advance payment option of the EIC serves as a precedent of sorts for the advance payment of the proposed credit. An employer includes the EIC advance payment amount in the paycheck of an employee who has selected the option. However, the health insurance advance payment would be an innovation, in two respects. First, the advance payment would go directly to a third party (the insurer) rather than to the taxpayer. Second, the health insurance advance payment would be much more heavily promoted than the EIC advance payment option has been. Participation in the EIC advance payment program has been very low,[18] and because of concerns about noncompliance the IRS makes little effort to promote the program. It may be acceptable that the advance payment option for the EIC is rarely used, since those who fail to participate in the advance payment program eventually obtain their credits after filing their tax returns. Distributing the EIC as a lump sum, payable in arrears, is consistent with a high participation rate. In contrast, if the health insurance credit were distributed in this

way, anyone who was unwilling or unable to be out-of-pocket the entire cost of insurance coverage for many months would not participate. In short, achieving high participation rates for the health insurance credit depends on an effectively designed and promoted advance payment option.

F. Income Reconciliation

An advance payment system requires a reconciliation after the close of the year, based on the difference between the amount of the advance payments and the correct amount of the credit, based on actual MAGI for the year.[19] This presents no particular problem when the advance payments are *less* than the proper amount of the credit, but recapturing excess advance payments may be hard on taxpayers and burdensome for the IRS. A conflict arises between the goals of accuracy and participation. An advance payment/reconciliation system could be designed with encouraging participation as the overriding concern, but many people would then receive excessive advance payments. The system could be designed instead to achieve a high level of accuracy—at the extreme, the credit could be available only as a lump sum, payable in arrears—but this might greatly reduce participation. The proposed advance payment/reconciliation system is described below.[20]

The advance credit amount would be limited to 60 percent of the expected credit amount, like the partial advance payment system for the EIC. Suppose a taxpayer with an age/sex index number of 1 estimates that his annual income will be low enough that he will not be subject to the phaseout. He expects to be entitled to a $2,000 credit, which would pay the entire $167 monthly premium on a $2,000 policy. However, he would be entitled to an advance payment amount of only 60 percent of the full credit amount, or $100 per month. The taxpayer would have to put up $67 of his own money every month in order to be insured.[21] He would know that if his estimate turned out to be right, he would be reimbursed at the end of the year for all of his out-of-pocket premium payments. Some taxpayers would still owe money to the IRS at the end of the year, but such cases would be fewer, and the recapture amounts much lower, than if the advance payment were 100 percent of the estimated credit amount.

The problem, of course, is that requiring taxpayers to pay significant amounts of their own money, even temporarily, might seriously depress participation rates.[22] On the other hand, participation might still be quite high if aggressive steps are taken to encourage participation. It would be especially helpful if the credit program used payroll deductions to cover the portion of premiums not covered by advance payments, rather than requiring workers to write periodic checks to their insurance companies.[23]

Although employers may find it burdensome to administer a payroll deduction system, employers will benefit if their employees are covered by federally subsidized health insurance. There is federal precedent for requiring employers to deduct expenses other than taxes from payroll, for example, child and spousal support obligations,[24] and federal student loans in default.[25]

If employees select so many different insurers that distribution of the premiums becomes unreasonably burdensome to employers, a state could establish a premium clearinghouse, which would receive all payroll deduction premiums from employers and forward them to the appropriate insurers.

Some insurers might respond to a 60 percent limit on advance payments by lending participants the other 40 percent of the premiums, with repayment due when the rest of the credit is received the following year. Participants who borrowed their 40 percent share of the premiums would not need payroll deductions. Insurer loans might encourage participation; they would enable participants to take advantage of the credit without even a temporary out-of-pocket cost. There would be a concern, however, about insurers charging very high interest rates on the loans. A similar problem currently exists with "refund anticipation loans" offered by some tax-return preparation services. If insurers turn out to charge unreasonably high interest rates for loans when the HITC comes into effect, and if state usury laws prove inadequate, federal regulation would certainly be appropriate.

G. Publicity

The credit will be a success only if people entitled to participate are aware of their eligibility. Therefore the proposal mandates that employers notify all potentially eligible employees of the existence of the HITC. The IRS would furnish employers with copies of an IRS publication (one piece of paper should suffice) explaining the basic elements of the credit program. Employers would be required to give a copy of the publication to all potentially eligible employees when the credit is introduced, to all new potentially eligible employees thereafter, and to any employees who become potentially eligible thereafter because they cease to be covered by employer-sponsored insurance. The same publication would be given to the newly unemployed by unemployment offices. In addition, employers and employment insurance offices would display IRS-provided posters publicizing the credit.

VI. SOME CONCERNS

A. Take-Up, Crowd-Out, and Buying the Base

The credit must be attractive enough so that many uninsured people participate, but not so attractive that large numbers of people move from employer-sponsored plans to the credit. This proposal makes participation—that is a high take-up rate—the top priority; some crowd-out will be unavoidable. For a taxpayer in the 15 percent income tax bracket with an index number of 1, for example, the combined value of the income tax and wage tax exclusions of $2,000 of employer-provided coverage is approximately $600, a much smaller subsidy than a $2,000 credit. If the taxpayer switches to the credit, the cost to the government increases by $1,400. The government gains nothing in terms of expanded insurance coverage for its additional cost.

Three factors, however, diminish the seriousness of the crowd-out problem. First, as noted earlier, adjusting the credit amount for age- and sex-based cost differences means that the credit will not provide special incentives for young and healthy employees to leave employer groups. Second, employer group coverage has a significant advantage over individual coverage, not related to taxes. Because of administrative expenses and adverse selection, individual coverage costs at least 30 percent more than group coverage for all but the smallest employer groups.[26] Finally, the phaseout of the credit will reduce the amount of the subsidy for many workers. The latter two factors work together to reduce crowd-out. For example, a childless single worker with an index number of 1 and MAGI of $23,900 is entitled to a credit of $950 after the phaseout, so that $2,000 non-group coverage will cost her $1,050 in permanent out-of-pocket expense. If her combined income/wage tax marginal rate is 30 percent, it will take $1,500 of pretax compensation to cover her $1,050 cost. Suppose equivalent insurance through her employer group would cost $1,500. Since this can be provided free of both income tax and wage tax, $1,500 of pre-tax compensation will pay for this insurance. The cost is thus the same as for the equivalent credit-eligible insurance, and there would be no reason for the worker to leave the employer group.

