



Who Gains and Who Loses under the Better Care Reconciliation Act

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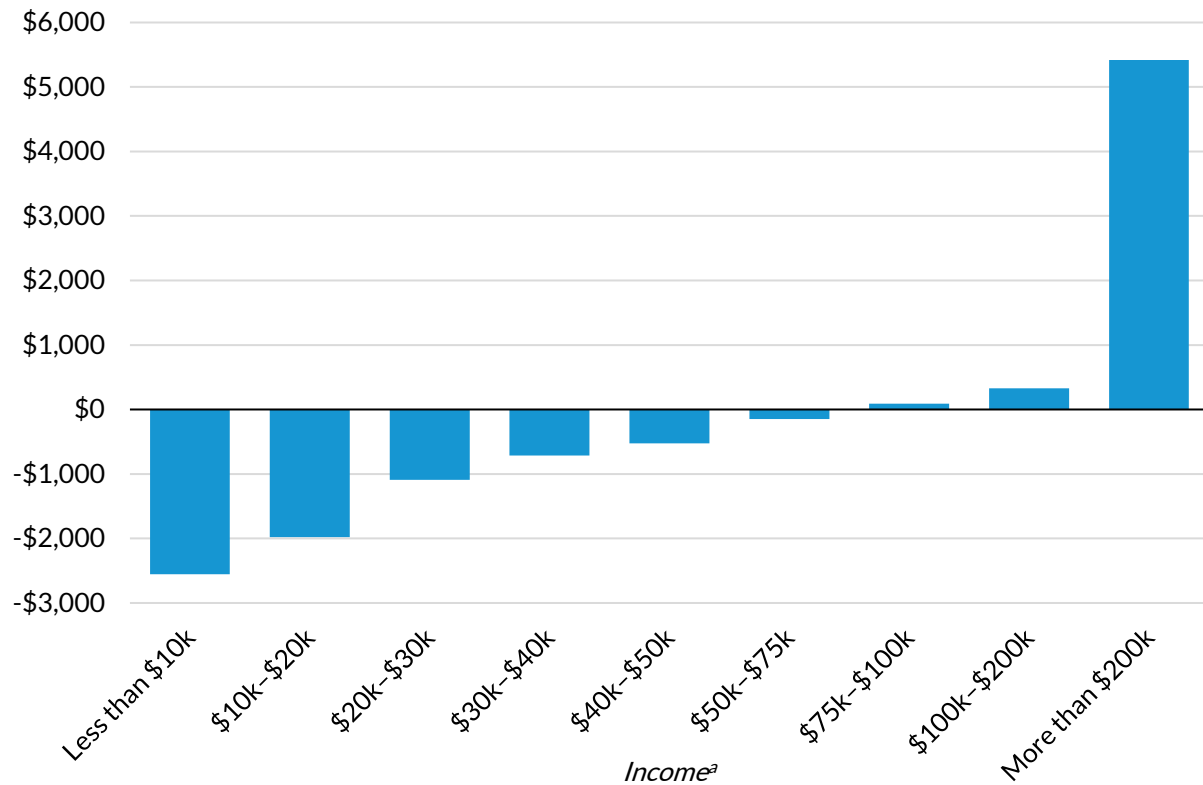
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The proposed Better Care Reconciliation Act (BCRA) would repeal large portions of the Affordable Care Act (ACA), including most of its sources of revenue, and it would significantly change the Medicaid program and the private nongroup insurance market.¹ We use the Urban-Brookings Tax Policy Center Microsimulation Model and the Urban Institute Health Policy Center's Health Insurance Policy Simulation Model (HIPSM) to analyze the effects of the bill and to allocate changes in taxes and federal health benefits across families grouped by income.

