REPORT 4 OF THE COUNCIL ON MEDICAL SERVICE (A-00)
(June 2000)
Principles for Structuring Health Insurance Tax Credits
(Reference Committee A)

EXECUTIVE SUMMARY

At the 1998 Annual Meeting, the House of Delegates adopted the recommendations in Council on Medical Service Report 9, thereby establishing the considerable AMA policy base that underlies the AMA's current health insurance reform proposal. The key aspects of the proposal include the following:

- Support for individually owned health insurance as the preferred method for people to obtain health insurance coverage.

- Preference for replacing the present exclusion from employees' taxable income of employer-provided health expense coverage with tax credits.

- Support for unions, trade associations, health insurance purchasing cooperatives, farm bureaus, fraternal organizations, chambers of commerce, and similar groups serving as "voluntary choice cooperatives" for the purchase of health insurance.

During the past year, the use of tax credits to expand health insurance coverage has been gaining bipartisan Congressional support. In order to further delineate the AMA's proposal, and to better evaluate proposals put forth by others, the Council has developed guiding principles for structuring a health insurance tax credit.

The attached report recommends the adoption of a series of principles to guide AMA support for replacement of the present exclusion from employees' taxable income of employer-provided health expense coverage with tax credits. A rationale is provided for each recommended principle. A Technical Appendix contains impact estimates of five health insurance tax credit scenarios from the "Tax Credit Simulation Project" that has been undertaken by the AMA Center for Health Policy Research. Several principles are illustrated using scenarios from the tax credit simulation. The simulations demonstrate that tax credits, in combination with increased enrollment of those uninsured who are currently eligible for Medicaid, would result in coverage for approximately 95% of the U.S. population, and that this level of coverage can be achieved with reasonable budgetary commitments. In addition, the report recommends that portions of Policy H-165.920[12-14] be modified and rescinded, as a means of removing repetitive and outdated policy statements, and of streamlining of the AMA's comprehensive policy base on health insurance reform.

CMS Report 4 - A-00
(June 2000)

Subject: Principles for Structuring Health Insurance Tax Credits

Presented by: Eugene Ogrod, MD, Chair

Referred to: Reference Committee A
     (Susan R. Wynn, MD, Chair)

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1 At the 1996 Interim Meeting, the House of Delegates adopted policy supporting individually
2 selected and individually owned health insurance as the preferred method for people to obtain
3 health insurance coverage (Policy H-165.920[5], AMA Policy Database). To assist in the
4 development of that policy, the Council on Medical Service undertook the development of further
5 recommendations as to how a system of individually owned insurance should be structured.
6
7 At the 1998 Annual Meeting, the House of Delegates adopted the 17 recommendations in CMS
8 Report 9, thereby establishing the considerable policy base that underlies the AMA's current health
9 insurance reform proposal. Among the key policies established by CMS Report 9 (A-98) were the
10 following:
11
12 • Preference for replacing the present exclusion from employees' taxable income of employer-
13 provided health expense coverage with a tax credit for individuals equal to a percentage of the
14 total amount spent for health expense coverage by the individual and/or his/her employer, up to
15 a specified actuarial value or "cap" in coverage so as to discourage over-insurance (Policy H-
16 165.920[12]).
17
18 • Preference for relating the individual tax credit for all health expense coverage expenditures by
19 individuals and/or their employers to the individual's income, rather than being a uniform
20 percentage of such expenditures (Policy H-165.920[13]).
21
22 • Support for strong tax incentives, such as making tax credits contingent on purchase of a
23 specified minimum level of coverage, as opposed to compulsory approaches, to encourage
24 individuals to obtain coverage providing a specified minimum level of protection against out-
25 of-pocket expense for health services and incorporating provisions of the AMA Patient
26 Protection Act, whether through a traditional insurance or managed care plan or a medical
27 savings account (Policy H-165.920[14]).
28
29 • Support for unions, trade associations, health insurance purchasing cooperatives, farm bureaus,
30 fraternal organizations, chambers of commerce, churches, religious groups, ethnic coalitions,
31 and similar groups serving as voluntary choice cooperatives for both children and the general
32 uninsured population, with emphasis on formation of such pools by organizations which are
33 national or regional in scope (Policy H-165.882[15]).
34