Even though these three factors should reduce it, there will be some crowd-out. It is also likely that crowd-out will increase over time, as employers and employees adapt to the credit. A possible additional response to the crowd-out problem would be to impose a waiting period of six months or a year between the end of participation in an employer-sponsored plan and the beginning of eligibility for the credit. That option is discussed, but not recommended, in section V.B. of this paper.

As indicated in Table 1A,[27] the expected crowd-out effect of the proposed credit is modest. Only about 3 percent (5.3 million people) of those currently covered by employer-sponsored insurance would be likely to give up their coverage and switch to subsidized non-group insurance as a result of the credit. Less than 1 percent (1 million people) of those currently covered by employer-sponsored insurance would purchase unsubsidized non-group coverage because their employers stopped sponsoring their insurance in response to the credit.

Table 1A
Refundable $2,000/$4,000 Credit for Non-Group Insurance, All Eligible

	Number of People (Millions)	Percent of Insurance Category	Net Cost (1999 Millions $)
Total Cost in 1999 $	—	—	25,877
Total Take-Up of Subsidy	22.82	9.4	—
Previously non-group	8.13	49.6	10,592
Previously uninsured	8.43	17.7	11,287
Previously employer-insured	5.27	3.6	4,341
Previously Medicaid	0.99	3.4	-344
Total Change in Population Size			
Non-group	14.68	89.6	—
Uninsured	-7.94	-16.7	—
Employer-Insured	-5.75	-3.9	—
Firm dropped to non-group	-1.02	-0.7	—
Firm dropped to uninsured	-0.08	-0.06	—
Switch to non-group	-4.25	-2.9	—
Uninsured due to decreased contributions	-0.40	-0.3	—
Medicaid	-0.99	-3.4	—
Cost per Newly Insured (1999 $)			$3,258

Although ideally there would be no crowd-out, the amount predicted here seems an acceptable price to pay, since the anticipated take-up of the credit by those currently without insurance would be high. An estimated 19 percent of those currently uninsured—8.4 million people—would purchase subsidized non-group health insurance in response to the credit.

In addition to take-up and crowd-out, another criterion for evaluating the subsidy is the extent to which it results in the government "buying the base." The credit would be available not only to individuals who purchase non-group insurance because of the credit, but also to those who would have purchased such insurance even without the

credit. An estimated 8.1 million people who already have non-group insurance would take up the credit, at an estimated cost to the government of $10.6 billion.[28] It is unthinkable on fairness grounds (and probably impractical as well) to make people currently buying non-group insurance ineligible for the credit, but making them eligible is undeniably expensive.

Some "buying the base" is inherent in this proposal, and there are two ways to justify it. First, it may be a reasonable price to pay to insure the 8.4 million currently uninsured people who would take up the credit. Even with "buying the base" and crowd-out, the estimated net cost per newly insured person is just over $3,200.

Second, a health insurance subsidy for lower-income workers may be attractive on fairness grounds, quite apart from its effect on behavior. Under current law, everyone with health insurance receives a federal subsidy (through Medicaid or the Children's Health Insurance Program for the poor, and through the income tax and wage tax exclusions for workers with employer-sponsored insurance), *except* those who purchase non-group coverage.[29] Extending a subsidy to this one excluded category of insured people may improve the overall fairness of federal subsidies for health insurance.

The distributional analysis in Table 1B[30] indicates that 34 percent of the cost of the credit will benefit people with incomes at or below the FPL, 46 percent will benefit people with incomes ranging from the FPL to twice the FPL, and 16 percent of the cost will benefit people with incomes from two to three times the FPL. Although the average income of people claiming the credit who would have bought non-group insurance anyway may be somewhat higher than the average income of all people claiming the credit, the overall analysis suggests that the transfer payments involved in the buying of the base are, at the least, not distributionally offensive.

B. State-Level Anti-Crowd-Out Provisions

Medicaid provides more generous benefits (at least in terms of coverage) than would be available through private purchase using the tax credit. Nonetheless, some individuals might prefer tax credit-subsidized private coverage to public coverage. Others might find it easier to learn about tax credit-subsidized coverage than about private coverage. State efforts to discourage Medicaid enrollment could lead to more enrollment in the tax credit program. Because tax credits are 100 percent federally financed, while Medicaid requires a state match, states will have an incentive to encourage those eligible for both programs to use the tax credit rather than enrolling in Medicaid. State action of this sort would work

to the detriment of those eligible for Medicaid because Medicaid has more comprehensive benefits than private insurance.

Table 1B: Distributional Analysis

Group	Net Cost (1999 Millions $)	Percent of Costs	Subsidy Take-Up (Millions)	Percent of Group	Change in Uninsured (Millions)	Percent of Uninsured	Cost per Newly Insured (1999 $)
<100% of FPL	$9,671	37.4	7.94	15.4	-3.12	-17.9	$3,095
100%–200% of FPL	$12,311	47.6	9.85	21.3	-3.89	-30.6	$3,164
200%-300% of FPL	$3,608	13.9	4.12	10.3	-0.87	-14.2	$4,134
300%–400% of FPL	$273	1.1	0.85	2.7	-0.05	-1.8	$5,977
>400% of FPL	$15	0.1	0.06	0.1	0.00	-0.1	$3,060

There is no simple way to design the credit to prevent states from encouraging people to choose the credit rather than Medicaid. Those eligible for Medicaid could be made ineligible for the credit, but such a rule would be difficult for the IRS to enforce. The IRS makes eligibility determinations for the credit, while states make eligibility determinations for Medicaid. Thus, the IRS would have to determine whether a credit applicant was eligible for Medicaid in that applicant's state of residence. Since Medicaid eligibility rules differ among the states, and some Medicaid eligibility rules involve information not readily available to the IRS, such as asset ownership, this would be a very difficult task for the IRS. Furthermore, many people might fall between the cracks if they apply for the credit, are deemed ineligible, and then have to apply for Medicaid.

A more feasible, though less politically palatable, provision would impose a federal mandate that states maintain financial effort with respect to their existing Medicaid programs. The rule governing state-only programs under the Children's Health Insurance Program works in this way. Those states that had expanded coverage before 1996 must maintain at least their 1996 level of funding for child health insurance.

