Tax Subsidies For Health Insurance: Costs And Benefits

Even the most effective tax subsidies would cost almost $40 billion a year and cover only 30 percent of the uninsured.

by Jonathan Gruber and Larry Levitt

PROLOGUE: There is growing support across the political spectrum—from Rep. Dick Armey (R-TX) on the right to Rep. Pete Stark (D-CA) on the left—for using federal tax credits as a sensible way to expand health insurance coverage. Tax credits would support the voluntary purchase of private insurance. However, a key question is how much broadened coverage the federal government could anticipate through this approach. In this paper Jonathan Gruber and Larry Levitt, using a new microsimulation model developed specifically for this purpose, assert that the ability of tax subsidies to greatly reduce the number of uninsured persons remains uncertain and unproven. But they also write that if Congress decides to pursue the expansion of coverage through changes in tax policy, some approaches are distinctly better than others are from the standpoint of sound public policy.

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ABSTRACT: The continued rise in the uninsured population has led to considerable interest in tax-based policies to raise the level of insurance coverage. Using a detailed microsimulation model for evaluating these policies, we find that while tax subsidies could significantly increase insurance coverage, even very generous tax policies could not cover more than a sizable minority of the uninsured population. For example, a generous refundable credit that costs $13 billion per year would reduce the ranks of the uninsured by only four million persons. We also find that the efficiency of tax policies, in terms of the cost per newly insured, inevitably would fall as more of the uninsured were covered.

DESPITE AN ECONOMIC BOOM that has had only one interruption in fifteen years and low levels of health care cost increases, uninsurance rates in the United States continue to rise. This has motivated considerable policy discussion at both the federal and state levels. At the federal level, it was one of the factors that led the Clinton administration to promote comprehensive health system reform. The policy focus has now shifted to incremental reforms, particularly to the idea of using the tax system to subsidize individuals' purchase of insurance. This would provide financial benefits to individual coverage holders that are now enjoyed only by the self-employed or those with employer-sponsored coverage. Also, tax subsidies for buying insurance would rely on the private insurance system rather than on a government-sponsored program that might carry stigma for some people. 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 in yearly federal tax subsidies for the purchase of employer-sponsored health coverage—tax subsidies' ability to meaningfully reduce the number of uninsured persons remains uncertain and unproven. Moreover, the spectrum of tax-based approaches that has been proposed is quite broad, ranging from deductibility of insurance costs for individuals to refundable tax credits that might cover most or all of the cost of a typical health insurance policy.

In this paper we assess the potential implications of a range of tax-based approaches using a new microsimulation model developed specifically for this purpose. We examine how various characteristics of these proposals are likely to affect the overall cost to the federal government, the number of uninsured persons who would gain coverage, which income groups would benefit from the subsidies, and how those who now have employer-sponsored coverage would be affected.

■ **Background.** Health insurance is now subsidized through the tax code in four ways. First, and most importantly, employers' pay-

ments toward health insurance are excluded from employees' taxable income. Second, those who spend more than 7.5 percent of their incomes on health care and health insurance can deduct the excess expenditures on their income tax returns. Third, workers in firms with a group health insurance plan that qualifies under Section 125 of the Internal Revenue Service (IRS) code can make before-tax premium contributions. Finally, the self-employed can deduct from their income tax a portion of their insurance expenditures, currently 60 percent but rising to 100 percent by 2003.

Persons who are not self-employed but who are not offered health insurance by their employers remain outside the current scheme of tax subsidies. In addition, much of the spending on insurance, even by those whose employer spending is tax-subsidized, is through nonsubsidized employee contributions. Using the model described below we calculate that roughly 16 percent of the nonelderly population is not eligible for a tax subsidy for health insurance at some point in time.

■ **Methodology.** In this paper we model a variety of approaches to expand tax subsidies, to consider their impact on health insurance coverage and costs. We use a detailed microsimulation model, based on the February/March 1997 Current Population Survey (CPS) and augmented with data from a variety of sources on health insurance costs in the group and nongroup 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 (1) the uninsured would purchase insurance if it were subsidized; (2) those now holding nongroup insurance would take up the subsidy; (3) firms would drop group coverage or reduce their premium contributions if nongroup coverage were subsidized; (4) those who hold group insurance would switch to nongroup insurance if it were subsidized; and (5) those whose employers raise contributions would drop their group insurance and become uninsured.[1] For this analysis we consider the following types of policies.

