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REVISITING THE EFFECTIVENESS OF THE HEALTH INSURANCE TAX CREDIT

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Abstract

With the push to repeal the Affordable Care Act (ACA) and replace it with the American Health Care Act (AHCA), there is renewed interest in using tax credits to increase health insurance coverage. A similar tax credit-driven policy, the Health Insurance Tax Credit (HITC), was implemented from 1991 to 1993. To date, only one paper (Cebi & Woodbury, 2014) has analyzed the effectiveness of the HITC in increasing health insurance coverage. This paper re-examines the efficacy of the HITC by using a different data set from the Survey of Income and Program Participation (SIPP). This examination yields similar results to those in Cebi & Woodbury (2014), which is that the HITC increased health insurance coverage among single mothers by about 6.6 percentage points. Further, this study finds that the HITC appeared to influence the rates of usage of health care services. This paper concludes by discussing the implications of these findings for the broader debate surrounding health care reform in the present moment.

Keywords: Tax credits, Health insurance, Health care utilization

1. INTRODUCTION

Health insurance access and affordability continues to dominate the political landscape in the United States. A significant component of the debate regarding health care reform is the change in the amount and eligibility for receiving tax credits in purchasing health insurance. On March 6th, 2017, Speaker of the House Paul Ryan unveiled the highly anticipated health care plan, the American Health Care Act (AHCA), as an alternative to the current Affordable Care Act (ACA). One key difference between the ACA and AHCA is that the AHCA explicitly relies on tax credits to prompt people to purchase coverage, as

it removes a provision of an individual mandate. To be more specific, while tax credits are still refundable, the AHCA offers a flat dollar amount that varies by age and phases out at a higher level of income. Due to this, the AHCA provides lower tax credits for low income populations than the ACA. As a result, the new plan is projected to decrease enrollment among low-income families (CBO Report, 2017)

Although the AHCA was pulled from the floor when it was first introduced, the House of Representatives passed a new version of the bill in early May 2017. The AHCA shares some similarities with an earlier bill, the Health Insurance Tax Credit (HITC), implemented in the U.S. from 1991 to 1993. Both bills are designed to use tax credits as a way to motivate individuals to sign up for health insurance. This paper revisits the HITC in order to analyze the effectiveness of tax credits in the acquisition of coverage and utilization of medical services.

It is important to note that there exists a difference between the current situation and the period in which the HITC was implemented. In the HITC, some people were given subsidies that they did not have before. In contrast, if we transition from the ACA to the AHCA, most of the previous tax credit eligible individuals will receive less assistance in subsidizing the cost of health insurance. Although the overall circumstances of tax credits offered under the HITC differed from what is offered under the current law and proposed legislation, it provides a natural experimental setting to explore the responsiveness of tax credits, which has implications for the larger health care debate of the present moment. To date, only Cebi and Woodbury (2014); (C&W hereafter) has explored the effectiveness of the HITC on increasing health insurance coverage.

This paper replicates C&W with different data from the Survey of Income and Program Participation (SIPP) and expands that analysis to include health care utilization, as this is what ultimately matters to policy makers. It is reasonable to hypothesize that if low-income populations experienced a significant increase in insurance enrollment, health care utilization in the HITC period might have subsequently increased.

This expanded replication study reaffirms that tax credits influence a person's decision-making regarding health insurance and appear to increase health care utilization. This paper begins by outlining the empirical strategy of the HITC. The next section describes the data set used in this study. Finally, this paper concludes with an analysis of results and a discussion of their implications.

1.1. Methods

1.1.1. Empirical Strategy

The HITC, enacted from 1991 to 1993, was a supplemental form of the Earned Income Tax Credit (EITC) and based on the Omnibus Budget Reconciliation Act of 1990. Participants could receive a refund even if they had no federal tax liability. Because the HITC had similar criteria to that of the EITC, private health insurance was required to cover at least one qualified child, who had to satisfy two requirements: "(1) be a child, stepchild, grandchild,

foster (i.e. cared for as own child) or adopted child of the taxpayers and (2) have the same place of residence as the taxpayer for more than half of the tax year "(C&W). Those enrolled in either non-group or employer-provided private insurance plans were eligible for the HITC, which was structured to vary by earned income. For example, if one's income was from $1 to $7,140, they would have received 6 percent of their income.