Even without a special rule to discourage the states from moving people from Medicaid to the tax credit, only 5 percent (1 million people) of those currently covered by Medicaid would be expected to take up the credit, at a net *savings* to the federal government of $344 million (see Table 1A). It does not seem crucial to include special provisions to prevent so modest an amount of state-encouraged migration.

C. The Phaseout As a Hidden Marginal Tax Rate

For a person with an index number of 1, the phaseout functions as a 15 percent tax over the phaseout range. The effective tax rate will be higher for people with index numbers above 1 (e.g., 22.5% for an index number of 1.5), and lower for people with index numbers below 1 (e.g., 7.5% for an index of 0.5). Low-income workers may face very high marginal rates when the HITC phaseout is combined with other taxes operating over the same range, such as federal and state income taxes, social security tax, and in some income ranges the EIC phaseout. If taxpayers understand the marginal rates, the phaseout may be a significant work disincentive. Even (or especially) if taxpayers do not understand them, high marginal rates on low-income workers raise fairness concerns. For this reason, the phaseout is not very steep. In addition, because the phaseout does not begin until 200 percent of the FPL, it is less likely to overlap with the EIC phaseout range than if it started at a lower level. For 2000, the range of the EIC phaseout (15.98% rate) for a one-child taxpayer (or couple) is $12,690 to $27,413 MAGI, and for a taxpayer (or couple) with two or more children the range of the phaseout (21.06% rate) is $12,690 to $31,152 MAGI. For a married couple with one child, there is no overlap (i.e., no income range where both phaseouts apply simultaneously). The EIC phaseout is complete at $27,413, and the HITC phaseout does not being until $28,100. Not every case will be this tidy, however. For a single taxpayer with two children, there is overlap between $28,100 and $31,152. Considering just federal income tax, the two phaseouts, and the employee's portion of the social security tax, that taxpayer would face a marginal rate in the overlap range of almost 59 percent (15% + 21.06% + 15% + 7.65%) if he had an index number of 1. Beginning the phaseout at a higher income level, or imposing a lower phaseout rate, could lower marginal tax rates in such cases. Those options deserve serious consideration, but if they were implemented the credit would be less narrowly targeted to lower income workers.[31]

D. Marriage Penalties

The proposed credit design involves a significant marriage penalty, because the beginning of the phaseout for couples ($22,500) is much lower than twice the beginning of the phaseout for singles ($16,900). For example, the marriage penalty (in the form of smaller credits) on a childless couple earning $16,900 each, and each having an index number of 1, would be almost $1,700.[32] The marriage penalties are inevitable, given the derivation of the phaseout starting points from the FPL, and given the nature of the FPL family-size adjustments.

The credit design could be modified to reduce or eliminate marriage penalties, but all modifications would create problems of their own. Marriage penalties would be eliminated if the phaseout for couples filing joint returns did not begin until $33,800 (assuming the phaseout for single taxpayers begins at $16,900). The obvious objection to

this is that it is inconsistent with targeting the credit to those with incomes at or below 200 percent of the FPL, since $33,800 is about 300 percent of the FPL for a two-person family. Extending the credit to people with such high incomes may cause significant crowd-out, while doing little to extend coverage to the currently uninsured. This approach would also create significant singles penalties. A childless single person with MAGI of $33,800 would be entitled to no credit, but a married worker with the same income and a non-earning spouse would be entitled to the full credit. Increasing the beginning of the joint-return phaseout to some dollar amount above $22,500 but below $33,800 would be a compromise. This would reduce, but not eliminate, marriage penalties. It would be subject to the same two objections noted above—concerning inefficient targeting and singles penalties—but to a lesser degree. If marriage penalties are a major concern, such a compromise merits serious consideration.

A different solution to the marriage penalty problem would be to disregard marital status for purposes of the credit phaseout, or in other words, to base the phaseout only on an individual's own income. Whatever the merits of this approach in the abstract, it seems unreasonable to abandon joint filing solely for this purpose, since joint filing remains the rule for all other federal income tax purposes. This approach would also be objectionable because a low-income spouse of a high-income earner would be eligible for the credit, and because one-income couples would incur a sort of homemaker penalty.[33]

E. An Alternative Credit Design

An alternative to a credit for 100 percent of the first $2,000 (index-adjusted) of the cost of insurance would be a credit for some lower percentage (e.g., 60%) of the cost of insurance, but with a substantially higher ceiling (or even no ceiling) on creditable insurance costs. Various combinations of lower credit percentages and higher ceilings could be found which would have approximately the same program cost as the proposed 100 percent credit. The major attraction of this alternative is that, unlike the credit proposed above, those people who have higher than average insurance costs, because of high-cost location or poor health, would receive a larger subsidy.[34] But this alternative might severely depress the participation rate, compared to the credit proposed above. A study by M. Susan Marquis and Stephen H. Long suggests that a credit of 100 percent (or nearly 100%) is necessary to achieve a high participation rate.[35]

Of course, some people in high-cost areas or in poor health will have to pay for part of their insurance even with the 100 percent credit, because of the $2,000 ceiling on the base credit amount. The same is true of participants whose credit amount is reduced by the phaseout. For those people, the Marquis and Long results suggest a participation

rate problem even with the 100 percent (but capped and phased out) credit. Still, the proposed credit would achieve high participation by low-income healthy people in low- and moderate-cost areas, which is more than could be expected if everyone were entitled to just a 60 percent credit.

VII. REGULATOR PERSPECTIVE

This section describes the operational flow of the credit system from the perspective of the Internal Revenue Service.

A. The Basic System

The following steps would apply in the case of a taxpayer who was eligible to participate in the credit program from the beginning of the year.

1. The taxpayer files a form shortly before the beginning of the year, indicating that he expects to be eligible for the HITC. The form will require the taxpayer's age and sex, a statement that the taxpayer does not expect to have health insurance coverage from another source, and an estimate of anticipated MAGI. A similar form (W-5) is currently used for the advance payment option of the EIC. Alternatively, a taxpayer could choose not to seek an advance payment; if she met all eligibility requirements she could still claim the credit after the end of the year, with the reconciliation form described in step 6.

