Tax Subsidies for Health Insurance: Micro-Simulation Estimates of Costs and Benefits

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The fact that uninsurance rates in the U.S. continue to rise, despite an economic boom that has had only one interruption in 15 years and low levels of health care cost increases, has motivated considerable policy discussion at both the Federal and state levels. At the Federal level, they were one motivation for the Clinton Administration's ultimately unsuccessful attempt to promote comprehensive health system reform. The failure of this attempt has returned the policy focus to incremental reforms, and particularly to the idea of using the tax system to subsidize the purchase of insurance by individuals, an approach that has a certain intuitive appeal. It would provide tax equity by providing financial benefits to those purchasing coverage individually that are now enjoyed only by the self-employed or those with employer-sponsored coverage. It would also rely on the private insurance system rather than a government-sponsored program that might carry stigma for some people. And finally, it can be seen as providing a tax cut rather than creating a more politically controversial new spending program.

Yet while the tax equity argument is compelling – especially given the estimated $100 billion that is now spent each year providing federal tax subsidies for the purchase of employer-sponsored health insurance -- the ability of tax subsidies to meaningfully reduce the number of uninsured remains uncertain and unproven. Moreover, the spectrum of tax-based approaches that have been proposed is quite large, ranging from deductibility of insurance costs for individuals to refundable tax credits that might cover most or all of the cost of typical health insurance policy.

In this paper, we assess the potential implications of a range of tax-based approaches using a new micro-simulation model developed specifically for this purpose. We examine how different characteristics of these proposals are likely to affect such outcomes as: the overall cost to the federal government, the number of the uninsured who would gain coverage, which income groups would

benefit from the subsidies, and how those who now have employer-sponsored coverage would be affected.

Part I: Background

Health insurance is currently subsidized through the tax code in four ways. First, and most importantly, employer payments towards health insurance are excluded from the taxable income of employees. Second, those who spend more then 7.5% of their incomes on health care and health insurance can itemize the excess expenditures on their taxes. Third, workers in firms with a group health insurance plan that qualifies under Section 125 of the IRS code can make their premium contributions on a pre-tax basis. Finally, the self-employed can deduct a portion of their insurance expenditures, currently 60% but rising to 100% by 2003.

Individuals who are not self-employed, but who are not offered employer-provided health insurance, remain outside of the current system of tax subsidies. In addition, much of spending on insurance even by those whose employer spending is tax subsidized is through non-subsidized employee contributions. Using the model described below, we calculate that roughly 16% of the non-elderly population is at a point in time not eligible for a tax subsidy to health insurance.

There are a large number of potential approaches to expanding tax subsidies to health insurance. We model a variety of these different approaches in an effort to consider the impact that different structures have on coverage and costs. We do so using a detailed micro-simulation model that is based on the February/March 1997 Current Population Survey (CPS), augmented with data from a variety of sources on health insurance costs in the group and non-group markets. The central feature of

this model is consideration of a wide variety of behavioral responses to tax subsidies, such as:

- the extent to which the uninsured will purchase insurance if it is subsidized;
- the extent to which those currently holding non-group insurance will takeup the subsidy;
- the extent to which firms will drop group coverage (referred to below as "dropping") or reduce their premium contributions if non-group coverage is subsidized;
- the extent to which those who hold group insurance will switch to non-group insurance if it is subsidized (referred to below as "switching");
- the extent to which those whose employers raise contributions will drop their group insurance and become unemployed

The exact structure of the model, and a detailed description of the behavioral responses we assume, can be found in a background report from the Kaiser Family Foundation.[1]

For this analysis, we will consider the following types of policies:

Refundable Tax Credit for Non-Group Insurance: We first consider the availability of a tax credit for the purchase of insurance that covers insurance costs up to $1000 for singles and $2000 for families (the "base" policy). This credit covers about 43% of the premiums of the typical non-group policy for an uninsured individual, and about 31% of the premiums of the typical uninsured family. This credit is refundable; that is, if the amount of the credit claimed exceeds the individual's tax liability, they can receive a refund for the difference. This is particularly important since 45% of the uninsured do not pay any taxes against which any subsidy can be applied. We assume that the availability of this credit is income-limited; the full amount of the credit is available only to joint filers with taxable incomes of $75,000 or less, phasing out to zero credit at taxable incomes of $100,000; the limits are $45,000 and

$60,000, respectively, for single filers. It is available only for non-employer provided insurance, so that it cannot be used towards the purchase of employer health insurance premiums; but it is available to all persons, even those offered employer-provided health insurance.