If one's income was between $7,140 and $11,250, the credit would stay constant at $428 in 1991 ($451 in 1992, and $465 in 1993) on top of basic EITC. Income up to but not exceeding $21,250 would make an individual eligible for the HITC. The average amount received by HITC-qualified individuals was quite modest at 23 about percent of the overall average cost for health insurance premiums (GAO, 1994).

To examine how the HITC affected single mothers, I follow C&W and use a difference-in-differences (DiD) strategy. The DiD estimates the effect of the HITC on the outcomes of interest by comparing the average change in the outcome variables for the treatment group with that of the control group. This assumes that the trend in the outcomes for both groups would have been the same without the HITC. Therefore, any deviation from this trend is attributed to the policy.

Following C&W, my treatment group is working single mothers not exceeding a high school education and the control group is working single women, without children, not exceeding a high school education.

My primary outcome of interest health insurance coverage is based on the following SIPP questions:

- 'Was the respondent covered by a private health insurance plan and under their own name?'
- 'Besides the respondent, were there any other children in the household covered by the respondent's plan?'

For the control group, I define respondents as covered if they answered 'yes' for the first question.Within the treatment group, they were defined as covered if they answered 'yes' to both questions. In the baseline specification, I include the primary background characteristics in C&W. I estimate the following equation using the linear probability model (OLS):

$$Yist = \beta 0 + \beta 1 * TREATist + \beta 2 * DuringHITCit + \beta 3 * TREAT * DuringHITCist + \beta 4 * Zist + \gamma 1 * URTst + \gamma 2 * URTst * TREATi + \gamma 3 * \theta s + \varepsilon it \quad (1)$$

where i, t and s index individual, time (years) and state, respectively.

The outcome variables of interest, Yist, are binary variables indicating whether the individual (i) in state (s) at time (t) was covered by private health insurance under the respondent's own name and had visited a physician at least once in the previous year. TREATist is equal to unity if she was a single mother. Otherwise, it is 0. DuringHITCit is a dummy variable for the years from 1991 to 1993. It is equal to 0 if the years are from 1989 to 1990. TREAT* DuringHITCist

is equal to unity, only if the individual (i) is in the treatment group, and the tax year is 1991, 1992 or 1993. The coefficient of interests are β1, β2 and β3. β1 would be negative if single mothers in general have less accessibility to health insurance and health care service than single women without children. To put it differently, it explains the preexisting difference in outcome variables between single mothers and single women without children.

As the percentage of coverage decreased over the analyzed period, I would also expect estimate of β2 to be negative. Estimate of β3 denotes the effect of the HITC. If there was a relatively positive increase in the treatment group's outcome of interests during the HITC period, estimate of β3 is expected to have a positive sign. Zist controls for individual characteristics. It includes race, age, earned and unearned income, work status, number of children in the household, and metropolitan residency. I also include state fixed effect (θs), year specific state unemployment rate (URTst), and the interaction of URTst and TREATi dummy. If the coefficient of this interaction term is positive, it suggests that single mothers are less susceptible to the business cycle in purchasing health insurance and utilizing health care service.

1.1.2. Data

I use data from the Survey of Income and Program Participation (SIPP). Households are interviewed once every four moths and answered about the previous four mononths. Within each SIPP panel, the sample is randomly divided into four groups. One rotation group is interviewed each month and after all rotation groups complete their first interview, the first wave of the panel concludes. This continues for eight waves of each panel over the course of three years (SIPP Users' Guide, 2001).