We find that the BCRA's changes to federal taxes and health care benefits would be very regressive: taking both tax reductions and benefit reductions into account, the average high-income family would be significantly better off, and the average low-income family would be significantly worse off. The average family with less than \$10,000 of income in 2026 would be \$2,550 worse off, a net reduction of more than 60 percent of the family's income. The average family with more than \$200,000 of income in 2026 would be \$5,420 better off, a net increase of 1 percent of the family's income. Most of the gain for high-income families would be concentrated among families with incomes above \$1,000,000. The average gain for this group would be \$49,000, a net increase of 1.5 percent of income. Using a measure of family income as a percentage of the federal poverty level (FPL), families with incomes below 400 percent of FPL would experience net tax and benefit losses, and families with incomes above 400 percent of FPL would experience net gains under the BCRA. The greatest net gains would go to families with incomes above 600 percent of FPL.

FIGURE 1

Distribution of Change in Average Net Transfers (Benefits less Taxes) under the BCRA, 2026



Sources: Urban-Brookings Tax Policy Center Microsimulation Model (version 0217-1) and Urban Institute Health Policy Center’s Health Insurance Policy Simulation Model (2017).

^a Income is modified adjusted gross income (MAGI), defined as adjusted gross income plus nontaxable Social Security benefits and tax-exempt interest. Analysis includes both filing and nonfiling units but excludes dependents of other tax units. Tax units with negative MAGI are excluded from the bottom income class but are included in the totals. Analysis includes provisions from the discussion draft version of BCRA released by the Senate Budget Committee on June 22, 2017.

Introduction

The version of the Better Care Reconciliation Act released by the Senate Budget Committee on June 22, 2017, would repeal and replace substantial portions of the Affordable Care Act. We analyze the distributional effects of changes to federal taxes and health care spending that would result from this bill, estimating net changes by income level and by income relative to poverty categories.

The BCRA would eliminate most of the ACA's revenue provisions starting in 2017 and nearly all of them by 2023. Beginning in 2020, Medicaid funding would be converted from an open-ended federal matching entitlement to a program based on per capita cap allotments and limits on annual growth. Beginning in 2025, the growth of federal Medicaid funding would be limited to the consumer price index for urban consumers (CPI-U), which is lower than the projected growth in health care costs. States could continue covering the population made eligible for Medicaid under the ACA expansion, but with substantially less federal support after 2020. Federal funding would be reduced for states with per capita spending more than 25 percent above the national average and increased for states with per capita spending more than 25 percent below the national average.

The BCRA would eliminate the ACA's cost-sharing reductions and limit premium tax credits to people with incomes up to 350 percent of FPL. Tax credits would vary by age and income and would be tied to health plans with 58 percent actuarial value. By contrast, the ACA offers tax credits based on 70 percent actuarial value, with cost-sharing reductions that reduce out-of-pocket health care costs for people with incomes up to 250 percent of FPL. Thus, out-of-pocket costs for plans with tax credits would be substantially higher under the BCRA.

The BCRA would also eliminate individual and employer mandate penalties (as of 2016), 3:1 premium age rating limits (in 2020), minimum medical loss ratio standards, tax credits for low-wage small employers, and funding for the Prevention and Public Health Fund (at the end of 2018). States could get Section 1332 waivers to change or eliminate essential health benefit requirements, actuarial value standards, and maximum out-of-pocket limits for nongroup and small group insurance. A State Stability and Innovation Fund would be established to provide grants to states for reinsurance and other uses. People who forgo insurance for more than 62 days would face a six-month waiting period before they could enroll in nongroup insurance.

We use the Urban-Brookings Tax Policy Center Microsimulation Model and the Urban Institute Health Policy Center's Health Insurance Policy Simulation Model to allocate changes in taxes and federal health benefits across income groups.

Methods

Our estimates of federal Medicaid spending, premium tax credits, and ACA cost-sharing reductions were produced by the Health Insurance Policy Simulation Model. We simulated the BCRA in 2026 using the same methods as in our recent analysis of the BCRA in 2022 (Blumberg et al. 2017). Our analysis takes into account the major health provisions of the bill: Medicaid per capita caps, elimination of the higher federal match rate for ACA Medicaid expansion enrollees, adjustments to federal payments to states with above- or below-average per capita spending, new tax credits tied to lower actuarial value plans (as low as 54 percent actuarial value, given allowed variation around target levels), changes in age rating, a six-month waiting period for nongroup coverage, and the State Stability and Innovation Fund (which we assumed would be used for reinsurance). We did not attempt to predict the granting of state waivers.