Non-Refundable Credit for Non-Group Insurance: We then consider a policy which is identical to that described above, but where the credit is not refundable, so that individuals can only claim it up to the level of their existing tax liabilities.

Deduction for Non-Group Insurance Expenditures: We then consider using instead of a tax credit an unlimited deduction for the costs of non-group insurance. This parallels the tax treatment of employer-provided insurance, with the exception of the fact that employer-provided insurance costs are also shielded from payroll taxation.

Refundable Credit for Non-Group Insurance Restricted to Those Not Offered: We then consider a policy which is identical to the base policy, but which is restricted only to those who are not offered non-group insurance. This approach imposes significant administrative and enforcement difficulties, but has the potential to more tightly target the tax subsidies to those that would otherwise be uninsured.

Refundable Credit for Any Insurance Expenditure: We then consider a policy which is identical to the base policy but applies to <u>any</u> individual insurance expenditure, not just non-group policy purchases. Thus, individuals can use this credit against the cost of their share of employer-provided insurance premiums.

II: Tax Policy: Insurance Coverage and Cost Implications

Base Policy

The impacts of this base case policy on insurance coverage and costs is presented in Tables 1 and 2. Table 1 shows the total cost of the policy; the takeup of the subsidy by various groups, categorized by their pre-subsidy insurance status; and the net change in the size of these groups from before to after the subsidy. We explore in particular, for the employer-insured, the avenues that lead to the net change in this group. Table 2 shows the distributional effects of the policy for different segments of the population relative to the federal poverty line ($17,274 for a family of four). For each group, we show: the net cost and the percent of costs attributable to the group; subsidy takeup in absolute and percentage (relative to group size before the policy impact) terms; the change in the uninsured in absolute and percentage terms; and the cost per newly insured person (i.e., total dollars spent on that group relative to the reduction in the uninsured).

Our key findings are:

- The total cost of this policy is $13.3 billion dollars per year (in $1999).
- Almost 18.4 million persons takeup the subsidy, which is 8.2% of the total non-elderly population.
- Of those taking up, 4.7 million were previously uninsured (11% of the uninsured), 8.6 million were previously covered by non-group insurance (57% of those covered by non-group insurance), 4.7 million were previously covered by employer-provided insurance (3.2% of those covered by employer-provided insurance), and 0.4 million were previously covered by Medicaid (1.8% of those covered by Medicaid).
- On net, the number of uninsured falls by slightly more than 4 million, which is 9.5% of the uninsured population.
- On net, the number of persons with non-group insurance rises by 9.8 million, which amounts to a rise of two-thirds in the size of this group

- On net, the number of persons with employer-provided insurance falls by 5.4 million, which is 3.6% of the size of this group. This change is comprised of:

  - 1.1 million persons whose firms stop offering group insurance, so that they move to the non-group market;
  - 0.1 million persons whose firms stop offering and they become uninsured;
  - 3.6 million persons who switch from group to non-group insurance;
  - and 0.6 million persons who become uninsured because their firms are raising the employee share of insurance premiums and they decide to drop coverage.

While this policy lowers the number of uninsured, it also induces a shift from employer to non-group coverage. Moreover, almost one-half of those taking up the subsidy are persons who are currently already purchasing non-group insurance. As a result, the *net cost of the policy per newly insured person is almost $3300*, which is substantial when compared to average employer-provided insurance costs of $1860 per person covered in our sample, and non-group insurance costs of $2100. That is, due to imperfect targeting, the government is paying about 50% more than the cost of the typical non-group policy per person newly insured.