1   During the past two years, the Council on Medical Service has continued to study issues involving
2   key aspects of the AMA's health insurance reform proposal. CMS Report 5 (A-99) presented
3   available information on existing employer health insurance purchasing cooperatives that have
4   implemented aspects of voluntary choice cooperatives. The report compared the experiences of
5   employer purchasing alliances in terms of legislative and market environments, membership
6   structure, standardization of benefits packages, contracting approaches, degree of consumer choice,
7   and other benefit designs. CMS Report 16 (I-99) presented a preliminary examination of the
8   economic issues in evaluating alternative proposals for providing individuals with a tax credit for
9   the purchase of health insurance. Specifically, the report summarized existing research, outlined an
10   analytical framework for examining alternative tax credit proposals, and presented estimates from
11   the first stage of a simulation model. In addition, CMS Report 5 (A-00), which is before the House
12   of Delegates at this meeting, discusses the benefits and limitations of an individual mandate for
13   individually owned health insurance.
14
15   The use of tax credits to expand health insurance coverage has been gaining bipartisan
16   Congressional support. There have been a number of recent Congressional proposals to provide
17   tax credits for the purchase of health insurance. The specifics of these legislative proposals vary.
18   Some proposals have suggested that the tax credits should be limited to those who lack access to
19   employer-sponsored health insurance, while others would provide tax credits to anyone purchasing
20   health insurance. Similarly, some proposals call for the addition of tax credits to the existing tax
21   exclusion, while others call for replacing the exclusion with credits.
22
23   To further delineate the AMA's proposal, and to better evaluate proposals put forth by others, this
24   report provides "guiding principles" for structuring a health insurance tax credit. The intent of the
25   report is not, however, to lock the AMA into specific parameters such as dollar amounts and
26   income ranges. Rather, it is to provide greater guidance in shaping federal legislation that would
27   move the current health insurance market place toward the AMA's vision where Americans have
28   both expanded access to health insurance coverage, and true choice.
29
30   EVALUATING ALTERNATIVE TAX CREDIT PROPOSALS
31
32   In evaluating tax credit proposals, it is important to consider tradeoffs among competing objectives,
33   most notably the objectives of cost-containment and reducing the number of uninsured. Another
34   policy tradeoff is between broadly distributing a given tax subsidy versus targeting it only to low-
35   income individuals and families. Economic simulation models are useful in assessing the
36   magnitudes of such tradeoffs. Several recent studies also have relied on simulation models to
37   estimate the effects of various tax credits for expanding coverage.
38
39   As described in CMS Report 16 (I-99), the Council on Medical Service has reviewed estimates
40   prepared by the AMA Center for Health Policy Research as part of its Tax Credit Simulation
41   Project. Using accepted modeling techniques, the Tax Credit Simulation Project involves assessing
42   the impact of alternative tax credit proposals, including the effect of various levels of tax credits on
43   insurance coverage, the federal budget, private health insurance expenditures, and other key aspects
44   of the health system.
45
46   The Technical Appendix of this report contains a description of the simulation model and presents
47   the estimated impacts of five health insurance tax credit scenarios. The simulation model
48   incorporates behavioral relationships among key economic variables influencing the demand for
49   coverage. The key outcome variables from the simulations include the change in coverage, the
50   change in federal spending, and changes in the distributional measures of the tax subsidy.

