

2009

# Health Insurance Tax Credits and Health Insurance Coverage of Low-Income Single Mothers

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## Citation

Cebi, Merve, and Stephen A. Woodbury. 2009. "Health Insurance Tax Credits and Health Insurance Coverage of Low-Income Single Mothers." *Employment Research* 16(2): [1]–3. [https://doi.org/10.17848/1075-8445.16\(2\)-1](https://doi.org/10.17848/1075-8445.16(2)-1)

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APRIL 2009

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*Employment Research* is published quarterly by the W.E. Upjohn Institute for Employment Research. Issues appear in January, April, July, and October.

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## Health Insurance Tax Credits and Health Insurance Coverage of Low-Income Single Mothers

**T**he Omnibus Budget Reconciliation Act of 1990 (OBRA) introduced a refundable tax credit for low-income families who purchased health insurance coverage for their children. This health insurance tax credit (HITC) existed during tax years 1991, 1992, and 1993, and was then rescinded. Curiously, although many economists have espoused a refundable tax credit directed toward low-income families (Burman et al. 2007; Cogan, Hubbard, and Kessler 2005; Furman 2008; and Pauly 1999, among others), no one has estimated the effects of the HITC on health insurance coverage.

This article summarizes the evidence we report in a recent study (Cebi and Woodbury 2009) in which we use Current Population Survey data and a difference-in-differences approach to estimate the effect of the 1991–1993 HITC on health insurance coverage of low-income single mothers. Access to health care for low-income women and their children is a concern that extends well beyond health policy. Indeed, for many TANF and Medicaid recipients, lack of affordable health insurance has been a key barrier

to escaping welfare. The findings of our study suggest that during 1991–1993, the health insurance coverage of single mothers was about 6 percentage points higher than it would have been in the absence of the HITC. These findings hardly suggest that an HITC would be a panacea for low-income families' access to health care, but they do suggest that an HITC could be an effective component of a broader set of policies to expand access to health care.

### The Health Insurance Tax Credit, 1991–1993

When Congress passed OBRA, it added a supplemental credit for health insurance purchases to the basic Earned Income Tax Credit (EITC) program. This HITC was a refundable tax credit for low-income workers with one or more children who bought health insurance—either employer-provided or private nongroup—covering the children. The credit offset only the cost of health insurance—not copayments, deductibles, or out-of-pocket health expenses. The credit was refundable, so taxpayers with no federal income tax liability could

still receive a payment from the Internal Revenue Service. The HITC was repealed effective December 31, 1993, so it was available only during tax years 1991, 1992, and 1993.

The HITC and the EITC had the same eligibility criteria, and their schedules were similar. For example, in 1991, a taxpayer with earnings and a qualifying child could receive a credit up to \$428 if he or she bought private health insurance that covered the child. For households with earned incomes of \$1 to \$7,140, the credit was 6 percent of earned income. For households with earnings between \$7,140 and \$11,250, the credit was \$428 (6 percent of \$7,140), and for households with earnings between \$11,250 and \$21,250, the credit phased out at a rate of 4.28 percent per added dollar earned. In 1991, the average credit was \$233, or 23 percent of the reported average annual health insurance premium of \$1,029. Also in 1991, 2.3 million taxpayers received health insurance credits of \$496 million (U.S. Government Accountability Office 1994).

**Main Findings**

To estimate whether the HITC affected the private health insurance coverage of low-income single mothers, we develop a difference-in-differences analysis using 1988–1993 Current Population Survey data on women aged 19–44 who worked (had annual hours greater than zero), were single (never married, widowed, or divorced), and had less than a high school education. We focus on high school dropouts because these women are likely to have low earnings and be eligible for the HITC. (We cannot explicitly examine low earners because the EITC creates incentives for earners to change their hours of work so as to qualify for the credit, and the sample would be self-selected.)

We divide the sample of low-education working single women into two groups—those with children and those without. The population potentially affected by the HITC—the “treatment” group—was low-income working families with children. If the HITC had any effect on private health insurance coverage, then the coverage of low-income working families with

children would have been greater than otherwise between 1991 and 1993. As a “control” group we use working single women without children and with less than a high school education. Because they do not have children, these women are ineligible for the HITC, but they should face essentially similar labor markets, tax policy (apart from the

**The estimates suggest that the Health Insurance Tax Credit increased health insurance coverage of working single mothers by about 6 percentage points.**