For each SIPP panel, I select a wave that represents each year from 1989 to 1993. I use of single women drawn from the third wave of the 1990 to 1993 panels (September to December for each year) and the sixth wave of the 1988 panel (September to December in 1989). The data that I use provides more point-in-time information of an individual's health insurance coverage status, allowing me a lower possibility of inaccurate recall than the Current Population Survey that C&W employed. I chose these waves because they include corresponding questions about health care utilization. Specifically, they include a proxy of health care utilization i.e. information on yearly physicians' visit which represents a key indicator of access to care, regardless of income level (Shi and Starfield, 2001).

Table 1 provides the descriptive statistics of the control and treatment groups. Table 2 shows the change in coverage during this period.

Table 1
Summary Statistics for Low-Educated Working Single Mothers with Children and Single Women Without Children, 1989-1993

Variables	Single Women	Single Mothers	Statistically Different
Age (in years)	32.6	32.8	
	(8.28)	(6.87)	
% w/<12 years of education	.152	.305	***
	(.360)	(.460)	
% w/=12 years of education	.847	.694	***
	(.360)	(.460)	
Number of Kids	0.00	1.85	***
	-	(1.07)	
% White	.765	.559	***
	(.424)	(.495)	
% Black	.151	.306	***
	(.359)	(.460)	
% Others	.083	.134	***
	(.276)	(.340)	
% Full Employed, Full -Month	.661	.469	***
	(.474)	(.498)	
% Full Employed, Part -Month	.004	.007	
	(.066)	(.088)	
% Part Employed, Full-Month	.240	.250	**
	(.430)	(.434)	
% Part Employed, Part-Month	.034	.033	
	(.183)	(.178)	
Earned Income (Monthly $	1491	968	***
at the time of the interview)	(977)	(859)	
Unearned Income (Monthly $	79.7	177	***
at the time of the interview)	(825)	(367)	
% Metropolitan Area	.800	.717	**
	(.401)	(.449)	
% Unemployment Rate in one's State	6.30	6.41	
	(1.47)	(1.45)	
Observations	1,025	1,755	2,780

***: statistically significant at 0.01 level

** : statistically significant at 0.05 level

Standard deviations are in parentheses. Weighted by SIPP individual weights. Dollar amounts are converted to 1993 dollars using CPI-U

Table 2

Health Insurance Coverage Rates & Annual Office Visits for Low-Educated Working Single Mothers with Children and Single Women without Children, 1989-1993

Outcome of Interests	1989	1990	1991	1992	1993	Total
Single Mothers with Children (Treatment Group)						
Private Health Insurance under own name	.550	.465	.476	.420	.401	
	(.032)	(.026)	(.033)	(.026)	(.027)	
Private Health Insurance under own name	.447	.416	.421	.376	.352	
that covers child (covered)	(.029)	(.024)	(.034)	(.024)	(.027)	
Office Visits (%)	.675	.685	.679	.679	.701	
	(.040)	(.023)	(.037)	(.030)	(.031)	
Observations	228	502	270	383	372	1,755
Single Women without Children (Control Group)						
Private Health Insurance under own name	.722	.762	.690	.651	.680	
(covered)	(.044)	(.025)	(.037)	(.029)	(.035)	
Office Visits (%)	.686	.783	.678	.656	.751	
	(.032)	(.027)	(.030)	(.021)	(.024)	
Observations	131	288	174	233	199	1,025

Standard errors are in parentheses. Weighted by SIPP individual weights.

Overall, during this analyzed period, Table 2 demonstrates that the percentage of coverage for single mothers with low levels of education fell from 43.12% (the combined average from 1989 to 1990) to 38.3% (the combined average from 1991 to 1993), while the insurance coverage for the control group decreased from 74.2% (the combined average from 1989 to 1990) to 67.4% (the combined average from 1991 to 1993). This falling trend for both groups, in general, shows the decrease in demand and opportunity to access employer-provided health insurance during the recession period around 1991, especially for single women. The first outcome of interests is whether a working single mother has private health insurance in her own name that covers her children, since the HITC could only offset the price of health insurance that covers a qualified child. As an extension toward measuring the indirect effect of the HITC on health care utilization, a relative change in office visits at least once during the previous year for single mothers from 1991 to 1993 is another outcome of interest.