It is interesting to note that most of the cost of imperfect targeting of this subsidy arises through takeup by the existing non-group insured, not through dropping or switching among the existing employer-insured. While those with employer insurance who drop or switch cost the government money through their takeup of the subsidy, they also save the government revenues by dropping their currently tax subsidized employer coverage. For example, for those workers whose firms drop their health insurance coverage, we assume that their wages will rise to reflect the fact that their employer is no long paying for health insurance, and can therefore afford higher wages. These higher wages will then be taxed, raising new revenues, and offsetting the cost of their takeup of the new insurance subsidy. For those who switch from group to non-group insurance, we assume that the cost savings to

the employer is passed back to workers on average in the form of higher wages (although not specifically to the switching employees), once again raising revenues. And revenues also rise since employers react to this policy to some extent by lowering their pre-tax contributions for health insurance, and once again raise wages to compensate for this.

Given the strong correlation between insurance status and income, it is important to consider not just the aggregate impacts of this subsidy, but its distributional implications as well. There are several findings of note from this distributional analysis, shown in Table 2:

- The lowest income group, which contains 45% of the uninsured, receives about 26% of the net spending on this policy. Only about 1.3 million of the uninsured in this group gain coverage (6.6% of the uninsured below the poverty line); this is about one-third of the total number of uninsured who gain coverage across all income groups. Overall, this policy is more efficient for this subgroup than for the full population, with a cost of $2740 per newly insured. This is primarily because there are few non-group insured taking up the policy in this income range, relative to the number of uninsured taking it up.

- Those between 100% and 200% of poverty, a group that contains another 30% of the uninsured, receive about 30% of the net spending from this policy, and there is a decline in the uninsured of about 1.6 million.

- Those between 200 and 300% of poverty receive almost 20% of the net spending from the policy, but there is a decline in the uninsured of only 0.7 million. As a result, spending is less efficient for this group, with a cost per newly insured of over $3500.

- Those above 300% of poverty receive 24% of the net spending of this policy, but there is only a very small change in the number of uninsured, in large part because there are so few uninsured in this income group. As a result, spending is much less efficient at these higher income levels (over $6000 per newly insured from 300-400% of poverty, and almost $11,000 per newly insured over 400% of poverty).

Thus, a majority of spending under this policy (56%) is targeted to those below 200% of the poverty line, and three-quarters is targeted to those below 300% of the poverty line. But the spending that is done on those above 300% of the poverty line is very inefficient, with a total of $3.3 billion spent

on this group for a reduction in the number of uninsured of only 400,000.

Alternative Policies

While the base policy mimics a number of proposed tax subsidies, there are at the same time a host of alternative structures that have been proposed. While we cannot do justice in this limited space to the full variety of alternatives available to policymakers, we consider several alternative approaches to provide a flavor of how the effects of tax policy change as the structure of the program is altered. We present the key findings for each of these alternatives in Table 3, including: the takeup of the subsidy; the cost; the change in the uninsured, non-group insured, and employer-insured; the cost per newly insured; and the percentage of benefits that flow to those with incomes below 200% of the poverty line.

Making the Credit Non-Refundable: One option that will lower costs substantially, and simplify administration, is to make the subsidy non-refundable. On the other hand, this will severely limit the benefits of this subsidy for the uninsured, more than 60% of whom have tax liabilities less than $1000 (meaning they can only partially benefit from a non-refundable credit).

The impacts of a non-refundable $1000/$2000 credit are presented in the second row of Table 3. This does indeed lower the costs of the subsidy, which fall to almost half the cost of the non-refundable credit ($7 billion). But the impact on the size of the uninsured population falls even more, with fewer than two million uninsured gaining coverage (only 4.3% of the uninsured). As a result, the cost per newly insured person is even higher than with the refundable credit ($3800), largely a function

of the fact that such a high share of the dollars are going to the previously non-group or employer-insured. Moreover, the distributional consequences of this approach are much less attractive. Only 23% of the spending through this policy goes to those below the twice poverty line, and only 2% goes to those below the poverty line.