Refundable tax credit for nongroup insurance. We first consider the availability of a tax credit for the purchase of insurance that covers insurance costs up to $1,000 for singles and $2,000 for families (the "base" policy). This credit covers about 43 percent of the premiums of a typical nongroup policy for an uninsured individual and about 31 percent of the premiums for a typical uninsured family. This credit is refundable; that is, if the amount of the credit claimed exceeds the individual's tax liability, he or she can receive a refund for the difference. This is particularly important because 45 percent of the uninsured do not pay any taxes against which a subsidy could 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; for single filers, the limits are $45,000 and $60,000, respectively. It is available only for non-employer-sponsored insurance, so that it cannot be used toward the purchase of employer health insurance premiums, but it is available to all persons, even those whose employers offer health insurance.

Nonrefundable credit for nongroup insurance. This policy is identical to the base policy except that the credit is not refundable, so individuals can only claim it up to the level of their existing tax liabilities.

Deduction for nongroup insurance expenditures. We next consider using instead of a tax credit an unlimited deduction for the costs of nongroup insurance. This parallels the tax treatment of employer-sponsored insurance, except that the costs of that insurance also are shielded from payroll taxation.

Refundable credit for nongroup insurance restricted to those not offered insurance. This policy is identical to the base policy but is restricted to those who are not offered nongroup insurance. This approach imposes significant administrative and enforcement difficulties but has the potential to target the tax subsidies more precisely to persons who otherwise would be uninsured.

Refundable credit for any insurance expenditure. Finally, we consider a policy that is identical to the base policy but applies to any individual insurance expenditure, not just to nongroup policy purchases. Thus, persons can use this credit against the cost of their share of employer-sponsored insurance premiums.

Costs And Coverage Under The Base Policy

■ **Aggregate impacts.** Using our microsimulation model we show the impacts of the base policy on the total cost of the policy; the take-up 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 (Exhibit 1). We explore in particular, for the employer-insured, the avenues that lead to the net change in this group.

The total cost of using the base policy would be $13.3 billion per year (in 1999 dollars). Almost 18.4 million persons would take up the subsidy (8.2 percent of the total nonelderly population). Of those taking it up, 4.7 million would be previously uninsured, 8.6 million would be previously covered by nongroup insurance, 4.7 million would be previously covered by employer-sponsored insurance, and 0.4 million would be previously covered by Medicaid. On net, the number of uninsured persons would fall by slightly more than four million, the number of persons with nongroup insurance would rise

EXHIBIT 1
Impact Of A Refundable $1,000/$2,000 Credit For Nongroup Insurance, For All Eligible Persons

	Number of persons (millions)	Percent of category	Net cost ($1999, millions)
Total cost			$13,285
Total take-up of subsidy	18.37	8.2%	–[a]
Previously nongroup	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			
Nongroup	9.77	65.0	–[a]
Uninsured	−4.03	−9.5	–[a]
Employer-insured	−5.37	−3.7	–[a]
Firm dropped to nongroup	−1.05	−0.7	–[a]
Firm dropped to uninsured	−0.12	−0.1	–[a]
Switched to nongroup	−3.64	−2.5	–[a]
Uninsured due to decreased contributions	−0.57	−0.4	–[a]
Medicaid	−0.36	−1.8	–[a]
Cost per newly insured			$3,296

SOURCE: Authors' calculations.
[a] Not applicable.

by 9.8 million, and the number of persons with employer-sponsored insurance would fall by 5.4 million. This latter change would be made up of 1.1 million persons whose firms stopped offering group insurance and who moved to the nongroup market; 0.1 million persons whose firms stopped offering insurance and who became uninsured; 3.6 million persons who switched from group to nongroup insurance; and 0.6 million persons who became uninsured because their firms raised the employee share of insurance premiums and who decided to drop coverage.

While the base policy would lower the number of uninsured persons, it also would induce a shift from employer to nongroup coverage. Moreover, almost half of those taking up the subsidy would be persons who were already purchasing nongroup insurance. As a result, the net cost of the policy per newly insured person would be almost $3,300, which is substantial when compared with average employer-based insurance costs of $1,860 per person in our sample and nongroup insurance costs of $2,100. That is, because of imperfect targeting, the government would pay about 50 percent more than the cost of the typical nongroup policy per newly insured person.

