Health Coverage Tax Credits: A Small Program Offering Large Policy Lessons

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Summary

The Health Coverage Tax Credit (HCTC), which pays 65 percent of health insurance premiums for about 16,000 trade-displaced workers, early retirees receiving payments from the Pension Benefit Guaranty Corporation, and their families, is the country's only use of refundable federal income tax credits to cover the otherwise uninsured. Available in "advanceable form" paid directly to insurers when monthly premiums are due, similar credits play a significant role in many national health reform proposals that seek to cover large numbers of uninsured. For example, in the current presidential campaign, three Democratic and three Republican candidates propose such tax credits.

HCTCs thus provide a unique opportunity to learn lessons that can shape the design of policies intended to help large groups of uninsured. However, the HCTC program has experienced significant problems. No more than 15 percent of eligible workers and their families participate. Moreover, administrative costs are high, consuming roughly 34 percent of all national spending related to HCTC advance payment.

Congressional proposals to reauthorize Trade Adjustment Assistance (TAA) would increase the percentage of premiums covered by the credit from 65 percent to somewhere between 80 and 95 percent, depending on the bill. Such an increase would lower the most serious barrier to participation—namely, that most eligible workers are unable to afford their current 35 percent premium share. However, to fully remedy the low level of HCTC participation, proposals must also address the program's complexity; the requirement for workers to pay premiums in full before the credits begin in advanceable form; and the absence of coverage options, for many workers, that are viewed as sufficiently valuable to purchase. This paper describes these congressional proposals and suggests additional approaches both to address HCTC's problems and to prevent similar difficulties with future tax credits aimed at a larger group of uninsured Americans.

Why does HCTC matter?

As explained in more detail below, Health Coverage Tax Credits (HCTCs) pay 65 percent of health insurance premiums for workers displaced by trade liberalization and certain other people. During a typical month, HCTC subsidizes health coverage for 16,000 households. Its success or failure matters, not just to the workers who depend on the program for health coverage, but also to broader national trade and health policy.

In terms of trade, HCTC represents the country's first attempt to ensure that, when workers are displaced by trade liberalization, they retain health insurance. Both supporters and opponents of trade liberalization agree that, whether or not globalization improves the nation's *net* well-being, it benefits some and hurts others. Along with other Trade Adjustment Assistance (TAA), HCTC cushions the blow experienced by the latter.

From a health policy perspective, federal income tax credits to subsidize coverage for millions of uninsured Americans figure prominently in national health reform proposals by both parties. The current presidential campaign, for example, has featured tax credit proposals from leading candidates in both parties.[1]

Enacted as part of the Trade Act of 2002, the HCTC program represents the country's only current use of federal income tax credits to subsidize health coverage for people who might otherwise be uninsured. The only previous use of credits to help the uninsured involved the so-called "Bentsen child health tax credits" in the early 1990s, which were quickly repealed after little utilization by low-income families[2] and reports of widespread marketing fraud by insurers.[3]

HCTC's administrative infrastructure was developed from 2002 to 2003 as the foundation for a much larger tax credit system.[4] President Bush was then proposing health insurance tax credits for two additional groups: low-income families without access to employer-based coverage and workers laid off due to the economic slowdown at the time. While HCTC has achieved important objectives, serious problems have also emerged. Lessons learned from this program can thus improve the design of future tax credits serving a much larger group of Americans.

In addition, the success or failure of HCTC may directly affect the fate of broader national reforms. Health insurance tax credits are one of the few health policy proposals that have

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The current HCTC program

In addition to the aspects mentioned above, HCTC's general features[5] include the following:

- ***Eligibility***. Two main groups qualify for HCTC: displaced workers whose job loss is certified by the U.S. Department of Labor (DOL) as trade-related and who qualify for TAA income support, which lasts for up to two years after the end of unemployment compensation; and early retirees, age 55-64, who receive payments from the Pension Benefit Guaranty Corporation (PBGC) because their former employers experienced financial hardship and no longer pay promised defined-benefit pensions. Workers in disqualifying coverage (e.g., Medicare and employer coverage where the firm pays at least 50 percent of premiums) are ineligible for HCTC.
- ***Refundability***. The credit is refundable. This means that it is paid in full to eligible individuals, whether or not they otherwise owe federal income tax.
- ***Advanceability***. Credits can be claimed either at the end of the year or in "advanceable" form, paid directly to insurers when monthly premiums are due.
- ***Qualified health plans***. HCTC generally[6] subsidizes only COBRA coverage[7] offered by former employers and state-qualified plans that meet the following consumer protection requirement: If an HCTC-eligible worker was covered during three of the five months preceding enrollment in a state-qualified plan, the insurer may not exclude treatment of preexisting conditions and must guarantee issue of a policy.[8]

received strong bipartisan support over the years. The challenging task of developing consensus around reform would grow still harder if HCTC's problems led policy-makers to take tax credits off the table as a viable option for the uninsured.