We assume that under the BCRA, states would eliminate Medicaid eligibility for the ACA expansion population, unless the state had expanded eligibility for childless adults with incomes up to 100 percent of FPL at the traditional federal matching rate before the ACA. This differs from the assumption the Congressional Budget Office used in its analysis of the bill, so our estimates of the BCRA's impact on the federal deficit are smaller (CBO 2017a).

For 2026, we did not simulate any state changes in Medicaid eligibility in response to the lower per capita federal payment growth rate beginning in 2025. This would virtually guarantee that federal payments grow more slowly than medical costs (CBO 2017b). Over time, states would respond to this federal funding shortfall by cutting enrollment, raising taxes, paying providers less, and/or cutting Medicaid benefits.

We simulated the BCRA's tax changes using the Tax Policy Center Microsimulation Model. We simulated repeal of the following ACA tax provisions:²

- 3.8 percent net investment income tax and 0.9 percent additional Medicare hospital insurance tax for individuals with incomes above \$200,000 and couples with incomes above \$250,000
- individual and employer mandate penalties for inadequate health insurance
- excise taxes on health insurance providers and pharmaceutical and medical device manufacturers and importers
- additional limitations on the medical expense deduction

To make the analyses consistent, we distributed HIPSM projections of Medicaid benefits, cost-sharing subsidies, and premium tax credits to tax units in the TPC model in the same income groups.

Results

Table 1 shows the distribution of tax changes resulting from the BCRA in 2026 by tax unit income group; we refer to tax units as families for convenience.³ The tax changes include repeal of almost all the ACA’s revenue provisions and the individual and employer mandate penalties, as well as modifications to the ACA’s premium tax credit. Table 2 shows the distribution of federal benefit changes proposed in the BCRA, including the new Medicaid per capita caps, federal matching rate changes, federal payment adjustments for states with per capita spending well above or well below the national average, and elimination of the ACA’s cost-sharing subsidies. Table 3 combines the findings from tables 1 and 2 into net federal tax and benefit changes by income group. Comparable distributional findings by income relative to the poverty level are found in appendix tables A.1 through A.3. In each table, average tax changes and benefit changes are calculated over the total number of families in each income group, not only over families that would experience a change.

TABLE 1

Distribution of Federal Tax Change under the BCRA, 2026

Income ^a	Number of tax units (thousands)	Share of all tax units (%)	Average tax change per tax unit (\$)	Average tax change as percentage of income (%)	Share of total tax change (%)
< \$10,000	15,110	8.1	-240	-5.7	3.9
\$10,000–\$20,000	18,710	10.1	160	1.1	-3.2
\$20,000–\$30,000	22,820	12.3	240	1.0	-6.0
\$30,000–\$40,000	19,350	10.4	110	0.3	-2.4
\$40,000–\$50,000	13,980	7.5	40	0.1	-0.6
\$50,000–\$75,000	29,300	15.8	-130	-0.2	4.1
\$75,000–\$100,000	17,870	9.6	-250	-0.3	4.9
\$100,000–\$200,000	33,050	17.8	-410	-0.3	14.7
> \$200,000	14,210	7.7	-5,480	-1.0	84.6
All	185,420	100.0	-500	-0.5	100.0
Addendum					
> \$1,000,000	1,100	0.6	-49,090	-1.5	58.9

Sources: Urban-Brookings Tax Policy Center Microsimulation Model (version 0217-1) and Urban Institute Health Policy Center’s Health Insurance Policy Simulation Model (2017).