It is interesting to note that most of the cost of imperfect targeting of this subsidy would arise through take-up by those with nongroup insurance, not through dropping group coverage or switching to nongroup insurance by those with job-based insurance. Although persons with employer insurance who dropped or switched insur-

ance would cost the government money through their take-up of the subsidy, they also would save the government revenues by dropping their currently tax-subsidized employer coverage. For example, for those workers whose firms dropped their health insurance coverage, we assume that their wages would rise because their employer would no longer be paying for health insurance and could therefore afford higher wages. These higher wages would then be taxed, raising new revenues and offsetting the cost of their take-up of the new insurance subsidy. For those who switched from group to nongroup insurance, we assume that the cost savings to the employer would be passed back to workers in the form of higher wages (although not specifically to the switching employees), once again raising revenues. Revenues also would rise because employers would react to this base policy to some extent by lowering their pretax contributions for health insurance and again raise wages to compensate for this.

■ **Distributional impacts.** Given the strong correlation between insurance status and income, it is important to consider not just the aggregate impacts of the base-policy subsidy, but its distributional implications as well. Exhibit 2 shows the distributional effects of the policy for different segments of the population relative to the federal poverty level ($17,274 for a family of four). For each group we show the net cost and the percentage of costs attributable to the group; the subsidy take-up 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 (that is, total dollars spent on that group relative to the reduction in the uninsured).

First, we find that the lowest income group, which contains 45 percent of the uninsured, would receive about 26 percent of the net spending on this policy. Only about 1.3 million of the uninsured in this group would gain coverage, which is about one-third of the total number of uninsured who would gain coverage across all in-

EXHIBIT 2
Distributional Analysis Of Model Tax-Subsidy Policy

Income group (percent of FPL)	Net cost ($1999, millions)	Percent of costs flowing to income group	Overall subsidy take-up in group (millions)	Percent of income group taking up	Change in uninsured within income group (millions)	Percent change in uninsured within group	Cost per newly insured within group ($1999)
<100%	$3,489	26.2%	4.39	8.6%	−1.27	−6.6%	$ 2,739
100–200%	4,012	30.2	5.31	11.6	−1.64	−13.1	2,447
200–300%	2,478	18.7	3.50	9.2	−0.71	−13.1	3,506
300–400%	1,466	11.0	2.20	7.7	−0.24	−11.3	6,040
>400%	1,840	13.9	2.97	4.8	−0.17	−5.3	10,956

SOURCE: Authors' calculations.
NOTE: FPL is federal poverty level ($17,274 for a family of four).

come groups. Overall, this policy is more efficient for this subgroup than for the full population, with a cost of $2,739 per newly insured person. This is primarily because there would be few persons with nongroup insurance taking up the policy in this income range, relative to the number of uninsured persons taking it up.

Second, those with incomes between 100 percent and 200 percent of poverty, a group that contains another 30 percent of the uninsured, would receive about 30 percent of the net spending from this policy, and about 1.6 million fewer persons in this group would be uninsured.

Third, persons with incomes between 200 and 300 percent of poverty would receive almost 20 percent of the net spending from the policy, but the number of uninsured persons would fall by only 0.7 million. As a result, spending would be less efficient for this group, with a cost per newly insured person of more than $3,500.

Finally, persons with incomes above 300 percent of poverty would receive 24 percent of the net spending of this policy, but the number of uninsured persons would change only slightly, mostly because so few persons in this income group are uninsured. As a result, spending would be much less efficient at these higher income levels.

Thus, a majority of spending (56 percent) under this policy would be targeted to those with incomes below 200 percent of the poverty level, and three-quarters would be targeted to those with incomes below 300 percent of poverty. But the spending for those above 300 percent of poverty would be very inefficient: A total of $3.3 billion would be spent on this group to reduce the number of uninsured persons by only 400,000.

Costs And Coverage Under Alternative Policies

The base policy mimicks a number of proposed tax subsidies; however, a host of alternative structures have been proposed. We cannot do justice in this limited space to the full variety of alternatives available to policymakers, so we consider several alternative approaches to provide a flavor of how the effects of tax policy change as the structure of a program is altered.