1 PRINCIPLES FOR STRUCTURING THE TAX CREDIT
2
3 The Council believes that with the addition of the following principles, which further delineate
4 how tax credits should be structured for the purchase of health insurance, portions of Policy
5 H-165.920[12-14] need to be modified and rescinded. In addition to refining AMA tax credit
6 policy, such actions will remove repetitive and outdated policy statements, and contribute to the
7 overall streamlining of the AMA's comprehensive policy base—a continuing priority of the
8 Council on Long Range Planning and Development.
9
10 1. Tax credits should be contingent on the purchase of health insurance, so that if insurance is not
11   purchased, the credit is not provided.
12
13   Discussion and rationale: This principle, which is consistent with the underlying intent of
14   Policy H-165.920[14], provides a strong incentive for people to purchase health insurance
15   voluntarily. Unlike the current system, it makes tax subsidies for insurance independent of
16   employment or an employer's health benefit offerings. It also ensures that the subsidy is used
17   as intended, to encourage people to have health insurance. Although the issue of what
18   constitutes health insurance can be resolved a number of ways, it is suggested that to qualify
19   for a tax credit, health insurance must provide coverage for hospital care, surgical and medical
20   care, and catastrophic coverage of medical expenses as defined by Title 26 Section 213(d) of
21   the United States Code: "For purposes of this section, the term 'medical care' means amounts
22   paid for the diagnosis, cure, mitigation, treatment, or prevention of disease, or for the purpose
23   of affecting any structure or function of the body." A minimum of stipulations and restrictions
24   should be imposed on health insurance products beyond requiring that they broadly cover
25   standard medical services and provide catastrophic protection in order to maximize the
26   affordability of basic coverage, and to permit maximum flexibility for developing insurance
27   choices that meet the needs of various groups of consumers, whether through a traditional
28   insurance or managed care plan or a medical savings account (MSA).
29
30 2. Tax credits should be refundable.
31
32   Discussion and rationale: The tax credit should be refundable to those who purchase health
33   insurance, but who have tax liability less than the value of the tax credit. This principle is
34   particularly essential for low-income individuals and families that are relatively unlikely to be
35   insured in the absence of subsidies. CMS Report 5 (A-00), which is before the House at this
36   meeting, addresses, in part, possible mechanisms to assure that those without the means to
37   purchase health insurance could receive their tax credits in advance of the end of the year.
38
39 3. The size of tax credits should be inversely related to income.
40
41   Discussion and rationale: Policy H-165.920[13] states that the size of tax credits should be
42   income-related. The intent of this principle is to provide greater subsidy to those with lower
43   income. The current tax exclusion, which is not income-related, provides a regressive subsidy
44   for health insurance both because individuals in higher tax brackets get larger tax breaks for
45   every dollar spent on insurance, and because individuals with higher incomes tend to spend
46   more on health insurance. Further, those families that earn too little to owe any income tax
47   currently get no tax subsidy on health insurance. Inversely relating tax credits to income
48   targets the tax subsidy toward those who would otherwise be most likely to be uninsured, and
49   conserves budgetary resources.

1 The most likely methods of structuring tax credits under this principle are to tie the amount of
2 tax credits to individual and family federal income, or to multiples of the federal poverty level
3 (e.g., 100%, 200%, 300%). Another complementary method of targeting tax credits to lower
4 income groups is to impose an income cutoff for eligibility for tax credits. Simulations of
5 alternative tax credit scenarios show that restricting eligibility to the lowest income categories
6 reduces cost per newly insured and increases coverage for any given level of new federal
7 spending. Making the tax credit progressive has little negative impact on coverage as long as
8 the credit is sufficient to cover a substantial portion of the premium costs for individuals in the
9 low income categories. Compared to a neutral tax credit, a progressive tax credit significantly
10 reduces the federal spending necessary to reach a coverage level. Given full participation in
11 the lowest income categories, the simulation results suggest that between 24-26 million more
12 persons could be covered at a cost of $40 billion to $65 billion in new federal spending.
13
14 A consequence of moving from the current, regressive tax subsidy to tax credits which are
15 inversely related to income is that members of upper income groups will lose some or all of
16 their current subsidy. However, this reduction in subsidy will have several offsetting effects.
17 First, redirecting the subsidy to lower income groups will achieve coverage more efficiently
18 than the status quo, thereby reducing the amount of uncompensated care. Since
19 uncompensated care is ultimately paid for through higher taxes and higher premiums,
20 expanded coverage confers benefits to upper income groups. Second, market competition
21 under individually owned health insurance will lead to greater price and quality competition
22 among insurers, greater individual choice of plans, and lower premiums. Third, to the extent
23 that some employers no longer subsidize health insurance for their employees, they may have
24 to compensate employees with higher wages and salaries in order to remain competitive in
25 labor markets. Finally, a likely alternative to tax credits for the purchase of individually owned
26 health insurance is a single-payor system. The redistributive consequences for the well-to-do
27 are likely to be worse under a single-payor system than under the AMA proposal.
28
29 4. The size of tax credits should be large enough to ensure that health insurance is affordable for
30   most people.
31
32 Discussion and rationale: This principle supports long-standing AMA policy aimed at
33 achieving health care coverage for all Americans (Policies H-165.904, H-165.882, H-165.877,
34 H-165.919, and H-165.960). In combination with the preceding principle that advocates for
35 tax credits that are inversely related to income, this principle acknowledges the need for tax
36 credits that are large enough to empower virtually all individuals to obtain and maintain health
37 insurance coverage. The simulation results suggest that tax credits, in combination with
38 increased enrollment of those uninsured who are currently eligible for Medicaid, would result
39 in coverage for approximately 95% of the U.S. population. A comparison of simulation results
40 suggests, however, that the credit must be sufficient to cover a substantial portion of the
41 premium costs for individuals in the low-income categories. At the lowest income levels the
42