Notes: The BCRA would repeal the following ACA taxes: 3.8 percent net investment income tax; 0.9 percent additional Medicare hospital insurance tax; excise tax on employers offering inadequate health insurance coverage; excise tax on individuals without adequate health insurance; increase in the threshold for medical expense deductions; and excise taxes on health insurance providers, pharmaceutical manufacturers and importers, and medical device manufacturers and importers. The bill would also modify the premium tax credit. Analysis excludes changes to health savings accounts and medical flexible spending accounts. Analysis captures change in taxes and credits but does not include the impact of changes in premiums or the welfare impact of changes in health insurance coverage or coverage generosity.

^a Income is modified adjusted gross income (MAGI), defined as adjusted gross income plus nontaxable Social Security benefits and tax-exempt interest. Analysis includes both filing and nonfiling units but excludes dependents of other tax units. Tax units with negative MAGI are excluded from the bottom income class but are included in the totals.

On average, taxes would decrease for families with annual incomes of \$50,000 or more. Most families with incomes below \$50,000 would receive a small tax cut, but some would get a substantially lower premium tax credit, resulting in an average net tax increase for families with incomes between \$10,000 and \$50,000 (table 1). Though the BCRA reduces the premium tax credit for many, it does extend eligibility to families with the lowest incomes, resulting in average net tax cuts for those with incomes below \$10,000. However, as shown in table 2, simultaneous Medicaid benefit losses for this income group would be much larger than the decrease in taxes. For families with annual incomes above \$50,000, the average tax reduction increases markedly as income increases.⁴ The average family with more than \$200,000 of income would receive a \$5,480 tax reduction, and this high-income group would account for 84.6 percent of the net tax decrease under the BCRA. Families with incomes above \$1,000,000 would see tax cuts of \$49,090 on average, accounting for 58.9 percent of the net tax decrease for the whole population. This decrease would amount to 1.5 percent of their income.

TABLE 2

Distribution of Change in Federal Medicaid and Cost-Sharing Benefits under the BCRA, 2026

Income ^a	Number of tax units (thousands)	Share of all tax units (%)	Average benefit change per tax unit (\$)	Average benefit change as percentage of income (%)	Share of total benefit change (%)
< \$10,000	15,110	8.1	-2,790	-67.4	32.8
\$10,000–\$20,000	18,710	10.1	-1,820	-12.1	26.5
\$20,000–\$30,000	22,820	12.3	-850	-3.4	15.1
\$30,000–\$40,000	19,350	10.4	-600	-1.7	9.0
\$40,000–\$50,000	13,980	7.5	-480	-1.1	5.3
\$50,000–\$75,000	29,300	15.8	-280	-0.5	6.4
\$75,000–\$100,000	17,870	9.6	-160	-0.2	2.3
\$100,000–\$200,000	33,050	17.8	-80	-0.1	2.1
> \$200,000	14,210	7.7	-60	0.0	0.7
All	185,420	100.0	-690	-0.7	100.0

Sources: Urban-Brookings Tax Policy Center Microsimulation Model (version 0217-1) and Urban Institute Health Policy Center's Health Insurance Policy Simulation Model (2017).

^a Income is modified adjusted gross income (MAGI), defined as adjusted gross income plus nontaxable Social Security benefits and tax-exempt interest. Analysis includes both filing and nonfiling units but excludes dependents of other tax units. Tax units with negative MAGI are excluded from the bottom income class but are included in the totals.

Table 2 shows the change in federal health care spending resulting from Medicaid funding reductions and elimination of the ACA's federal cost-sharing reductions. The average reduction in federal health care benefits would increase quickly as income decreases, reflecting that these benefits accrue largely to low- and middle-income populations under the ACA. Almost 74.5 percent of the federal funding losses under the BCRA would come from families earning less than \$30,000 a year. Most of the remaining funding reductions would come from families with incomes between \$30,000 and \$75,000. The federal benefit losses to families with incomes below \$10,000 would amount to 67.4 percent of their income on average. As table 2 shows, federal funding losses as a share of income decrease dramatically as income increases.