There are a number of political and administrative arguments against refundability, most significantly the question of whether net tax refunds to low income families are hidden forms of "welfare" payments. But the results here speak clearly: refundability is critical for appropriate targeting of tax incentives to the low income uninsured.

Using a Deduction: Another alternative that can limit costs further is to use a deduction rather than a credit, but this approach has similar problems as non-refundability in reaching the uninsured. Moreover, of the half of the uninsured that do pay taxes, 90% are in the 15% tax bracket, so that a subsidy in the form of a deduction is worth relatively little to them.

The results of an unlimited deduction of non-group health insurance costs are presented in the third row of Table 3; we assume that this is an "above the line" deduction that is available to all taxpayers and not just those that itemize. The costs of this policy are dramatically lower than for the alternatives (only $870 million per year). But the impact on insurance coverage is also much more modest, with only 250,000 uninsured gaining coverage. This is because there is only modest overall takeup of this subsidy by the uninsured to begin with (600,000 persons), and much of this is then offset by firm dropping and reduced coverage due to firm contribution reductions. Estimating with precision the change in the number of uninsured in the range around zero is difficult, but it is clear that effects of

deductibility will likely be minimal on both costs and coverage. At the same time, this policy has much worse distributional characteristics, with less than 30% of the benefits flowing to those below 200% of the poverty line.

Note that the cost that does arise from this policy is not due to takeup by the previously employer-insured; the government actually makes money on this population, with the government revenue from higher wages due to firm dropping and contribution reductions outweighing the government cost of subsidy takeup. Rather, the inefficiency arises primarily from the fact that *three-quarters of those taking up this subsidy were already non-group insured*.

Limiting the Credit to Those Not Offered Employer Coverage: One alternative to try to better target the subsidy is to limit the credit to those not eligible for employer insurance coverage. There are of course difficult administrative issues associated with implementing and enforcing such a policy.[2] But the advantage is that being offered insurance by one's employer is tightly related to being covered by insurance, so this policy provides a device for better targeting subsidy dollars to the currently uninsured.

We consider the impact of a refundable $1000/$2000 credit that is limited to those not offered employer insurance in the next row of Table 3. The total cost of this option is much lower than the base policy, at only $6.2 billion per year, although the number of persons newly insured falls as well (to 2.1 million). The efficiency of this alternative is somewhat better than in the base case, at $2930 per newly insured person. This increase in efficiency arises from the lower takeup of this policy by the existing non-group insured, since many of them are offered employer-provided insurance. On the other hand, there is a much larger increase in the uninsured pool from firm dropping; we estimate that 3.2 million

persons are dropped by their firms, and 630,000 of them remain uninsured.

This policy is somewhat more distributionally attractive than the base policy, with over two-thirds of the benefits flowing to those below 200% of the poverty line. These modest distributional gains, however, must be balanced against the costs and difficulty of enforcing this administratively awkward restriction (which we have not accounted for in the estimates).

Expanding the Subsidy to Apply to All Insurance Spending: An alternative direction is to expand from the base case subsidization of just non-group premiums to subsidization of all spending on insurance, even the employee portion of employer-provided coverage. On the one hand, this would greatly increase costs, as over 70% of the employer-insured pay some or all of their premiums, and all of these costs would be now paid by the government. On the other hand, the Current Population Survey reports that almost 40% of the uninsured are offered group health insurance, and a large subsidy would essentially make insurance free for this population, with dramatic impacts. Moreover, there would be neither firm dropping nor employee switching to non-group insurance under a policy such as this.

The net results of this policy are presented in the next row of Table 3. The cost of the policy is indeed substantial, at $62.2 billion per year. On the other hand, the impact on the uninsured is equally dramatic, with over 12.4 million uninsured gaining insurance coverage. Overall, however, this is the least efficient of the policies considered, with a cost of over $5000 per newly insured person.

This policy has a very broad reach, with over 127 million persons taking it up. This group is of course predominantly comprised of the employer-insured, who takeup the insurance subsidy to cover their share of premiums. Indeed, a major difference between this and earlier policy options is that the

number of employer-insured is rising, not falling, which may be of intrinsic value to some policymakers.