■ **Making the credit nonrefundable.** One option that would greatly lower costs and simplify administration is to make the subsidy nonrefundable. However, this would severely limit the benefits of this subsidy for the uninsured, more than 60 percent of whom have tax liabilities of less than $1,000 (and therefore can only partially benefit from a nonrefundable credit).

A nonrefundable $1,000/$2,000 tax credit would indeed lower the costs of the subsidy, which would fall to almost half the cost of the refundable base-policy credit (Exhibit 3). But the impact on the

EXHIBIT 3
Alternative Policies For Tax Subsidization Of Health Insurance

	Total take-up (millions)	Total cost (billions)	Change in uninsured (millions)	Change in nongroup insured (millions)	Change in employer insured (millions)	Cost per newly insured (thousands)	Percent of benefits for < 200% FPL
Base policy	18.37	$13,285	−4.03	9.77	−5.37	$3,296	56.4%
Nonrefundable 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
Limited to those not offered insurance	10.03	6,153	−2.10	6.36	−4.07	2,927	68.8
Credit for all insurance	127.30	62,177	−12.43	3.41	9.60	5,003	36.5
$500/$1,000 credit	11.43	3,838	−1.71	4.07	−2.14	2,239	62.2
$2,000/$4,000 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
$2,000/$4,000 cap and no liquidity constraints	37.11	44,345	−12.10	27.13	−13.93	3,665	54.9

SOURCE: Authors' calculations.
NOTE: FPL is federal poverty level ($17,274 for a family of four).

size of the uninsured population would fall even more, with fewer than two million uninsured persons gaining coverage (only 4.3 percent of the uninsured). As a result, the cost per newly insured person ($3,827) would be even higher than with the refundable credit ($3,296), largely because such a high share of the dollars would be going to the previously nongroup- or employer-insured. Moreover, the distributional consequences of this approach are much less attractive. Only 23 percent of the spending through this policy would go to those with incomes below 20 percent of 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 low-income persons who are uninsured.

■ **Using a deduction.** Another alternative that could limit costs further is to use a tax deduction rather than a credit, but this approach has problems similar to those of nonrefundability in reaching the uninsured. Moreover, of the half of the uninsured who do pay taxes, 90 percent are in the 15 percent tax bracket, so a subsidy in the form of a deduction would be worth relatively little to them.

In our microsimulation model we assume that an unlimited deduction of nongroup health insurance costs is an "above-the-line" deduction that would be available to all taxpayers, not just to those who itemize their deductions. The costs of this policy (only $870 million per year) would be dramatically lower than those of the alternatives. But its impact on insurance coverage would be much more modest, with only 250,000 uninsured persons gaining cover-

age. This is because there would be only a modest overall take-up of this subsidy by the uninsured to begin with (600,000 persons), and much of this would then be offset by firms' dropping group coverage and reduced coverage because of firm contribution reductions. Estimating with precision the change in the number of uninsured persons in the range around zero is difficult, but it is clear that the effects of a deduction on both costs and coverage would likely be minimal. At the same time, this policy would have much worse distributional characteristics: Less than 30 percent of the benefits would accrue to persons with incomes below 200 percent of the poverty line.

Note that the cost that would arise from this policy would not be the result of take-up by the previously employer-insured. The government would actually make money on this population, because the government revenue from higher wages as a result of firms' dropping coverage and reducing contributions would outweigh the government's cost of subsidy take-up. Rather, the inefficiency would arise primarily from the fact that three-quarters of those who would take up this subsidy would already have nongroup insurance.

■ **Limiting the credit to those not offered coverage.** One way to better target the subsidy may be to limit the refundable $1,000/$2,000 credit to those who are not eligible for employer-sponsored insurance. 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 closely related to being covered by insurance, so this policy provides a device for better targeting subsidy dollars to the currently uninsured.

The total cost of this option is much lower than that of the base policy, only $6.2 billion per year, although the number of newly insured persons would fall as well (to 2.1 million) (Exhibit 3). The efficiency of this alternative would be somewhat better than in the base case, at $2,930 per newly insured person. This increase in efficiency arises from the lower take-up of this policy by persons with nongroup insurance, since many of them are offered employer-based insurance. On the other hand, firms' dropping group coverage would cause a much larger increase in the uninsured pool. We estimate that firms would drop 3.2 million persons from their insurance rolls, and 630,000 of them would remain uninsured.