TABLE 3

Distribution of Change in Net Transfers (Benefits less Taxes) under the BCRA, 2026

Income ^a	Number of tax units (thousands)	Share of all tax units (%)	Average net transfer change per tax unit (\$)	Average net transfer change as percentage of income (%)
< \$10,000	15,110	8.1	-2,550	-61.7
\$10,000–\$20,000	18,710	10.1	-1,980	-13.1
\$20,000–\$30,000	22,820	12.3	-1,090	-4.4
\$30,000–\$40,000	19,350	10.4	-710	-2.1
\$40,000–\$50,000	13,980	7.5	-530	-1.2
\$50,000–\$75,000	29,300	15.8	-150	-0.2
\$75,000–\$100,000	17,870	9.6	90	0.1
\$100,000–\$200,000	33,050	17.8	330	0.2
> \$200,000	14,210	7.7	5,420	1.0
All	185,420	100.0	-200	-0.2
Addendum				
> \$1,000,000	1,105	0.6	49,090	1.5

Sources: Urban-Brookings Tax Policy Center Microsimulation Model (version 0217-1) and Urban Institute Health Policy Center's Health Insurance Policy Simulation Model (2017).

^a Income is modified adjusted gross income (MAGI), defined as adjusted gross income plus nontaxable Social Security benefits and tax-exempt interest. Analysis includes both filing and nonfiling units but excludes dependents of other tax units. Tax units with negative MAGI are excluded from the bottom income class but are included in the totals.

Table 3 shows the net effect of the BCRA's federal tax and health benefit changes. On average, families with incomes below \$75,000 would be worse off, and the loss in both absolute dollars and as a share of income would increase as income falls. For example, the net loss for families with incomes below \$10,000 would amount to 61.7 percent of income, but the net loss for families with incomes between \$50,000 and \$75,000 would amount to 0.2 percent of income. Families with incomes over \$75,000 in 2026 would see net gains under the BCRA, but the gains would constitute a small percentage of income (less than 0.3 percent) for those with incomes below \$200,000. Families with incomes above \$200,000 would receive substantial net gains in absolute dollars (\$5,420 on average) and as a share of income (1 percent). Absolute and relative net gains would be even larger for families with incomes above \$1,000,000 (\$49,090 and 1.5 percent of income, respectively). Appendix table A.3 shows that families with incomes below 400 percent of FPL would experience net losses, but those with incomes above 600 percent of FPL would gain the most, \$2,480 on average.

Conclusion

Higher-income families would receive net benefits from the tax and spending changes proposed in the BCRA, and lower-income families would experience net losses. Higher-income families benefit the most from the tax cut; those with incomes over \$200,000 would receive 84.6 percent of the tax reductions in 2026, and those with incomes over \$1,000,000 would receive 58.9 percent of the tax reductions.

Reductions in federal funding for health benefits would hurt lower-income families the most; families with incomes below \$30,000 would sustain nearly three-quarters of the losses in benefits. Taking both tax and benefit changes into account, the largest average gains under the BCRA would go to those with the highest incomes (\$5,420 for families with incomes over \$200,000), and the largest average losses would go to those with the lowest incomes.

APPENDIX TABLE A.1

Distribution of Federal Tax Change under the BCRA, 2026

Income relative to FPL ^a	Number of tax units (thousands)	Share of all tax units (%)	Average tax change per tax unit (\$)	Average tax change as percentage of income (%)	Share of total tax change (%)
< 50% of FPL	12,940	7.0	-220	-6.1	3.1
50–100% of FPL	17,570	9.5	-290	-1.9	5.5
100–138% of FPL	14,370	7.7	410	1.7	-6.4
138–200% of FPL	22,870	12.3	340	1.0	-8.3
200–300% of FPL	30,390	16.4	-40	-0.1	1.3
300–400% of FPL	22,960	12.4	-80	-0.1	1.9
400–500% of FPL	16,500	8.9	-280	-0.3	5.0
500–600% of FPL	13,030	7.0	-330	-0.3	4.6
> 600% of FPL	33,770	18.2	-2,540	-0.8	93.0
All	185,420	100.0	-500	-0.5	100.0

Sources: Urban-Brookings Tax Policy Center Microsimulation Model (version 0217-1) and Urban Institute Health Policy Center's Health Insurance Policy Simulation Model (2017).