Because of the multistage-stratified sampling of the SIPP, I report both the weighted and unweighted estimates of the linear regression analyses.

2.1. Results

2.1.1. Effects on Coverage Rates

Table 3, columns 2-3, comprise the main findings of this paper, and indicate that health insurance coverage rates were greater by about 6.6 percentage points than otherwise would have been for single mothers from 1991 to 1993. If we take the estimate for the number of the HITC eligible families headed by working single mothers with low education levels from the 1991 Current Population Survey (CPS) (i.e., 2,485,000) and the estimated coverage increase of about 6.6 percentage points, there would be an increase in enrollment by about 149,100 people because of the HITC who would have otherwise not enrolled in health insurance. Even with a different data set, my results are very similar to that of C&W (column 1, Table 3) who estimated an increase in coverage rates of about 4.7 percentage points due to the HITC; this supports that tax credits for health insurance effectively increased the coverage for low income populations.

In addition to this, Appendix Table 1 shows the event history analysis where I disaggregated the HITC effect by years to explore whether the estimated HITC effect did have the same magnitude in all three years. This shows that the magnitude of the HITC effect on the outcome of interest changed over time during the HITC period. Further, leaving out the interaction term of 1989 and the treatment dummy, there was no significant pre-treatment effect in 1990, possibly supporting the validity of the common trend assumption. As we need an assumption that both treatment and control groups should experience a similar trend, if there were any significant effects on the treatment group before the HITC enactment (Ashenfelter Dip) (i.e. strategically postponing the purchasing insurance), it would overestimate the effect of the HITC.

Table 3

Main Estimates from Equation (1)

covered by private health insurance	(1)	(2)	(3)
	Cebi et al. (2014)	WLS	OLS
Treat	-.128***	-.088	-.016
	(.024)	(.071)	(.065)
During HITC	-.142***	-.019	-.033
	(.001)	(.004)	(.040)
Treat*During HITC	.047***	.066*	.058
	(.012)	(.038)	(.040)
State FE	Y	Y	Y
Observations	21,152	2,755	2,780
R-squared	0.336	0.406	0.400

Notes: (2) and (3) specifications include age, race, number of children, work status, unearned income, earned in- come, state unemployment rate, interaction term between treat group and state unemployment rate. State-clustered standard errors are in parentheses. Full set of covariates are available from the author.

In Table 4, I verify the robustness of the results by considering additional specifications. First, given that respondents may adjust their incomes in order to be eligible for the HITC (Elissa and Hoynes, 2006), I explore equation (1) without using income as a measure. While I exclude income controls, I consider education level and labor union membership instead. The results are in Table 4, columns 1-2; they are comparable to the results that include income (Table 3, columns 2-3).

Second, there were statewide reforms that may have differentially impacted both groups (i.e., state Aid to Families with Dependent Children reforms (AFDC) and state own-EITCs). AFDC was reformed by restricting time limits on welfare eligibility as well as adding work requirements that drew single mothers into the labor force. Also, several states implemented their own EITC standards during the HITC period. Changes in the EITC at the state level provide an additional source of exogenous variation by which to measure the impact of the credit on coverage (Baughman, 2005). As such, following C&W, in Table 4, columns 3-4 do not include states that had AFDC reform and columns 5-6 exclude states that had their own EITC benefits. Overall, though the magnitudes of effect slightly changed, Table 4 suggests that the responsiveness of the HITC on health insurance coverage rates is robust.