2. Based on this form, the IRS sends the taxpayer a notice indicating the amount of the advance credit to which the taxpayer is entitled.

3. The taxpayer selects an insurer and notifies the IRS of the selection.

4. The IRS makes premium payments directly to the insurer selected by the taxpayer.[36] The process described in steps 2 through 4 does not involve a voucher, in the sense of a physical object such as a food stamp.

5. The taxpayer must pay the portion of the premium not covered by the advance payment. A participant could send a check to the insurer, but for participants who are employed the payroll deduction system described above (in section V.G.) would be much simpler.

6. After the end of the year, the taxpayer files a reconciliation form as an attachment to her Form 1040; reconciliation may result in either recapture of some of the advance credit or payment of an additional credit amount to the taxpayer.

B. Taxpayer Loses Other Insurance Coverage During the Year, Thus Becoming Credit-Eligible

The following steps would apply in the case of a taxpayer who became eligible to participate at some time after the beginning of the year because of loss of other health insurance coverage during the year.[37]

1. The taxpayer files a form with the IRS, indicating that she is now eligible for the credit, because she no longer has other health insurance (employer-sponsored, Medicaid, or Medicare).

2. The IRS calculates the advance payment to which the taxpayer is entitled for the remainder of the year, and notifies her of the result.[38]

3–6. The remaining steps are the same as those described above for a taxpayer who was credit-eligible for the entire year.

C. Taxpayer Obtains Other Coverage During the Year, Thus Becoming Credit-Ineligible

A midyear correction is also necessary if a taxpayer who has been receiving advance payments becomes credit-ineligible during the year, because she obtains employer-sponsored health insurance or coverage under Medicaid.

1. The taxpayer files a form with the IRS, indicating that she is no longer eligible for the credit because she has obtained other health insurance coverage.

2. The IRS receives the form and stops making advance payments to the insurer on the taxpayer's behalf.[39]

D. Changed Circumstances During the Year Decreasing the Expected Credit Amount

Suppose a taxpayer has been receiving advance payments based on a filing which indicated expected income low enough that the phaseout would not apply, but that during the year it becomes clear to the taxpayer that his income for the year will be higher than expected, and that the phaseout will reduce the amount of his credit, or, at the extreme, make him ineligible for any credit. It would be possible to require the taxpayer to notify the IRS of the change, so that the IRS could reduce or eliminate the advance payments. On balance, however, it seems better to make notification optional under these circumstances, to avoid imposing too much complexity on HITC participants. In many cases, the 60 percent limitation will prevent the advance payments from exceeding the total amount of the

credit, even for those who earn higher income than expected during the year. Of course, if a taxpayer chooses not to give the IRS the optional notification and advance payments do exceed the correct credit amount, the end-of-year reconciliation procedures will apply. A taxpayer who wants to avoid repaying part of the advance payments can file the optional notification. This would also reduce the risk of interest charges if repayment is not timely, and the risk of a penalty for underpayment of estimated tax.

Entitlement to an unexpectedly low credit amount could also result because the number of people for which the credit is claimed decreases during the year (e.g., one spouse obtains employer-sponsored coverage during the year, but the other spouse continues with credit-eligible insurance). In this situation, taxpayer notification of the IRS should be mandatory. The bright line nature of the change makes a duty to notify easier on the taxpayer than a duty to notify because of unexpectedly high income, and the decrease in the amount of the credit because of the change will be substantial.

E. Changed Circumstances During the Year Increasing the Expected Credit Amount

Some credit-eligible taxpayers receiving advance payments may become *more* credit-eligible during the year. The most obvious causes would be unexpectedly low income, reducing or eliminating the effect of the phaseout, and an increase in the number of credits claimed. The addition of a new family member would also increase the income level at which the phaseout begins. The system should be responsive to changing circumstances, but the IRS should not be overburdened. A reasonable compromise is to permit midyear filing to increase the advance payment amount in only two circumstances: (1) change of work status from employed to unemployed, and (2) an increase in the number of credits claimed (i.e., claiming an additional credit for a spouse or adult dependent who becomes credit-eligible during the year). Even when an increase in the advance payment is not permitted, the calculation of the final credit amount (as determined after the close of the year) will reflect all the relevant facts for the year.

VIII. TARGET POPULATION PERSPECTIVE

See section VII, which describes the flow of the system in terms of both the IRS and the covered worker. The major administrative burden for the worker will be the need to file a new form before the beginning of the year in order to be eligible for the advance payment. It should be possible to make the form simple enough so that few people would need to use a commercial return preparer for the form. Taxpayers would also need to prepare the reconciliation form as a 1040 attachment; it seems unlikely that many taxpayers who currently prepare their own returns would switch to commercial preparers

because of this new attachment. It should be no more complicated than the EIC calculations to which most of the target population is already subject.

The procedural burden—and accompanying risk of non-participation—would be greater, of course, for anyone who would be eligible for the credit but who does not currently file a Form 1040. Since the target population—the *working* poor and near-poor—is basically the same as that of the EIC, however, virtually all people eligible for the health insurance credit *should* already be filing to obtain the EIC. An aggressive campaign would be in order to reach current non-filers who fail to obtain the EIC to which they are entitled, and who would suffer the additional loss of not obtaining the health insurance credit if they continue not to file.

The target population may face two cash-flow problems, both of which may discourage some eligible people from participating. First, credit recipients will have to pay part of the premiums themselves, either permanently (for those in the phaseout range) or temporarily (because the advance payment is limited to less than the full credit). A payroll deduction would ease the procedural but not the financial burden of these payments. In addition, some eligible people may decide not to participate in order to avoid the possibility that they will have to repay part of the advance credit at the time of the required reconciliation.

IX. SUCCESS

The obvious measure of success is the number of newly insured people per dollar spent on the program. Two items of particular interest are the participation rate by those currently uninsured (take-up) and the extent to which those currently covered by employer-plans switch to the credit to obtain a larger subsidy (crowd-out). The compromise initially chosen between take-up and crowd-out concerns can be adjusted based on experience. If crowd-out proves to be a major problem initially, Congress could experiment with a less generous credit, to see if the gain in reduced crowd-out would exceed the loss from decreased take-up.

APPENDIX

This Appendix describes three advance payment/reconciliation systems, which could be used as alternatives to the proposed system.