This policy is somewhat more distributionally attractive than the base policy, with more than two-thirds of the benefits accruing to persons with incomes below 200 percent of poverty. These modest distributional gains, however, must be balanced against the costs and difficulty of enforcing this administratively awkward restric-

tion (which we have not accounted for in our estimates).

■ **Expanding the subsidy to apply to all insurance spending.** An alternative direction is to expand from the base-case subsidization of just nongroup premiums to subsidization of all spending on insurance, even the employee portion of employer-sponsored coverage. On the one hand, this would greatly increase costs, as more than 70 percent of the employer-insured pay some or all of their premiums, and all of these costs would now be paid by the government. On the other hand, the CPS reports that almost 40 percent 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 firms dropping group insurance nor employees switching to nongroup insurance under a policy such as this.

The cost of this policy would indeed be substantial: $62.2 billion per year (Exhibit 3). On the other hand, the impact on the uninsured would be equally dramatic, with more than 12.4 million uninsured gaining coverage. Overall, however, this is the least efficient of the policies considered, with a cost of more than $5,000 per newly insured person.

Expanding the subsidy would have a very broad reach, with more than 127 million persons taking it up. This group would of course be predominantly made up of the employer-insured, who would take up the subsidy to cover their share of premiums. Indeed, a major difference between this and the policy options mentioned earlier is that the number of employer-insured persons would be rising, not falling, which may be of intrinsic value to some policymakers.

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

■ **Changing the scale of the subsidy.** While we have chosen a credit of $1,000 for singles and $2,000 for families as our base-case policy, one could consider less or more generous alternatives as well. Thus, we now 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. For example, with a credit of $500 for singles and $1,000 for families, we estimate that costs would be only

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30 percent of those of the base case, but the reduction in the uninsured would be almost half as large. As a result, spending per newly insured person would be only $2,239, well below even average group costs per person. On the other hand, with a credit of $2,000 for singles and $4,000 for families, which would approximate the full cost of insurance for these populations, we estimate that costs would rise almost threefold, but the number of newly insured persons would almost double, so that spending per newly insured would rise to $4,915 per person. At the same time, the small credit would cover only 2.1 million newly insured persons, whereas the larger credit would cover more than 7.7 million.

The smaller subsidy also would target its spending more directly to the poor, with more than 60 percent of the dollars flowing to those with incomes below 200 percent of poverty. On the other hand, the $2,000/$4,000 credit would spend less than half of its dollars on those with incomes below 200 percent of poverty. This worsening of the distributional impacts as generosity rises reflects the dramatic increase in take-up by both the (relatively high income) nongroup-insured and the employer-insured.

Thus, there is a clear trade-off 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 persons who are covered tend to be those with the lowest incomes. Very large tax credits can induce substantial changes in the uninsured population, but only at a very steep cost per newly insured person.

■ **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 that would like to take advantage of tax credits during a given year, but that only receive their credit the next spring, may face liquidity problems. If the government can find a solution to this timing mismatch, it could increase the propensity of the uninsured to take up 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 can easily be overcome: Although persons can claim their EITC throughout the year, and presumably for many it would be of some value to do so, more than 99 percent of claimants receive the credit as a lump sum the next spring.[4]

We have assumed that liquidity constraints reduce take-up in our base-case calculations; however, it is important to assess the impact of easing these constraints by assuming that the government would solve the liquidity problem. As shown in Exhibit 3, easing liquidity constraints would increase by $1.4 billion the cost of the base policy (absent any additional interest or other costs to the government of easing these constraints) and would insure an additional 1.4 million persons, for a total of 5.5 million newly insured persons. This implies a substantial increase in the efficiency of the policy, with a cost of only $2,683 per newly insured person. Moreover, the impacts of easing liquidity constraints would also be heightened for larger tax credits. With a $2,000/$4,000 credit, the costs would increase by $6 billion per year, but the number of newly insured persons would rise to more than twelve million.