1   credit must approach 100% of the premium. This would require a credit of about $2,000 for
2   single coverage and $4,000 for family coverage.
3
4   5.   The size of tax credits should be capped in any given year.
5
6   Discussion and rationale: In any given year, the amount of tax credits should be capped to
7   discourage overinsurance. If, as suggested by the next principle, the credit does not vary with
8   health insurance expenditure, there is an implicit cap equal to the amount of the highest tax
9   credit. However, it is important that the capped credits be stated as an independent principle in
10   case there is growing support for a tax credit proposal in which the credits vary with the level
11   of insurance premiums. In the event that such a proposal is deemed the most politically viable
12   way of implementing tax credits, the AMA should advocate capping the credits.
13
14   6.   Tax credits should be fixed-dollar amounts for a given income and family structure.
15
16   Discussion and rationale: For a given individual or family, tax credits should be fixed-dollar
17   amounts and independent of health insurance expenditures. The fact that the existing tax
18   exclusion is proportionate to health insurance expenditures encourages overinsurance, and
19   directs the subsidy disproportionately to those with higher incomes, making the subsidy
20   inefficient at expanding coverage. Fixed-dollar amounts will provide consumers with
21   incentives to be cost-conscious. The benefits from the risk-adjustment effects of making the
22   tax credits proportionate to health insurance expenditures are minimal. Relating tax credits to
23   health insurance expenditures would also significantly increase the administrative complexity
24   of the system. The addition of this principle necessitates amending Policy H-165.920[12],
25   which calls for making the amount of the tax credit equal to a percentage of health insurance
26   expenditures.
27
28   7.   The size of tax credits should vary with family size to mirror the pricing structure of insurance
29   premiums.
30
31   Discussion and rationale: For several reasons, the premium for a family policy is generally less
32   than the sum of premiums for individual members. In general, the larger the group, the easier
33   it is to predict costs, thereby reducing the "cost of risk" to the insurer. On average, health care
34   costs for first children are higher than for subsequent children because inexperienced parents
35   rely more heavily on the health care system. Furthermore, insurers typically keep
36   administrative and underwriting costs down by limiting the number of premium categories for
37   family size and structure (e.g., individual adults, adult plus one, and family [three or more]).
38
39   Since the purpose of the tax credit is to subsidize the purchase of health insurance, the structure
40   of credits should generally mirror the pricing structure of premiums. Under the current
41   structure of health insurance premiums, the credit for a couple would be greater than the credit
42   for a single adult, and the credit for an adult would be greater than the credit for a child. The
43   credits would increase with family size up to a cap at a specified number of dependents,
44   possibly one, or two or more. This would mirror premiums since a family of eight, for
45   example, generally pays the same premium as a family of three.
46
47   In the event that some family members have insurance not purchased by the family (e.g.,
48   CHIP, Medicare), the size of tax credit would be adjusted accordingly. This principle has the
49   important advantage of simplifying the structure and administration of the tax credits.