This policy alternative is less distributionally attractive than a refundable credit, but spends a higher share of its dollars at the bottom of the income distribution than does the non-refundable credit or deduction. Only 36.5% of the spending is on those below 200% of the poverty line. It is worth noting, however, that the inefficiency of this policy comes more from its scale than from its structure. As we will show in the next section, the cost per newly insured from this approach is not appreciably higher than that from the base policy that is extended in generosity to provide higher levels of coverage to the uninsured.

Changing the Scale of the Subsidy: While we have chosen a credit of $1000 for singles and $2000 for marrieds as our base case policy, one could consider less or more generous alternatives as well. In the next two rows of Table 3, we consider first halving, then doubling, the generosity of this policy. We find that smaller credits cover fewer people, but do so in a more targeted way. At a credit of $500 for singles and $1000 for marrieds, we estimate costs that are only 30% of the base case, but the reduction in the uninsured is over one-half as large. As a result, the spending per newly insured person is only $2200, which is substantially below even average group costs per person. On the other hand, at a credit of $2000 for singles and $4000 for families, which would approximate the full cost of insurance for these populations, we estimate that costs rise three-fold, but the number of newly insured less than doubles, so that the spending per newly insured rises to $4915 per person. At the same time, the small credit covers only 2.1 million new persons, while the larger credit covers over 7.7 million.

The smaller subsidy also targets its spending more directly at the bottom of the income

distribution, with over 60% of the dollars flowing to those below 200% of poverty. On the other hand, the $2000/$4000 credit spends less than half its dollars on those below 200% of poverty. This worsening of distributional impacts as generosity rises reflects the dramatic increase in takeup by both the (relatively high income) non-group insured and employer-insured.

Thus, there is a clear tradeoff as the generosity of the tax credit is changed. Modest credits cannot deliver a very large change in the uninsured population, but the newly insured that are covered tend to be the lowest income and are low cost. Very large credits can induce substantial changes in the uninsured population, but only at a very steep cost per newly insured.

Easing Liquidity Constraints: A key issue in implementing tax credits is the mismatch between the flow of tax subsidies and the flow of insurance premium payments. Low income households who would like to take advantage of tax credits during a given year, but who only receive their credit the next Spring, may face liquidity problems. If the government can find a solution to this timing mismatch, it can increase the propensity of the uninsured to takeup tax subsidies. A variety of analysts have proposed solutions to this problem, such as paying tax credits directly to insurers.[3] But our track record with the Earned Income Tax Credit (EITC) suggests caution in assuming that this problem is easily overcome: while individuals can claim their EITC throughout the year, and presumably for many individuals it would be of some value to do so, over 99% of claimants receive the credit as a lump sum the next Spring.[4]

While we have assumed that liquidity constraints reduce takeup in our base case calculations, it is important to assess the impact of easing them by assuming that the government solves the liquidity

problem. As shown in Table 3, easing liquidity constraints increases by $1.3 billion the cost of the base policy (absent any additional interest or other costs to the government of easing these constraints), and results in an additional 1.4 million newly insured persons, for a total of 5.5 million newly insured. This implies a substantial increase in the efficiency of the policy, with a cost of only $2683 per newly insured. Moreover, for larger tax credits, the impacts of easing liquidity constraints are also heightened (as shown in the following row of Table 3). For a $2000/$4000 credit, the costs increase by $6 billion per year, but the number of newly insured rises to over 12 million.

III: Conclusions

Federal policymakers continue to look to tax policy as a politically attractive vehicle for addressing the problems of the uninsured in the U.S., making it critical to carefully assess the implications of alternative approaches to tax subsidization. While point estimates of the effects of any major change in health financing cannot be estimated with perfect precision, simulation analyses using common assumptions are particularly useful for comparing the effects of alternative proposals. Our approach in analyzing alternative tax-based mechanisms for covering the uninsured in this way is similar to a recent series of analyses carried out by a Kaiser Family Foundation project on incremental health reform.[5]

We have compared alternative tax policy designs using a consistent set of measures, including: the cost to the federal government, the number of uninsured who gain coverage, the federal cost per person newly insured (a measure of how efficiently federal dollars are being used), and the proportion of benefits that flow to those below 200% of the poverty level (a measure of the degree to which the

policy targets those with low incomes).