1. *Full advance payment with reconciliation.* One possibility (the simplest to describe, but not the simplest to administer) would be to use advance payments equal to *100 percent* of the expected credit, with reconciliation after the end of the year in connection with that year's income tax return. This would undoubtedly lead to major reconciliation problems resulting both from genuinely surprised taxpayers and from intentionally low estimates of expected income. The burden on the IRS—of collecting credit overpayments from thousands upon thousands of low- and moderate-income taxpayers with few assets—would be considerable, if not overwhelming.

2. *The one-year delay system.* Another possibility would be to use *last* year's income (MAGI) for the purpose of determining *this* year's advance payment. The attraction of this approach is that last year's income is objectively determinable, whereas a forecast of the coming year's income is only a guess. One drawback, of course, is that very large income fluctuations may occur from year to year. The other drawback—which is probably even more serious—is that this year's phaseout could not be calculated until last year's return had been filed. The advance payments for the first four (or so) months of the year would have to be determined using some other method. One possibility would be to use the MAGI from *two* years ago for the first four months, but a system that slow to respond to changing circumstances does not seem attractive.

3. *Require more frequent reporting of income by advance payment recipients.* Another possibility would be to have no initial taxpayer estimate of annual income, but instead to require the taxpayer to report income to the IRS periodically (e.g., monthly or quarterly) during the year. The IRS would pay the credit periodically (e.g., monthly premium payments from the government directly to the insurer), and would use some sort of annualizing-of-income approach to determine the appropriate credit amount for each period.

   Example. Suppose the full credit amount is $2,000 and the phaseout starts at $24,000 AGI. If a taxpayer reports $2,000 income in each of the first 10 months of the year, then his annualized income will be $24,000 for each of those 10 months,

and he will get the full credit amount ($167) for each of the first 10 months. For November the taxpayer reports $4,000 income. This would change the calculation of annualized income, although different annualization methods are possible. One would be to calculate annualized income as $26,184 (i.e., $24,000 income year-to-date x 12/11); another would be to assume that this month's increase is permanent, so annualized income is calculated to be $28,000 (i.e., assuming December's income will also be $4,000). Assume for illustration the method producing $28,000 is used. At a 15 percent phaseout rate, the annual credit is now calculated as $1,400. Since the taxpayer has already received advance payments of $1,667, he gets no credit this month (and no credit next month, unless his December income turns out to be very low), and he will also owe $267 of credit recapture at the end of the year (if his December income is, in fact, $4,000). The taxpayer could keep the insurance in force for the no-credit months by paying the entire premium himself.

The burden of monthly reporting and credit calculation is substantial, and even with that burden the need for end-of-year recapture is not eliminated. On the other hand, in the example the recapture amount is reduced from $600 to $267 (compared to a system that simply uses an initial estimate without reporting during the year). In addition to reduced recapture, this system would be less susceptible to cheating (or taxpayers resolving doubts in their own favor) than a system based on an initial estimate. The problem with this system, of course, is that it imposes especially heavy burdens on both the IRS and the participant.

NOTES

[1] U.S. General Accounting Office, *Tax Policy: Health Insurance Tax Credit Participation Rate Was Low*, Report Number GGD-94-99, May 2, 1994.

[2] Because of the phaseout, participants with incomes above that level will incur some permanent out-of-pocket cost.

[3] The phaseout of the credit for an adult dependent is based on the income of the supporting person, not on the income of the dependent. For purposes of this rule, a person is a dependent if he is claimed (or is eligible to be claimed) as a dependent on another person's federal income tax return.

[4] It is worth noting, however, that the credit may cause a general decrease in the cost of non-group health insurance. The subsidy should increase the incidence of the purchase of non-group insurance by healthy people, thus decreasing adverse selection, which in turn should decrease premiums.

[5] The index for women ages 35–44 is 1.431.

[6] It would also be possible, in theory, to adjust the amount of the credit for regional differences in the cost of health insurance. This seems politically out of the question, however, given the firmly established tradition of not adjusting income tax rate brackets to take into account regional differences in the cost of living. It might also be subject to constitutional challenge under the tax uniformity clause. (U.S. Constitution, Art. I,. sec. 8, requires that "all Duties, Imposts and Excises shall be uniform throughout the United States.") In any event, regional cost differences are small compared with age and sex differences. Costs in the highest-cost region (New England) are about 30% higher than costs in the lowest-cost region (the Mountain West). In contrast, the index number for women in the 55–64 age group is 325% of the index number for 25–34-year-old men.

[7] If a single taxpaying unit claimed more than one credit (e.g., for husband and wife, or for parent and dependent adult child), each credit would be $2,000 multiplied by the index number for the covered individual.

[8] Examples include IRC secs. 22(b)(1) (a taxpayer must be at least 65 to claim the credit for the elderly), 32(c)(1)(A)(ii) (the earned income tax credit for childless workers is available only to people 25 to 64), and 63(f) (providing an increased standard deduction for taxpayers 65 or older).

[9] IRC sec. 213(d)(10)(A).

[10] IRS Publication 1457.

[11] In U.S. v. Virginia, 518 U.S. 515 (1996), the Supreme Court stated that "exceedingly persuasive justification" is needed to defend the constitutionality of sex-based classifications. The Court held that Virginia's operation of a military college open only to men could not meet this demanding constitutional standard. The Court noted, however, that "physical differences between men and women are enduring," and suggested that a classification based on physical differences between the sexes might pass constitutional muster, if the classification was not "used . . . to create or perpetuate the legal, social, and economic inferiority of women."

In the tax case most nearly on the point, the Second Circuit upheld against a constitutional challenge sex-based valuation tables which formerly applied for estate tax purposes. Manufacturers Hanover Trust Co. v. U.S., 775 F2d 459 (2d Cir. 1985). The Second Circuit distinguished Los Angeles v. Manhart, 435 U.S. 702 (1978), in which the Supreme Court had ruled that an employer violated Title VII of the Civil Rights Act of 1964 by requiring women to make larger pension fund contributions than men to compensate for women's longer life expectancies. The Second Circuit explained (among other grounds of distinction) that "Title VII's standard is not the same as the standard set by the equal protection component of the Fifth Amendment."