1   8. Tax credits for families should be contingent on each member of the family having health
2   insurance.
3
4   <u>Discussion and rationale</u>: The purpose of requiring all members of a family to be covered in
5   order to receive a tax credit is to encourage maximum coverage and to prevent "gaming" of the
6   system. In the absence of this principle, adults might purchase coverage only for themselves,
7   in the hope that their children remain healthy. Gaming would occur if families failed to
8   purchase coverage for healthy members, waiting until such members experienced a need for
9   health care before seeking coverage for them.
10
11   9. Tax credits should be applicable only for the purchase of health insurance, not for out-of-
12   pocket health expenditures.
13
14   <u>Discussion and rationale</u>: Basing tax credits on total health expenditures, including out-of-
15   pocket health expenses, encourages excess consumption of health care services. It also may
16   necessitate the development of detailed rules regarding which out-of-pocket health expenses
17   may qualify for a credit versus those that may not. In general, for a given "budget" of tax
18   credits, subsidizing direct health expenditures means there will be smaller subsidies available
19   for health insurance. Furthermore, if individuals know that some tax credits are available for
20   "uncovered" health expenses, it dilutes the incentive to purchase health insurance. Separate
21   subsidies should be developed and/or considered for those individuals whose health spending is
22   atypically high due to chronic disease or health catastrophe.
23
24   <u>CONCLUSION</u>
25
26 In the development of CMS Report 9 (A-98), the Council emphasized that the AMA's participation
27 and leadership in efforts to implement a system of individually owned health insurance would be
28 best guided by agreement on the basic policy agenda for change that should be advocated by the
29 Association. In particular, the Council stressed that an exhaustively detailed "all or nothing" AMA
30 proposal for moving to an individually owned system was contraindicated because:
31
32 •   it deprives the AMA of the flexibility to respond to evolving initiatives in Congress on this
33   subject and to participate effectively in debate on more limited aspects of reform; and
34
35 •   it may be difficult to understand or be perceived by a significant segment of the membership
36   and/or the public as a return to the massively complicated health system reform proposal
37   debate and rejected by Congress and the public in 1993.
38
39 The Council believes that this premise is equally important as the House of Delegates further
40 delineates AMA policy on the structure of health insurance tax credits. As noted earlier in this
41 report, the intent of the Council in developing the recommended set of guiding principles is not to
42 lock the AMA into specific parameters such as dollar amounts and income ranges. Rather, it is to
43 provide greater guidance to the Board of Trustees, the Council on Legislation, and AMA advocacy
44 staff in shaping federal legislation that would move the current health insurance market place
45 toward the AMA's vision of a system of individually owned health insurance, where Americans
46 have both expanded access to coverage, and true choice.
47
48 Tax credits for the purchase of health insurance would be both feasible and effective, as
49 demonstrated by the simulations contained in the Technical Appendix of this report. The
50 simulations of the impacts of several different systems of tax credits illustrate how the AMA

1 proposal can expand choice and achieve health insurance coverage for essentially all Americans for
2 reasonable budgetary commitments. The simulations also demonstrate that the design principles
3 articulated in this report are sound and can produce the objective of expanded coverage for
4 reasonable expenditure. As previously noted, the simulation results suggest that approximately 25
5 million more persons could be covered at a cost of $40 billion to $65 billion in new federal
6 spending. Tax credits, in combination with increased enrollment of those uninsured who are
7 currently eligible for Medicaid, would result in coverage for approximately 95% of the U.S.
8 population. This level of coverage compares favorably with other industrialized countries that
9 have achieved "universal" coverage.

11 RECOMMENDATIONS

13 The Council on Medical Service recommends that the following be adopted and the remainder of
14 the report be filed:

16 1. That Policy H-165.920[12] be amended by addition and deletion to read as follows:

18   The AMA supports a replacement of the present exclusion from employees' taxable income of
19   employer-provided health expense coverage with ~~a~~ tax credit<u>s</u> for individuals <u>and families</u>
20   ~~equal to a percentage of the total amount spent for health expense coverage by the individual~~
21   ~~and/or/his/her employer, up to a specified actuarial value or "cap" in coverage so as to~~
22   ~~discourage over insurance~~.

24 2. That AMA support for replacement of the present exclusion from employees' taxable income
25   of employer-provided health expense coverage with tax credits, be guided by the following
26   principles:

28   (a)   Tax credits should be contingent on the purchase of health insurance, so that if
29   insurance is not purchased the credit is not provided.

31   (b)   Tax credits should be refundable.

33   (c)   The size of tax credits should be inversely related to income.

35   (d)   The size of tax credits should be large enough to ensure that health insurance is
36   affordable for most people.

38   (e)   The size of tax credits should be capped in any given year.

40   (f)   Tax credits should be fixed-dollar amounts for a given income and family
41   structure.
42   (g)   The size of tax credits should vary with family size to mirror the pricing structure
43   of insurance premiums.

45   (h)   Tax credits for families should be contingent on each member of the family having
46   health insurance.

48   (i)   Tax credits should be applicable only for the purchase of health insurance,
49   including all components of a qualified MSA, and not for out-of-pocket health
50   expenditures.

1 3. That Policies H-165.920[13] and H-165.920[14] be rescinded.
2
3 4. That it is the policy of the AMA that in order to qualify for a tax credit for the purchase of
4   individual health insurance, the health insurance purchased must provide coverage for hospital
5   care, surgical and medical care, and catastrophic coverage of medical expenses as such
6   expenses are defined by Title 26 Section 213(d) of the United States Code.