There are several clear conclusions from this analysis. First, it is difficult to design a tax policy that insures a large number of new persons at a modest cost per person. The base policy considered here -- a refundable credit of $1000 for singles and $2000 for families -- is more generous than many of the proposals being considered by federal policymakers, and yet still subsidizes less than half of the estimated cost of non-group insurance for a typical person. While it would decrease the number of uninsured by an estimated 4 million persons (less than 10% of the number of uninsured in the U.S.), the average cost per person newly insured is $3300. Raising the value of the credit would insure more people, but also raise the cost per person newly insured significantly.

Second, there are clearly more and less efficient ways to cover a given number of uninsured. We find in particular that non-refundable credits are much more expensive per uninsured person covered, while covering fewer of the uninsured. We also find that policies that can match the timing of tax subsidies with the timing of insurance payments can improve both the scope and efficiency of tax policy.

Third, different approaches to tax subsidies vary also in how effective they are at targeting resources to those with low incomes. For example, a policy that targeted refundable credits of $1000 for singles and $2000 for families towards people would provide 56% of its benefits to those below 200% of the poverty level. In contrast, a policy that allowed people to deduct non-group insurance premiums would provide less than 30% of its benefits to people below 200% of poverty, and a credit that was not refundable would target an even smaller portion of aid to that income group.

Finally, tax-based subsidies – particularly those whose subsidies are most generous – would

likely lead to reductions in the number of people with employer-based coverage. For example, we estimate that the base case would reduce the number of people with employer coverage by 5.4 million. Most of these people (3.6 million) would switch from employer to non-group insurance because they would find the new tax subsidies more attractive than their current situations. However, the remainder would either be dropped by their firms or become uninsured because their employers increased the amount they must pay for insurance. Policies that mitigate firm dropping or switching to non-group insurance by employees (e.g., by allowing the credit to be used towards the purchase of employer coverage) tend to cost more in total and also per person newly covered.

If there are pooling advantages to having individuals obtain their insurance through the workplace, then this is a potential concern with policies targeted only to non-group coverage. Our analysis, in fact, assumes that policies in the individual market are universally available (at health risk adjusted prices). While such "guaranteed issue" in the individual market is required in some states, most states allow insurers to exclude people who are in poor health, which could reduce takeup. It is possible that state or federal regulators could accompany tax subsidies with individual market regulations to limit such practices, but these regulations are controversial. And, the net impact of insurance market reforms in the context of tax subsidies is uncertain, as it would raise costs for the most healthy and lower them for the least healthy.

On the other hand, however, doubling the size of the non-group market (as we estimate would occur in the base policy) could substantially improve the functioning of this market, both in terms of administrative efficiency and reduced adverse selection. And non-group insurance plans might design policies targeted specifically to the available level of the credit, further increasing takeup from what is

modeled here (although this takeup might be in plans with significantly less generous benefits than are typical today). Moreover, de-linking insurance from the workplace could improve the functioning of the labor market by reducing insurance-induced immobility across jobs, or "job lock".

In summary, tax policy does hold some promise as a means of providing health insurance to some of the uninsured, albeit with some potential disruption associated with the shift from employer to non-group coverage.. But providing coverage to substantial numbers will require very large expenditures, both overall and per person newly covered. Even the most effective policy considered here, a $2000/$4000 credit that is accompanied by a solution to liquidity problems, costs almost $40 billion per year and covers only 30% of the uninsured. Thus, tax policy can likely be most useful as one part of an overall strategy to address uninsurance in the U.S., rather than as a solution in and of itself.