Notes: FPL = federal poverty level. The BCRA would repeal the following ACA taxes: 3.8 percent net investment income tax; 0.9 percent additional Medicare hospital insurance tax; excise tax on employers offering inadequate health insurance coverage; excise tax on individuals without adequate health insurance; increase in the threshold for medical expense deductions; excise taxes on health insurance providers, pharmaceutical manufacturers and importers, and medical device manufacturers and importers; and the premium tax credit. Analysis excludes changes to health savings accounts and medical flexible spending accounts. Simulation of health insurance credits calibrated to match HIPSM. Analysis captures change in taxes and credits but does not include the impact of changes in premiums or the welfare impact of changes in health insurance coverage or coverage generosity.

^a Income is modified adjusted gross income (MAGI), defined as adjusted gross income plus nontaxable Social Security benefits and tax-exempt interest. Analysis includes both filing and nonfiling units but excludes dependents of other tax units. Tax units with negative MAGI are excluded from the bottom income class but are included in the totals.

APPENDIX TABLE A.2

Distribution of Change in Federal Medicaid and Cost-Sharing Benefits under the BCRA, 2026

Income relative to FPL ^a	Number of tax units (thousands)	Share of all tax units (%)	Average benefit change per tax unit (\$)	Average benefit change as percentage of income (%)	Share of total benefit change (%)
< 50% of FPL	12,940	7.0	-2,730	-75.2	27.5
50–100% of FPL	17,570	9.5	-1,800	-11.9	24.6
100–138% of FPL	14,370	7.7	-1,910	-8.0	21.3
138–200% of FPL	22,870	12.3	-700	-2.2	12.5
200–300% of FPL	30,390	16.4	-320	-0.7	7.5
300–400% of FPL	22,960	12.4	-160	-0.2	2.9
400–500% of FPL	16,500	8.9	-110	-0.1	1.4
500–600% of FPL	13,030	7.0	-80	-0.1	0.8
> 600% of FPL	33,770	18.2	-60	0.0	1.6
All	185,420	100.0	-690	-0.7	100.0

Sources: Urban-Brookings Tax Policy Center Microsimulation Model (version 0217-1) and Urban Institute Health Policy Center's Health Insurance Policy Simulation Model (2017).

^a Income is modified adjusted gross income (MAGI), defined as adjusted gross income plus nontaxable Social Security benefits and tax-exempt interest. Income includes both filing and nonfiling units but excludes dependents of other tax units. Tax units with negative MAGI are excluded from the bottom income class but are included in the totals.

APPENDIX TABLE A.3

Distribution of Change in Net Transfers (Benefits less Taxes) under the BCRA, 2026

Income relative to FPL ^a	Number of tax units (thousands)	Share of all tax units (%)	Average net transfer change per tax unit (\$)	Average net transfer change as percentage of income (%)
< 50% of FPL	12,940	7.0	-2,500	-69.1
50–100% of FPL	17,570	9.5	-1,510	-10.0
100–138% of FPL	14,370	7.7	-2,320	-9.8
138–200% of FPL	22,870	12.3	-1,040	-3.2
200–300% of FPL	30,390	16.4	-280	-0.6
300–400% of FPL	22,960	12.4	-80	-0.1
400–500% of FPL	16,500	8.9	170	0.2
500–600% of FPL	13,030	7.0	250	0.2
> 600% of FPL	33,770	18.2	2,480	0.8
All	185,420	100.0	-200	-0.2

Sources: Urban-Brookings Tax Policy Center Microsimulation Model (version 0217-1) and Urban Institute Health Policy Center's Health Insurance Policy Simulation Model (2017).

^a Income is modified adjusted gross income (MAGI), defined as adjusted gross income plus nontaxable Social Security benefits and tax-exempt interest. Analysis includes both filing and nonfiling units but excludes dependents of other tax units. Tax units with negative MAGI are excluded from the bottom income class but are included in the totals.