A technical report on the Tax Credit Simulation Project is available at http://www.ama-assn.org/ama/pub/category/3373.html and from the AMA Division of Economic and Statistical Research.

Technical Appendix
Tax Credit Simulation Model

The simulation model incorporates behavioral relationships among key economic variables influencing the demand for coverage. The change in the demand for health insurance is specified as a function of the expected response to changes in the value of the after-tax premium as a percentage of income, income level, and the base participation rates. The modeling approach incorporates the role of risk preferences in making coverage decisions and the ability of individuals and families to bear risk. The key outcome variables from the simulations include the change in coverage, the change in federal spending, and changes in the distributional measures of the tax subsidy. Only the health insurance premium portion of the federal revenue foregone or "tax subsidy" is included in the model. The credits are set at a fixed-dollar amount for single coverage and for family coverage.

The simulations were performed using data from nationally representative samples of the U.S. population in the March Current Population Survey (CPS) and the Medical Expenditure Panel Survey (MEPS). Data from the CPS and MEPS can be used to identify the populations eligible for the tax credit, and estimate the number and distribution of persons by health insurance status, type of coverage, and broken out by income category. Employer-based offer and take-up rates are derived from MEPS data. Employer-based health insurance premiums and the share of the premium paid by the employer are derived from KMPG surveys. Effective average tax rates are derived from data from the Congressional Budget Office.

To aid in the evaluation of alternative tax credit proposals, five health insurance tax credit scenarios are simulated. The specific characteristics of the tax credit structures were selected to portray some of the trade-offs among different plan designs. The five scenarios vary by dollar amounts and various eligibility criteria. In particular, the structure of the credit varies along the following dimensions:

- How the credit varies by income level. Progressive tax credits (a decreasing dollar credit as income rises) and neutral tax credits (the credit is independent of income level) are considered.

- The maximum income level for being eligible for the credit. A maximum income of $75,000 is set as an eligibility criteria for two of the tax credit designs simulated, and a maximum income of $100,000 is set as the eligibility criteria for the last scenario.

The simulation model incorporates the following assumptions:

- All credit-eligible persons who purchase coverage receive the credit.

- The total individual and family tax credits are capped at the corresponding level of the health insurance premium.

- Offer rates of employer-based health insurance are held constant in the simulations.

- The employers' contributions as a share of employer-based health insurance premium are held constant in the simulations. The value used is 75% and is the average of single and family coverage based on data from KMPG's survey of employers.

- Participation rates are determined by the expected response to changes in the value of the after-tax premium as a percentage of income, income level, and the base participation rates. The simulations utilize estimated elasticities of the demand for health insurance (-0.2 to – 0.6), changes in plan choice, for example, fee-for-service, HMO, or PPO (-1.0 to –2.0), and small firm demand for coverage (-3.9 to -5.9) derived from the literature on economic models of the decisions to purchase insurance and the amount to spend on coverage. Participation rates are projected to be more responsive (about one-third more) for the uninsured and those with non-group coverage than for individuals with employer-based coverage. Participation rates also are expected to be inversely related to the after-tax premium as a percentage of income. To account for variation in responses across sub-populations a range of coverage elasticities (-0.2 to -2.8) was used in the simulations. In the last two tax credit scenarios simulated, the model is recalibrated to have 95% participation in the $0 to $10,000 and the $10,000 to $20,000 income categories. This assumption was introduced to examine the impact of "full participation" in the lower income categories

- The simulations assume that there is no switching between the alternative insurance coverages (i.e., employer-based and non-group) options. That is for example, individuals currently with employer-based coverage select either employer-based coverage or go uncovered after the tax credit proposal is implemented. Likewise, if an individual has non-group coverage before the tax credit goes into effect, if she selects coverage it would be in the non-group market. Individuals who are currently uninsured may select non-group coverage, or if employed and offered employer-based coverage, take up that coverage.

- Non-group premiums are assumed to be on average 80% of employer-based premiums. No source of national representative data on non-group health insurance premiums is currently available. Other research on the impact of tax credit and health insurance reform proposals use a variety of methods to derive non-group premiums. While costly actuarial analysis can be utilized at the level of aggregation of the AMA's simulation model, much of that level of detail and variation in premiums would be lost. Another approach, the one used here, is to assume that non-group premiums are some fraction of employer-based premiums. The premiums in the non-group market reflect the lower levels of benefits in the typical plan relative to those in employer-based benefit packages. As the extent of the non-group or individual market expands, the array of benefit plans is also expected to expand. Compared to the current non-group market, these market driven benefit mixes and corresponding premiums will more fully reflect the level and diversity of coverage demands. As a result, premiums in all markets may fall.