This brief review of the cases suggests that sex-based adjustments to the credit would probably, but not definitely, survive constitutional scrutiny. In defense of the constitutionality of a sex-based adjustment, it is noteworthy that the income tax exclusion for employer-provided health insurance has a similar (but less obvious) sex-based effect. Because health insurance for a 35-year-old woman is worth more than health insurance for a 35-year-old man, a tax exemption for the insurance received by both

results in a larger tax benefit for the woman. No one has ever suggested that differential effect violates the Constitution.

[12] For example, the index numbers for people ages 25–34 are 0.574 for men and 1.153 for women.

[13] For $2,000 a healthy young man should be able to buy non-group insurance with first-dollar coverage and no coinsurance, or nearly so.

[14] COBRA insurance is not considered employer-sponsored for purposes of the credit-eligibility determination. Thus a person who lost his job and elected under COBRA to stay with his ex-employer-sponsored health insurance would be eligible for the credit. He would not be forced to choose between the benefit of COBRA and the benefit of the HITC.

[15] This problem is discussed in section VI.A. of the paper.

[16] For a similar example, expanded to include the operation of the advance payment system, see footnote 21.

[17] This point is discussed more fully in section V.F. of this paper.

[18] U.S. General Accounting Office, *Earned Income Tax Credit: Advance Payment Option Is Not Widely Known or Understood by the Public* 3 (GAO/GGD-92-26, 1992) (in 1989 less than one-half of one percent of those eligible and claiming the EIC took advantage of the advance payment option).

[19] But see Pamela Farley Short, "Hitting a Moving Target: Income-Related Health Insurance Subsidies for the Uninsured," *Journal of Policy Analysis and Management* (Summer 2000). Short reports the results of simulations involving health insurance subsidies with advance payments and year-end reconciliation, and subsidies using definitive determinations of eligibility (i.e., with no year-end reconciliation) based on *last* year's income. She finds that not requiring reconciliation has a favorable effect on the participation rate by "true eligibles" (73% participation with no reconciliation, and 69% when reconciliation is required). She concludes that, despite the unavoidable inaccuracies in a system without reconciliation, "policymakers should not be afraid to give serious consideration to the possibility of guaranteeing subsidies for 6 to 12 months on a prospective basis."

Short's suggestion differs from the system described in part 2 of the Appendix, which would base prepayments of the credit on the previous year's income, but still require reconciliation based on actual income for the credit year. The objection to the system described in the Appendix is administrative complexity; the objection to Short's suggestion is the permanent inaccuracy in the targeting of the credit in cases where the previous year's income and the credit year's income differ significantly.

[20] Three other possible systems, which strike different balances between accuracy and participation concerns, are described in the Appendix.

[21] If, for example, the taxpayer's income estimate and index number indicated that he would be eligible for only a $1,500 credit, then the advance payment would be limited to $900 (60% of $1,500) for the year, or $75 per month.

[22] This is not a problem with the EIC, because whether or not one participates in the advance payment program, EIC participation never requires the taxpayer to be out-of-pocket any amount.

[23] Some mechanism enabling workers to pay a portion of premiums will be necessary, even if the advance payment is for the entire amount of the expected credit. Workers in the phaseout range will have to pay part of the cost of their insurance, and some workers in poor health will have to pay more than their full credit amount for non-group insurance.

[24] 42 U.S.C. sec. 666(a)(1)(A), (b). The statute permits, but does not require, states to provide for a payment to employers to cover the costs of processing the required payroll deductions. 42 U.S.C. sec. 666(b)(6)(A).

[25] 20 U.S.C. sec. 1095a.

[26] As noted earlier, however, the credit may decrease the significance of adverse selection in the non-group market.

[27] Estimates provided by Jonathan Gruber of MIT.

[28] The total number of currently insured people expected to take up the credit is 14.4 million. This includes, in addition to the 8.1 million who already had non-group insurance, 5.3 million previously covered by ESI, and 1.0 million previously covered by Medicaid.

[29] Premiums for non-group health insurance are theoretically deductible as medical expenses under IRC sec. 213(d)(1)(D), but this is a chimera for most people, because medical expenses are deductible only to the extent they exceed 7.5% of AGI (IRC sec. 213(a)), and even that excess is deductible only by taxpayers who itemize deductions (rather than claiming the standard deduction).

[30] Estimates provide by Jonathan Gruber of MIT. Note that estimates in Table 1B are based on a non age- and sex-adjusted tax credit.

[31] Generally speaking, income phaseouts of tax credits and other low-income subsidies are a bad idea. A phaseout functions as a hidden marginal rate increase (a marginal rate "bubble") over the phaseout range. As a result, the marginal rate structure is regressive—i.e., taxpayers with incomes above the phaseout range are subject to lower marginal tax rates than those lower-income taxpayers within the phaseout range. In the absence of a phaseout, high-income taxpayers would be notionally entitled to the credit (or other subsidy), but the credit would be effectively taxed away, even without a marginal rate bubble, in the sense that eventually tax liability exceeds the credit. A credit that is not phased out is not objectionable on distributional grounds as long as the combination of the tax rate structure and the credit produces net tax burdens (i.e., tax liabilities net of credit) which are considered distributionally appropriate. See Daniel Shaviro, *The Minimum Wage, the Earned Income Tax Credit, and Optimal Subsidy Policy,* 64 U. of Chi. L. Rev. 405, 462–466 (1997). If we were starting from scratch, then, the most attractive approach to a health insurance subsidy might be a universal (i.e., not phased out) tax credit to replace both Medicaid and the current exclusions for employer-provided insurance.

Even though phaseouts are unattractive, an incremental reform intended only to fill the subsidy and coverage gaps between Medicaid and the income tax and wage tax exclusions for employer-provided insurance must be considered differently. If not phased out, the credit would be available to middle- and high-income workers, and in some (perhaps many) cases would be more attractive than the alternative of tax-favored employer-provided insurance. This would result in significant crowd-out, while having virtually no positive effect on coverage rates (since the vast majority of middle- and high-income workers already have health insurance).

[32] Unmarried, each would be entitled to a $2,000 credit, for a combined subsidy of $4,000. Married, their combined income of $33,800 exceeds $22,500 by $11,300. Applying the 15% phaseout rate to $11,300 reduces their combined credits by $1,695, from $4,000 to $2,305.