Table 4

Robustness Check

covered by private health insurance	(1)	(2)	(3)	(4)	(5)	(6)
	WLS	OLS	WLS	OLS	WLS	OLS
Treat	-.117	-.035	-.039	.048	-.100	-.029
	(.090)	(.083)	(.076)	(.063)	(.089)	(.082)
During HITC	-.023	-.038	-.048	-.071	-.005	-.022
	(.042)	(.042)	(.043)	(.038)	(.045)	(.045)
Treat*During HITC	.065	.061	.096**	.098***	.043	.037
	(.040)	(.039)	(.040)	(.036)	(.044)	(.045)
State FE	Y	Y	Y	Y	Y	Y
Observations	2,755	2,780	2,352	2,372	2,485	2,508
R-squared	.356	.358	.366	.404	.350	.397

Notes: All specifications include age, race, number of children, work status, dummy for high school graduates and union membership, state unemployment rate, interaction term between treat group and state unemployment rate. (3) and (4) are the results based on the states that did not have welfare reform. (5) and (6) are the results based on the states that did not have own EITCs. State-clustered standard errors are in parentheses. Full set of covariates are available from the author.

2.1.2. Effects on Health Care Utilization

Using equation (1) with utilization as an outcome variable, Table 5 shows the effect of the HITC on the probability of visiting a physician (i.e., the extensive margin effects on care demand). Because the frequency of utilization can be confounded with the individuals' health status, I define utilization as a visit to the physician at least once per year. The primary reason for this is that using the exact number of visits might lead to biased estimates of the effect of the HITC on health care utilization. As Currie (1996) explains, the estimates might be downward biased if the improved health status is an omitted variable: "Increase in insurance coverage rates may have increased access to hospital or physicians' office visits, while they could have increased the use of preventive care, enhancing health status and reducing the demand for hospital care." One way to mitigate this issue is by focusing on utilization that is explicitly preventive and unaffected by health status. Physicians' visits for routine check-ups are recommended once a year for people of average age and health status. Therefore, I used at least one office visit per year as a proxy for health care utilization, since the absence of a visit to a physician in the previous year suggests a true access problem, regardless of health status.

To estimate the effect on utilization, I use the same control variable specification as Table 3; corresponding results are in Table 5, columns 1-2. Columns 3-4 use an alternative specification (i.e., excluding income measures, while including education and union membership). Overall, Table 5 displays the increase in coverage translated into a statistically significant increase in physicians' visits. The magnitude and effect size are relatively large compared to the increase in coverage (6.6 percentage points). Therefore, it could be unreasonable to attribute this effect solely to the HITC. Additional contributing factors on utilization might include Medicaid and EITC expansions in the early 1990s.

Table 5

Annual Office Visits from Equation (1)

Office Visits (%)	(1)	(2)	(3)	(4)
	WLS	OLS	WLS	OLS
Treat	.132	.158	.122	.154
	(.099)	(.105)	(.094)	(.101)
During HITC	-.004	-.036	-.007	-.037
	(.039)	(.036)	(.039)	(.037)
Treat*During HITC	.079*	.095**	.079*	.096**
	(.045)	(.036)	(.047)	(.037)
State FE	Y	Y	Y	Y
Observations	2,743	2,780	2,755	2,780
R-squared	.046	.042	.041	.039

Notes: (1) and (2) specification includes age, race, number of children, work status, unearned income, earned income, state unemployment rate, interaction term between treat group and state unemployment rate. (3) and (4) specification excludes income controls but includes dummy for high school graduates and union membership. State-clustered standard errors are in parentheses. Full set of covariates are available from the author.

3. CONCLUSIONS

After several months of disputes to repeal the ACA, on March 24th, 2017, House Republicans pulled the proposed replacement plan. While many parts of the replacement plan are controversial, the reliance on tax credits is a central feature. As such, by replicating a previous study on the HITC, my results add to the evidence that offering tax credits is an effective method for increasing coverage and therefore, hold relevance for current debates around health policy.