- The simulations include Medicaid eligibles in the counts of uninsured.

Tax Credit Scenarios Simulated

The following tax credit scenarios were simulated:

- Scenario A - a credit in the range from $900 to $1,000 for single coverage and a credit for family coverage in the range from $1,800 to $2,000, independent of income level.   Coverage increases between 16.2 and 18.6 million persons and requires an additional $29 to $41 billion in federal spending.

- Scenario B - a credit ranging between $1,800 and $2,000 for single coverage and a credit ranging between $3,600 and $4,000 for family coverage, independent of income level. In this scenario between 22 and 24 million persons are expected to acquire coverage and requires between $124 and $146 billion in added federal spending.

- Scenario C - progressive credits starting out in a range of $1,800 to $2,000 for single coverage and a range of $3,600 to $4,000 for family coverage at income from $0 - $10,000, with the single (family) coverage credit declining by $200 ($400) per income category, up to $75,000. A zero credit for incomes greater than $75,000. This progressive tax credit generates 18 to 20 million newly insured and costs between $31 and $49 billion in new spending.

- Scenario D - like Scenario C, a progressive credit which starts at out between $1,800 and $2,000 for single coverage and $3,600 and $4,000 for family coverage for income from $0 - $10,000, with the single (family) coverage credit declining by $200 ($400) per income category, up to $75,000. A zero credit for incomes greater than $75,000. The participation rates for individuals in the $0 - $10,000 and $10,000 - $20,000 income brackets are recalibrated to 95% participation. This is assumed to be full participation or take up in those income categories, in part to recognize the significant income effects the tax credits create. This results in 24 to 25 million more persons having coverage at a cost of $40 to $56 billion in new federal spending.

- Scenario E - like Scenarios C and D, a progressive credit of $1,800-$2,000 for single coverage and $3,600-$4,000 for family coverage for income from $0 - $10,000, with the single (family) coverage credit declining by $200 ($400) per income category. The credit eligibility ceiling is raised to incomes up to $100,000 with a zero credit for incomes greater than $100,000. As in Scenario D, the participation rates for individuals in the two lowest income categories are recalibrated to 95% participation. This results in 25 to 26 million more persons having coverage at a cost between $46 to $65 billion in new federal spending.

Discussion

Table 1 contains a summary of the estimated impacts of each of the five tax credit scenarios considered. The impacts on coverage and federal spending for each tax credit scenario are presented in Exhibit 1 and Exhibit 2, respectively.

Increasing access is not an inexpensive proposition. The results from Scenarios A, C, D, and E suggest that the cost of approaching full coverage requires $30 billion to $60 billion in new federal spending.

Among those scenarios, the estimates of the added insured range from 16 million to over 26 million people. Scenario A achieves expanded coverage at relatively low cost because of the low dollar

amounts of credits.