[33] For example, a couple in which each spouse earns $16,900 would be entitled to two $2,000 credits, whereas a couple in which the husband earns $33,800 and the wife earns nothing would be entitled to only one credit, for the wife. The husband's credit would be completely phased out.

[34] Another arguable advantage is that requiring participants to pay part of the cost of their insurance reduces the likelihood of purchases of "snake oil" policies providing very poor coverage. A person who must pay for part of his insurance himself will have more incentive to make sure the policy provides fair value. If this is considered a serious problem, however, a better-targeted solution would be to impose actuarial value requirements on all policies as a condition of credit eligibility.

[35] M. Susan Marquis & Stephen H. Long, "Worker Demand for Health Insurance in the Non-Group Market," *Journal of Health Economics* 14 (1995): 47–63 (predicting a low participation rate for a credit for 60% of the cost of health insurance).

[36] It is not crucial to the proposal how often the government pays the insurer. However, frequent (e.g., monthly) payments have two significant advantages: (1) it they are more likely to match the timing of the payment of an employee's share of premium cost by payroll deduction, and (2) they allow greater flexibility to increase or decrease advance payments because of changed circumstances during the year. With electronic funds transfers, monthly payments should not be unduly burdensome on the IRS.

[37] The same procedure could be made available to a taxpayer who originally did not file the advance payment request form because she expected to have disqualifyingly high income, but who discovers during the year that her income will be low enough to make her eligible for the HITC. If the

procedure is made available in that situation, it should probably be limited to taxpayers who become unemployed during the year. This limitation relates, of course, only to eligibility for advance payments. A taxpayer may receive no advance payments and still claim the credit on her tax return for the year, if she meets all eligibility requirements.

[38] The phaseout rules will have a dramatic effect on some people who lose employer-sponsored health insurance during the year. Consider, for example, a childless single person who loses his $70,000 job (and his employer-sponsored health insurance) at the end of June. Even if he remains unemployed for the remainder of the year, he will not be entitled to any credit; his credit phaseout is complete at about $30,000 annual income, and his income is already $35,000. This is an unavoidable problem with any tax-based system: it cannot be very responsive to changing circumstances, because an annual accounting system must be used for eligibility determinations.

Once the effect (if any) of the phaseout has been calculated, both the advance credit amount and the ultimate amount of the credit are prorated according to the portion of the year for which the taxpayer meets the credit eligibility standards. Suppose, for example, that a taxpayer became credit-eligible at the beginning of April (the fourth month), and that if she had been credit-eligible for the entire year her total credit (after taking the phaseout and the index number into account) would have been $2,000 and her advance payment would have been $1,200. With proration her total credit is $1,500 and her advance payment is $900 (i.e., $100 per month for nine months).

[39] The total credit to which the taxpayer is entitled for the year is determined by the same proration method described in the preceding footnote.

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#442 *Incremental Coverage Expansion Options: Detailed Table Summaries to Accompany Option Papers Commissioned by The Commonwealth Fund Task Force on the Future of Health Insurance* (January 2001). Sherry A. Glied and Danielle H. Ferry, Joseph L. Mailman School of Public Health, Columbia University. This paper, a companion to publication #415, presents a detailed side-by-side look at all the option papers in the series Strategies to Expand Health Insurance for Working Americans.

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#421 *Markets for Individual Health Insurance: Can We Make Them Work with Incentives to Purchase Insurance?* (December 2000). Katherine Swartz, Harvard School of Public Health. Efforts to improve the functioning of individual insurance markets require policy makers to trade off access for the highest-risk groups against keeping access for the lowest risk-groups. This paper, part of the series Strategies to Expand Health Insurance for Working Americans, discusses how individual insurance markets might best be designed in view of this trade-off.

#420 *A Workable Solution for the Pre-Medicare Population (December 2000).* Pamela Farley Short, Dennis G. Shea, and M. Paige Powell, Pennsylvania State University. Adults nearing but not yet eligible for Medicare are at high risk of being uninsured, especially if they are in poor health. This paper, part of the series Strategies to Expand Health Insurance for Working Americans, proposes new options to enable those 62 and older early buy-in to Medicare (or to subsidize other coverage) through premium assistance for those with low lifetime incomes and new health IRA or tax-deduction accounts for those with higher incomes.

#419 *Allowing Small Businesses and the Self-Employed to Buy Health Care Coverage Through Public Programs* (December 2000). Sara Rosenbaum, Phyllis C. Borzi, and Vernon Smith. Public programs such as CHIP and Medicaid offer the possibility of economies of scale for group coverage for small employers as well as individuals. This paper, part of the series Strategies to Expand Health Insurance for Working Americans, proposes allowing the self-employed and those in small businesses to buy coverage through these public plans, and providing premium assistance to make it easier for them to do so.

#418 *A Federal Tax Credit to Encourage Employers to Offer Health Coverage* (December 2000). Jack A. Meyer and Elliot K. Wicks, Economic and Social Research Institute. Employers who do not currently offer health benefits to their employees cite costs as the primary concern. This paper, part of the series Strategies to Expand Health Insurance for Working Americans, examines the potential of offering tax credits (or other financial incentives) to employers of low-wage workers to induce them to offer coverage.

#417 *Public Subsidies for Required Employee Contributions Toward Employer-Sponsored Insurance* (December 2000). Mark Merlis, Institute for Health Policy Solutions. Some uninsured workers have access to employer group coverage but find the cost of their premium shares unaffordable. This paper, part of the series Strategies to Expand Health Insurance for Working Americans, examines the potential for using a tax credit or other incentive to help employees pay their share of premium costs in employer-sponsored plans. The paper analyzes how such premium assistance might work as an accompaniment to a tax credit for those without access to employer plans.

#416 *Transitional Subsidies for Health Insurance Coverage* (December 2000). Jonathan Gruber, Massachusetts Institute of Technology and The National Bureau of Economic Research, Inc. The unemployed and those switching jobs often lose coverage due to an inability to pay premiums. This paper, part of the series Strategies to Expand Health Insurance for Working Americans, suggests ways that the existing COBRA program could be enhanced to help avoid these uninsured spells.