Weighing The Pros And Cons

Federal policymakers continue to look to tax policy as a politically attractive vehicle for addressing the problems of the uninsured in the United States, so the implications of alternative approaches to tax subsidization must be carefully assessed. Although the effects of any major change in health care 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 Henry J. Kaiser Family Foundation project to study incremental health reform.[5]

■ **Summary of findings.** Several clear conclusions follow from our 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 is more generous than are many of the proposals being considered by federal policymakers, and yet it still would subsidize less than half of the estimated cost of typical nongroup insurance. Although it would decrease the number of uninsured persons by an estimated four million (less than 10 percent of the uninsured population), the average cost per newly insured person would be $3,300. Raising the value of the credit would insure more people but also would raise the cost per newly insured person.

Second, there are clearly more and less efficient ways to cover a given number of uninsured persons. We find in particular that nonrefundable credits would be much more expensive per uninsured person covered and would cover fewer of the uninsured. We also find that policies that can match the timing of tax subsidies with the timing of insurance payments could improve both the scope and the

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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 would target refundable credits of $1,000 to singles and $2,000 to families would provide 56 percent of its benefits to persons with incomes below 200 percent of poverty. In contrast, a policy that allowed people to deduct nongroup insurance premiums would provide less than 30 percent of its benefits to people in that income group, and a credit that was not refundable would target an even smaller portion of aid to them.

Finally, tax-based subsidies—particularly those whose subsidies are most generous—would likely lead to reductions in the number of persons with employer-based coverage. For example, we estimate that the base-case policy would reduce the number of persons with employer coverage by 5.4 million. Most of these (3.6 million) would switch from employer to nongroup insurance because they would find the new tax subsidies more attractive than their current situations. However, the remainder would either be dropped from their firms' insurance rolls or become uninsured because their employers increased the amount that employees must pay for insurance. Policies that mitigate firms' dropping coverage or employees' switching to nongroup insurance tend to cost more in total and also per newly covered person.

■ **Potential impact of insurance market reforms.** 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 nongroup 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 take-up rates. State or federal regulators could accompany tax subsidies with individual market regulations to limit such practices, but these regulations are controversial. Also, the net impact of insurance market reforms in the context of tax subsidies is uncertain, because it would raise costs for the most healthy persons and lower them for the least healthy.

On the other hand, doubling the size of the nongroup insurance market (as we estimate would occur in the base policy) could

greatly improve the functioning of this market, in terms of both administrative efficiency and reduced adverse selection. Also, non-group insurance plans might design policies targeted specifically to the available level of the credit, further increasing take-up from what is modeled here (although take-up might be for plans with less generous benefits than are typical today). Moreover, delinking insurance from the workplace could improve the functioning of the labor market by reducing insurance-induced immobility across jobs, or "job lock."

ALTHOUGH TAX POLICY SHOWS PROMISE as a means of providing health insurance to some of the uninsured, covering substantial numbers of uninsured persons will require very large expenditures, both overall and per newly covered person. Even the most effective tax policy considered here—a $2,000/$4,000 credit accompanied by a solution to liquidity problems—would cost almost $40 billion per year and cover only 30 percent of the uninsured. Thus, tax policy can likely be most useful as one part of an overall strategy to address uninsurance in the United States, rather than as a solution in and of itself.

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NOTES

1. The exact structure of the model, and a detailed description of the behavioral responses we assume, can be found in J. Gruber, "Tax Subsidies for Health Insurance: Evaluating the Costs and Benefits" (Report prepared for the Henry J. Kaiser Family Foundation, 1999), available online at www.kff.org.
2. These issues are discussed in J. Meyer, S. Silow-Caroll, and E. Wicks, "Tax Reform to Expand Health Coverage: Administrative Issues and Challenges" (Report prepared for the Kaiser Family Foundation, 1999), available online at www.kff.org
3. L. Etheredge, "Tax Credits for Uninsured Workers" (Mimeo, Health Insurance Reform Project of the George Washington University, 1999).
4. J. Leibman, "The Impact of the Earned Income Tax Credit on Incentives and Income Distribution," *Tax Policy and the Economy 12*, ed. J. Poterba (Cambridge, Mass.: MIT Press, 1998), 83–120.
5. *The Conference Report*, by cochairs Judith Feder and Sheila Burke, is available at www.kff.org/content/1999/1531; and several expert proposals and issue papers are available on the Kaiser Family Foundation Web site, www.kff.org/docs/sections/kcmu/incrementalreformproject.html.