Scenarios C, D and E substantially redirect spending toward lower income groups and away from higher income groups. Replacing the tax exclusion of employer contributions for health insurance with tax credits of the amounts in the simulations raises the tax liability of the individuals in the highest income categories. Comparing the results from Scenario B with those from the last three scenarios suggests that making the tax credit progressive has little negative impact on coverage as long as the credit is sufficient to cover a substantial portion of the premium costs for individuals in the low income categories. Compared to a neutral tax credit, a progressive tax credit significantly reduces the federal spending necessary to reach a desired coverage level. Sensitivity analysis of tax credits of slightly smaller dollar amounts, with and without income caps, generally support these conclusions. The simulation results from those scenarios suggest that a cap based on income level is effective in increasing coverage and holding down cost.
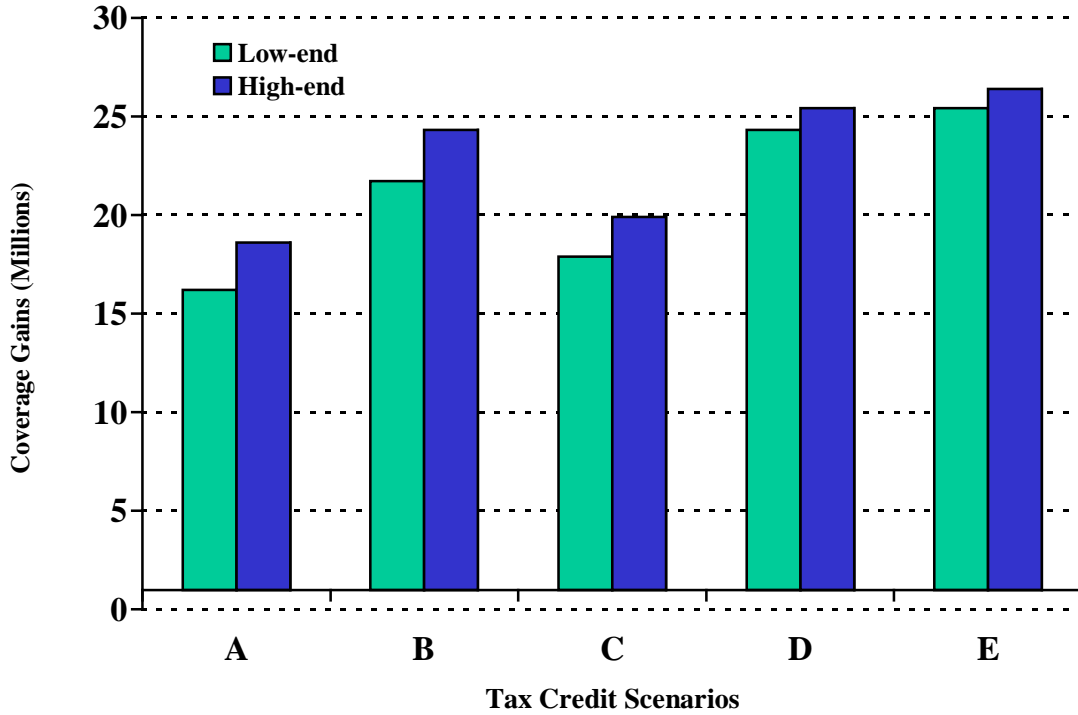
None of the proposals achieves 100% coverage. It needs to be recognized, however, that the estimates reflect measures of behavioral responses in the current system, which may differ from the responses in a fully implemented individually selected and owned health insurance system. The estimates presented for Scenarios C, D and E, relative to those for Scenarios A and B, capture some of the potential differences.

Table 1. Summary of Tax Credit Scenarios - Coverage and Spending Impacts

	Tax Credit Scenario				
Tax Credit Scenario Elements	A	B	C	D	E
Single Coverage Credit	$900 - $1,000	$1,800 - $2,000	$1,800 - $2,000, for income $0 - $10,000	$1,800 - $2,000, for income $0 - $10,000	$1,800- $2,000, for income $0 - $10,000
Family Coverage Credit	$1,800 - $2,000	$3,600 - $4,000	$3,600 - $4,000, for income $0 - $10,000	$3,600 - $4,000, for income $0 - $10,000	$3,600- $4,000, for income $0 - $10,000
Other Elements	Independent of income level	Independent of income level	Progressive credit, zero credit for incomes greater than $75,000	Progressive credit, $0 credit for incomes greater than $75,000, 95% participation in lowest two income brackets	Progressive credit, $0 credit for incomes greater than $100,000, 95% participation in lowest two income brackets
Impacts	A	B	C	D	E
Coverage Gains (millions)	16.2-18.6	21.7-24.3	17.9-19.9	24.3-25.4	25.4-26.4
Remaining Uninsured (millions)	25.7-28.1	20-22.6	24.4-26.4	18.9-20.0	17.9-18.9
Percentage of Population Remaining Uninsured	9.1%-10.0%	7.1%-8.0%	8.7%-9.4%	6.7%-7.1%	6.4%-6.7%
New Federal Spending (billions $)	$28.8-$40.8	$124.4-$146.4	$31.1-$48.7	$39.1-$55.8	$45.9-$65.0
Cost per Newly Insured	$1,776-$2,194	$5,726-$6,032	$1,807-$2,442	$1,607-$2,204	$1,810-$2,464
After-tax Premium as a Percent of Income, Income $0 - $50,000	4.7% - 11.9%	0% - 4.9%	0% - 7.3%	0% - 7.3%	0% - 7.3%

Source: Division of Economic and Statistical Research, American Medical Association, March 2000.

Exhibit 1. Range of Coverage Gains

Exhibit 2. Range of New Federal Spending

Source: Division of Economic and Statistical Research, American Medical Association, March 2000.