Notes

1. Better Care Reconciliation Act of 2017, H.R. 1628, 115th Cong. (2017), <https://www.budget.senate.gov/imo/media/doc/BetterCareReconciliationAct.6.26.17.pdf>.
2. For description and analysis of the distribution of ACA taxes, see Mermin (2017). We exclude BCRA provisions that enhance health savings accounts and reduce limits on medical flexible spending accounts.
3. A tax unit is a person or a married couple who files a tax return or would file a tax return if their income were high enough, along with all dependents of that person or married couple. A tax unit can differ from a family in certain situations.
4. Our analysis excludes the BCRA provision that increases contribution limits for health savings accounts. Including the provision would further tilt tax cuts toward high-income families because deductible contributions are worth more to families in higher tax brackets and because high-income families are more likely to be constrained by current contribution limits.

References

- Blumberg, Linda J., Matthew Buettgens, John Holahan, Bowen Garrett, and Robin Wang. 2017. *State-by-State Coverage and Government Spending Implications of the Better Care Reconciliation Act*. Washington, DC: Urban Institute.
- CBO (Congressional Budget Office). 2017a. *Cost Estimate: Better Care Reconciliation Act*. Washington, DC: CBO.
- . 2017b. *Longer-Term Effects of the Better Care Reconciliation Act of 2017 on Medicaid Spending*. Washington, DC: CBO.
- Mermin, Gordon. 2017. *Affordable Care Act Taxes*. Washington, DC: Urban Institute.

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Linda J. Blumberg is a senior fellow in the Health Policy Center at the Urban Institute, having joined in 1992. She is an expert on private health insurance (employer and nongroup), health care financing, and health system reform. Her recent work includes extensive research related to the Affordable Care Act (ACA)—in particular, providing technical assistance to states, tracking policy decisionmaking and implementation efforts at the state level, and interpreting and analyzing the implications of specific policies. She codirects a large multiyear project using qualitative and quantitative methods to monitor and evaluate ACA implementation in states and nationally. Examples of her research include several analyses of competition in nongroup Marketplaces, estimation of the implications of ACA repeal through the reconciliation process, strategies for improving the ACA, an array of studies on the implications of the *King v. Burwell* Supreme Court case, analysis of the remaining uninsured, and codirecting 22 state case studies of stakeholder perspectives on ACA implementation. She also led the quantitative analysis supporting the development of a “Roadmap to Universal Coverage” in Massachusetts, a project with her Urban colleagues that informed the 2006 comprehensive reforms in that state. She received her PhD in economics from the University of Michigan.



Matthew Buettgens is a senior research analyst in the Health Policy Center, where he is the mathematician leading the development of Urban's Health Insurance Policy Simulation Model (HIPSM). The model is currently being used to provide technical assistance for health reform implementation in Massachusetts, Missouri, New York, Virginia, and Washington as well as to the federal government. His recent work includes a number of research papers analyzing various aspects of national health insurance reform, both nationally and state-by-state. Research topics have included the costs and coverage implications of Medicaid expansion for both federal and state governments; small firm self-insurance under the Affordable Care Act and its effect on the fully insured market; state-by-state analysis of changes in health insurance coverage and the remaining uninsured; the effect of reform on employers; the affordability of coverage under health insurance exchanges; and the implications of age rating for the affordability of coverage.



John Holahan is an Institute fellow in the Health Policy Center, where he previously served as center director for over 30 years. His recent work focuses on health reform, the uninsured, and health expenditure growth. He has developed proposals for health system reform, most recently in Massachusetts. He has examined the coverage, costs, and economic impact of the Affordable Care Act (ACA), including the costs of Medicaid expansion as well as the macroeconomic effects of the law. He has also analyzed the health status of Medicaid and exchange enrollees, and the implications for costs and exchange premiums. Holahan has written on competition in insurer and provider markets and implications for premiums and government subsidy costs as well as on the cost-containment provisions of the ACA.



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