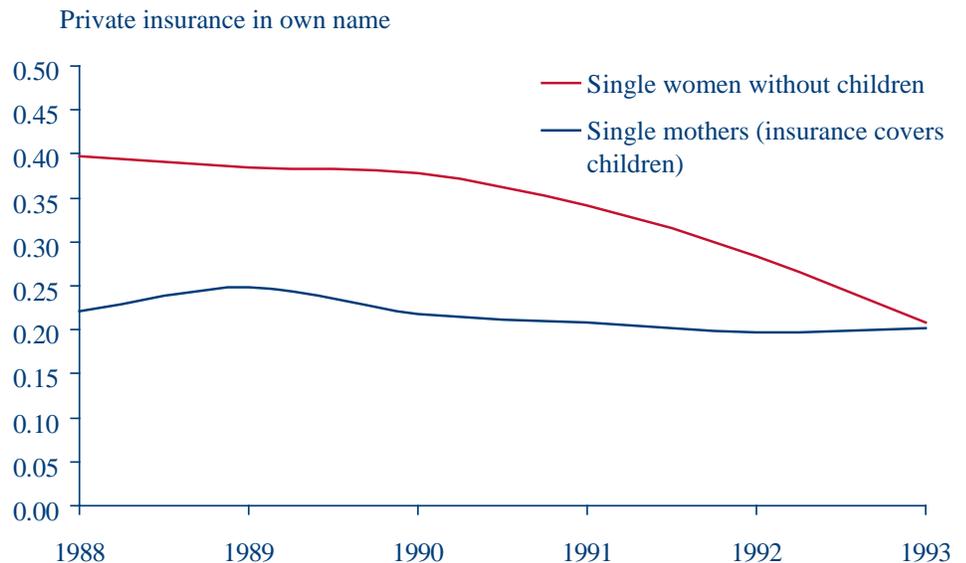
HITC), and other economic conditions as low-education working single mothers (the treatment group).

Figure 1 compares the average private health insurance coverage rates of working single mothers and of working single women without children during 1988 through 1993. The coverage rate for single women without children fell

between 1988 and 1993 (from 39.8 to 20.9 percent), with most of the drop occurring after 1990 (from 37.8 to 20.9 percent). A likely explanation for the drop after 1990 is the recession of 1991, which would have reduced both employment and access to employer-provided health insurance of single women. The private health insurance coverage rate of single mothers also fell from 1988 to 1993, but by much less—from 22.1 to 20.2 percent. Did the HITC cushion the fall of health insurance coverage of working single mothers?

Table 1 shows a simple difference-in-differences analysis of the HITC. It displays the average private health insurance coverage rates for single mothers and single women without children in the years before and during the HITC. The first row shows that health insurance coverage for single mothers (the treatment group) fell by 2.4 percentage points between 1988–1990 and 1991–1993. The second row shows that, over the same time period, coverage fell for single women without children

**Figure 1 Health Insurance Coverage Rates for Low-Education Working Single Mothers and Low-Education Working Single Women without Children**



NOTE: Data are from the March 1989–1994 Annual Demographic Supplements to the Current Population Survey (CPS). The samples include working single women with less than a high school education, with “working” as positive hours and positive earnings during the year. We exclude women who are in school full time, those who are separated from their spouses, and those who report being ill or disabled. Means are tabulated using CPS March supplement weights. Sample sizes are 2,228 (single mothers) and 1,433 (single women without children).

**Table 1 Private Health Insurance Coverage Rates for Low-Education Working Single Mothers and Low-Education Working Single Women without Children**

	Before HITC (1988–1990)	During HITC (1991–1993)	Difference
Single mothers	0.244 (0.013) [1,153]	0.220 (0.013) [1,075]	–0.024 (0.018)
Single women without children	0.389 (0.018) [741]	0.299 (0.017) [692]	–0.090 (0.025)
Difference	–0.145 (0.022)	–0.080 (0.022)	—
Difference-in-differences	—	—	0.065 (0.031)

NOTE: See Figure 1. Figures are average private health insurance coverage rates. Robust standard errors are in parentheses. Sample sizes are in brackets.

(the control group) by 9 percentage points. The implication is that, after netting out the declining trend in insurance coverage, the private health insurance coverage of single mothers was higher by 6.5 percentage points than it would have been without the HITC.

Without further tests, it would be unwise to conclude from the simple analysis in Table 1 that the HITC had a positive effect on the health insurance coverage of single women with children. Accordingly, we have developed difference-in-differences estimates controlling for individual characteristics that are correlated with health insurance coverage. The findings are similar to those in Table 1. We have also performed a number of falsification tests to check whether the findings hold up under closer examination. For example, because women with more education tend to have higher earnings and are less likely to be eligible for the HITC, we would expect to estimate a relatively small (or no) effect of the HITC on working single mothers with high school and college. We would also expect the effect of the HITC to be nil for single mothers who do not work, again because they were ineligible for the HITC. The data support these expectations. Finally, we have performed sensitivity tests to check whether changes in Medicaid, state-level economic condition, or state welfare programs may be responsible for the changes we attribute to the HITC. The main finding appears to hold up to these

sensitivity tests—the estimates suggest that the HITC increased health insurance coverage of working single mothers by about 6 percentage points.

### Conclusion

With a new administration in Washington, and both houses of Congress now led by Democrats, sweeping reform of the U.S. health care system is receiving far more attention than in recent years. But as Zelinsky (2009) notes, incremental change, or Charles Lindblom’s “muddling through,” is the style of change in democracy, so employer-provided health benefits are likely to remain a central feature of U.S. health care financing for the foreseeable future. It may be too early to dismiss incremental policy changes that have the potential to reduce health care costs or increase access to health care. A refundable tax credit for health insurance directed toward low-income families—like the HITC of the early 1990s—has been espoused by many economists. The estimates we describe here suggest that the HITC increased health insurance coverage of low-education working single mothers by about 6 percentage points. Perhaps the HITC should remain in the health policy discussion after all.

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