The HITC did in fact lead to a coverage increase of about 6.6 percentage points. A 6.6 percentage point relative in- crease in coverage implies that the price elasticity of health insurance is calculated to be -0.8, which is greater than that of C&W (-0.42). To estimate price changes in health insurance for the HITC eligible individuals, surveys conducted by the U.S. Government Accountability Office were used. These estimates suggest that there was a 26 percent reduction in the price of health insurance for the HITC recipients in 1991. Therefore, the 6.6 percentage relative (to single women without children) increase described in this paper suggests a 20.8 percent increase in coverage among single mothers. In other words, without the HITC, only 31.7 percent of single mothers would have been covered compared to 38.3 percent with the HITC. However, it is important to explore why the effect was not larger. One possible explanation could be that the modest amount of the tax credit was not enough to incentivize eligible, low-income populations to enroll (GAO, 1994). If this is the case, then it is arguable that under the AHCA, which offers an even smaller credit than the ACA (and also the HITC if converted into current dollar value) to low-income populations, the financial burden will be greater for eligible people and enrollment in coverage will decrease further. In connecting these findings to the ACA and the AHCA, it is important to note that differences still exist between these plans and the HITC. For example, in 1991, the phase-out range starts from an annual income of over $11,250. However, under the current proposal, the phase-out range begins at $75,000 for single individuals (i.e., approximately $42,323 in 1991), and includes more people who have a relatively higher income.

The other possible explanation would be the insufficient outreach and publicity regarding the HITC. This problem is also documented with the ACA health insurance marketplaces, as about half a million fewer people signed up for insurance into 2017, under the Trump Administration, than would have with the level of outreach and publicity that was seen under the Obama Administration. The third possible reason would be the liquidity constraint (i.e., cash-flow problems for low income families) resulting from timing mismatch. The mismatch between the timing of tax credits offered and that of insurance premium payments could exacerbate liquidity constraint problem. It means that even though the HITC eligible people would like to receive the tax credit benefits, as they only received their credit after filing their tax returns, they might more likely to face liquidity problems. This left them unable to take advantage of the tax credits (Gruber, 2000).

The finding that there was a non-statistically significant increase in utilization under the HITC following the in- crease in enrollment suggests that,

for low-income families, the inability to get coverage would be one of the primary barriers to truly being able to access preventive care. This demonstrates that tax credits for insurance premiums might also be effective at increasing health care utilization. Moreover, given this modest increase, it is reasonable to expect that under the AHCA, with an anticipated decrease in enrollment, resulting from smaller subsidies for low income populations, utilization is also likely to decrease.

Considering the aforementioned results and their respective implications, an empirically informed argument for tax subsidies can be made. However, policy makers are cautioned against the following: (1) assuming that all subsidies will have similar effects on enrollment and utilization, and (2) that subsidies can be conceptualized without regard for how they intersect with various elements of the broader policy. The HITC provides an excellent historical case study for these cautions, because despite its relative success, due to a lack of appropriate regulations, it was ultimately repealed on Dec 31st, 1993. Similar to what was proposed in the AHCA (i.e., removing 10 Essential Health Benefits of the ACA), the HITC did not specify minimum benefits that must be included in insurance plans, enabling insurance companies to abuse this policy and sell valueless plans to tax credit eligible individuals (Sanger-Katz, 2017). There- fore, for tax credits to be a true incentive to increase health care coverage, they must be implemented in tandem with appropriate market regulations.

Overall, this paper provides evidence that tax credits are an effective mechanism for increasing health insurance coverage and utilization. It serves as a case study for exploring how tax credits operate in conjunction with larger health care policy. While specific contexts should be considered, these findings can be extrapolated in further analyses exploring current and future health care policies.

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Appendix Table 1: Event History Analyses

covered by private health insurance	(1)	(2)
	WLS	OLS
Treat	-.093	-.018
	(.080)	(.078)
Treat*1989	-	-
Treat*1990	.021	.015
	(.057)	(.056)
Treat*1991	.089	.076
	(.059)	(.065)
Treat*1992	.086	.085
	(.065)	(.058)
Treat*1993	.059	.055
	(.057)	(.053)
State FE	Y	Y
Observations	2,755	2,780
R-squared	0.407	0.401

Notes:(1) and (2) are event history analyses and include year dummies from 1989 to 1993. State-clustered standard errors are in parentheses.