Table 1:
Refundable $1000/$2000 Credit for Non-Group Insurance, All Eligible

	Number of Persons (Millions)	Percent of Insurance Category	Net Cost ($1999 Millions)
Total Cost in $1999	----	—	$13,285
Total Takeup of Subsidy	18.37	8.2%	----
Previously non-group	8.60	57.2%	$7,006
Previously uninsured	4.72	11.1%	$4,655
Previously employer-insured	4.68	3.2%	$1,824
Previously Medicaid	0.36	1.8%	-$200
Total Change in Population Size			
Non-group	9.77	65.0%	----
Uninsured	-4.03	-9.5%	----
Employer-Insured	-5.37	-3.7%	----
Firm dropped to non-group	-1.05	-0.7%	---
Firm dropped to uninsured	-0.12	-0.1%	---
Switch to non-group	-3.64	-2.5%	---
Uninsured due to decreased contributions	-0.57	-0.4%	---
Medicaid	-0.36	-1.8%	----
Cost per Newly Insured ($1999)			$3,296

Table 2: Distributional Analysis

Income Group	Net Cost ($1999 Millions)	Percent of Costs Flowing to the Income Group	Overall Subsidy Takeup in Group (Millions)	Percent of Income Group Taking Up	Change in Uninsured Within The Income Group (Millions)	Percent Change in Unins. Within Group	Cost per Newly Insured Within Group ($1999)
<100% of FPL	$3.489	26.2%	4.39	8.6%	-1.27	-6.6%	$2,739
100-200% of FPL	$4,012	30.2%	5.31	11.6%	-1.64	-13.1%	$2,447
200-300% of FPL	$2,478	18.7%	3.50	9.2%	-0.71	-13.1%	$3,506
300-400% of FPL	$1,466	11.0%	2.20	7.7%	-0.24	-11.3%	$6,040
>400% of FPL	$1,840	13.9%	2.97	4.8%	-0.17	-5.3%	$10,956

Table 3: Alternative Policies

	Total Takeup (mns).	Total Cost ($ mn)	Change in Unins. (mns.)	Change in non-group insured (mns.)	Change in employer insured (mns.)	Cost per newly Insured (mns.)	% of Benefits for <200% FPL
Base Policy	18.37	$13,285	-4.03	9.77	-5.37	$3,296	56.4%
Non-Refundable Credit	11.10	$6,978	-1.82	5.95	-4.07	$3,827	23.1%
Deduction	6.32	$871	-0.25	1.59	-1.33	$3,544	26.8%
Limit to Non-Offered	10.03	$6,153	-2.10	6.36	-4.07	$2,927	68.8%
Credit for All Insurance	127.3	$62,177	-12.43	3.41	9.60	$5,003	36.5%
$500/$1000 Credit	11.43	$3,838	-1.71	4.07	-2.14	$2,239	62.2%
$2000/$4000 Credit	32.27	$37,945	-7.72	22.24	-13.95	$4,915	49.2%
No liquidity constraints	19.91	$14,652	-5.46	11.36	-5.37	$2,683	59.5%
$2000/$4000 cap and no liquidity constraints	37.11	$44,345	-12.10	27.13	-13.93	$3,665	54.9%

1.Kaiser Family Foundation (1999). "Tax Subsidies for Health Insurance: Evaluating the Costs and Benefits". Prepared by Jonathan Gruber. Available at www.kff.org.

2.These issues are discussed in "Tax Reform to Expand Health Coverage: Administrative Issues and Challenges." Report prepared for the Kaiser Family Foundation by J. Meyer, S. Silow-Caroll and E. Wicks, 1999. Available at www.kff.org

3. L. Ethridge (1999). "Tax Credits for Uninsured Workers," mimeo, Health Insurance Reform Project of the George Washington University.

4. J. Leibman (1998). "The Impact of the Earned Income Tax Credit on Incentives and Income Distribution," in James Poterba, ed., *Tax Policy and the Economy 12*, 83-120.

5.The Conference Report, by co-chairs Judith Feder and Sheila Burke, is available at http://www.kff.org/content/1999/1531; several expert proposals and issue papers are now available on our website at www.kff.org/docs/sections/kcmu/incrementalreformproject.html.