#414 *Increasing Health Insurance Coverage Through an Extended Federal Employees Health Benefits Program* (December 2000). Beth C. Fuchs, Health Policy Alternatives, Inc. The FEHBP has often been proposed as a possible base to build on for group coverage. This paper, part of the series Strategies to Expand Health Insurance for Working Americans, proposes an extension of FEHBP (E-FEHBP) that would operate in parallel with the existing program. The proposal would require anyone qualifying for a tax credit to obtain it through E-FEHBP and would also permit employees of small firms (<10 workers) to purchase health insurance through the program. The proposal would also provide public reinsurance for E-FEHBP, further lowering the premium costs faced by those eligible for the program.

#413 *Private Purchasing Pools to Harness Individual Tax Credits for Consumers* (December 2000). Richard E. Curtis, Edward Neuschler, and Rafe Forland, Institute for Health Policy Solutions. Combining small employers into groups offers the potential of improved benefits, plan choice, and/or reduced premium costs. This paper, part of the series Strategies to Expand Health Insurance for Working Americans, proposes the establishment of private purchasing pools that would be open to workers (and their families) without an offer of employer-sponsored insurance or in firms with up to 50 employees. All tax-credit recipients would be required to use their premium credits in these pools.

#425 *Barriers to Health Coverage for Hispanic Workers: Focus Group Findings* (December 2000). Michael Perry, Susan Kannel, and Enrique Castillo. This report, based on eight focus groups with 81 Hispanic workers of low to moderate income, finds that lack of opportunity and affordability are the chief obstacles to enrollment in employer-based health plans, the dominant source of health insurance for those under age 65.

#424 *State and Local Initiatives to Enhance Health Coverage for the Working Uninsured* (November 2000). Sharon Silow-Carroll, Stephanie E. Anthony, and Jack A. Meyer, Economic and Social Research Institute. This report describes the various ways states and local communities are making coverage more affordable and accessible to the working uninsured, with a primary focus on programs that target employers and employees directly, but also on a sample of programs targeting a broader population.

#411 *ERISA and State Health Care Access Initiatives: Opportunities and Obstacles* (October 2000). Patricia A. Butler. This study examines the potential of states to expand health coverage incrementally should the federal government decide to reform the Employee Retirement Income Security Act (ERISA) of 1974, which regulates employee benefit programs such as job-based health plans and contains a broad preemption clause that supercedes state laws that relate to private-sector, employer-sponsored plans.

#392 *Disparities in Health Insurance and Access to Care for Residents Across U.S. Cities* (August 2000). E. Richard Brown, Roberta Wyn, and Stephanie Teleki. A new study of health insurance coverage in 85 U.S. metropolitan areas reveals that uninsured rates vary widely, from a low of 7 percent in Akron, Ohio, and Harrisburg, Pennsylvania, to a high of 37 percent in El Paso, Texas. High proportions of immigrants and low rates of employer-based health coverage correlate strongly with high uninsured rates in urban populations.

#405 *Counting on Medicare: Perspectives and Concerns of Americans Ages 50 to 70* (July 2000). Cathy Schoen, Elisabeth Simantov, Lisa Duchon, and Karen Davis. This summary report, based on *The Commonwealth Fund 1999 Health Care Survey of Adults Ages 50 to 70,* reveals that those nearing the age of Medicare eligibility and those who recently enrolled in the program place high value on Medicare. At the same time, many people in this age group are struggling to pay for prescription drugs, which Medicare doesn't cover.

#391 *On Their Own: Young Adults Living Without Health Insurance* (May 2000). Kevin Quinn, Cathy Schoen, and Louisa Buatti. Based on The Commonwealth Fund 1999 National Survey of Workers' Health Insurance and Task Force analysis of the March 1999 Current Population Survey, this report shows that young adults ages 19–29 are twice as likely to be uninsured as children or older adults.

#370 *Working Without Benefits: The Health Insurance Crisis Confronting Hispanic Americans* (March 2000). Kevin Quinn, Abt Associates, Inc. Using data from the March 1999 Current Population Survey and The Commonwealth Fund 1999 National Survey of Workers' Health Insurance, this report examines reasons why nine of the country's 11 million uninsured Hispanics are in working families, and the effect that lack has on the Hispanic community.

#364 *Risks for Midlife Americans: Getting Sick, Becoming Disabled, or Losing a Job and Health Coverage* (January 2000). John Budetti, Cathy Schoen, Elisabeth Simantov, and Janet Shikles. This short report derived from The Commonwealth Fund 1999 National Survey of Workers' Health Insurance highlights the vulnerability of millions of midlife Americans to losing their job-based coverage in the face of heightened risk for chronic disease, disability, or loss of employment.

#363 *A Vote of Confidence: Attitudes Toward Employer-Sponsored Health Insurance* (January 2000). Cathy Schoen, Erin Strumpf, and Karen Davis. This issue brief based on findings from The Commonwealth Fund 1999 National Survey of Workers' Health Insurance reports that most Americans believe employers are the best source of health coverage and that they should continue to serve as the primary source in the future. Almost all of those surveyed also favored the government providing assistance to low-income workers and their families to help them pay for insurance.

#362 *Listening to Workers: Findings from The Commonwealth Fund 1999 National Survey of Workers' Health Insurance* (January 2000). Lisa Duchon, Cathy Schoen, Elisabeth Simantov, Karen Davis, and Christina An. This full-length analysis of the Fund's survey of more than 5,000 working-age Americans finds that half of all respondents would like employers to continue serving as the main source of coverage for the working population. However, sharp disparities exist in the availability of employer-based coverage: one-third of middle- and low-income adults who work full time are uninsured.

#361 *Listening to Workers: Challenges for Employer-Sponsored Coverage in the 21st Century* (January 2000). Lisa Duchon, Cathy Schoen, Elisabeth Simantov, Karen Davis, and Christina An. Based on The Commonwealth Fund 1999 National Survey of Workers' Health Insurance, this short report shows that although most working Americans with employer-sponsored health insurance are satisfied with their plans, too many middle- and low-income workers cannot afford health coverage or are not offered it.

#262 *Working Families at Risk: Coverage, Access, Costs, and Worries—The Kaiser/Commonwealth 1997 National Survey of Health Insurance* (April 1998). This survey of more than 4,000 adults age 18 and older, conducted by Louis Harris and Associates, Inc., found that affordability was the most frequent reason given for not having health insurance, and that lack of insurance undermined access to health care and exposed families to financial burdens.