HCTC's challenges

HCTC has numerous accomplishments to its credit, including avoidance of the kind of marketing fraud that plagued the Bentsen tax credits; recruitment of state-qualified plans in almost every state; and successful establishment of an unprecedented advance payment infrastructure less than a year following HCTC's statutory creation. Most important, HCTC has subsidized health coverage for tens of thousands of people, many of whom may have been uninsured without the credit. However, as one would expect with almost any groundbreaking initiative, HCTC has also experienced problems. Described below are two of the most significant problems: limited participation by eligible workers and high administrative costs.

Limited participation

Several months after HCTC advance payment first began, the program's failure to enroll more than a small proportion of eligible workers received significant press attention.[9]

Despite outreach efforts involving the national media, Governors' offices and state agencies, health plans, unions, community groups, and federal site visits and mailings, participation remains a problem. However, it is not easy to determine the precise percentage of eligible workers who receive HCTC. Approximately 362,000 households a year meet some of the primary requirements for HCTC eligibility—that is, they are either (a) laid-off workers who qualify for TAA because DOL has certified their displacement as resulting from trade liberalization; or (b) recipients of PBGC pensions who are age 55 through 64. Based on surveys suggesting that between 36 and 50 percent of otherwise eligible workers receive disqualifying coverage,[10] between 181,000 and 232,000 out of these 362,000 households qualify for HCTC. In 2006, 28,000 households received coverage financed by HCTC,[11] implying that between 12 and 15 percent of eligible households used the credit.

It bears emphasis that these participation estimates are approximations. Some of the above-described surveys are less reliable than surveys conducted by, for example, the Census Bureau. Moreover, surveys showing the characteristics of workers displaced from one industry may not predict the characteristics of those displaced from another. Accordingly, the above estimates describe the general magnitude of participation levels, rather than precise HCTC take-up rates.

Prior research has identified the following as the most important causes of low HCTC participation:

- **Affordability**. Many in the target group are unable to afford their 35 percent premium share. Several surveys of workers and state officials confirm that this is the most important barrier to program participation.[13]
- **Liquidity**. Beneficiaries must pay premiums in full before the start of advance payment. Typically, this leads to three months of unsubsidized premium payments, which many displaced workers and early retirees cannot afford. As of September 2006, 18 states used DOL grants to operate so-called "bridge" programs that pay 65 percent of premiums while workers wait for advance payment to begin.[14] In other states, workers pay full premiums while awaiting advance payment but can claim HCTCs for such payments on year-end tax forms.
- **Complex enrollment**. Many beneficiaries find the program confusing and hard to navigate. For example, application forms must be filed with between three and five public and private agencies,

depending on individual circumstances.[15]

- **Limited coverage**. Many beneficiaries find state-qualified coverage to be of little value. After job loss, many workers experience gaps in coverage[16] that permit state-qualified plans to exclude coverage of preexisting conditions, making the insurance substantially less beneficial.[17] Moreover, state-qualified coverage frequently includes nothing but high-deductible options. Some states offer only plans that exclude or severely limit such basic services as prescription drugs, mental health, maternity care, or preventive care. Not only does an absence of high-value coverage reduce participation, those who enroll may face out-of-pocket costs and restrictions on covered benefits that impede access to necessary care. Conversely, a number of states include no high-deductible plans, which some workers may prefer.[18]

High administrative costs

Although they have declined substantially over time, administrative costs for advance payment under HCTC remain high. As of 2006, $1 in IRS administrative costs was required to deliver each $5 in HCTC subsidies.[19] These costs result primarily from the many monthly transactions required for every beneficiary. Each month, the IRS invoices the beneficiary for his or her 35 percent share; tracks receipt of the beneficiary's payment; combines it with the 65 percent HCTC; forwards the full monthly premium payment to the Treasury Department's Financial Management Service, which sends it (along with information identifying the beneficiary) to the insurer in time for the plan's regular monthly due date for premiums; and provides the plan with additional confirmation of the monthly transaction.

This system was designed to recruit health plans by making their participation as simple and inexpensive as possible—and the strategy worked. By March 2006, 40 states, with 87 percent of potentially eligible individuals, had arranged state-qualified coverage, which included 280 plan options. However, this participation was achieved through the federal government's assumption of significant administrative costs that otherwise could have been borne by health plans.

Entirely apart from IRS spending, a portion of each premium paid to a health insurer covers the plan's administrative costs, which are particularly high with non-group coverage. Including both health plan and IRS expenses, total administrative costs consume approximately 34 cents out of every federal dollar spent on HCTC advance payment, according to one estimate.[21] Because the cost of running the program is so high relative to the benefits being provided, using tax credits in larger reforms would create considerable inefficiency unless administrative costs can be substantially reduced.

Addressing these problems

This section of the paper describes possible approaches to overcoming HCTC's problems. With Congress now considering changes to HCTC as part of TAA reauthorization,[22] the discussion below identifies ways to build on pending legislative proposals to make HCTC more effective, while highlighting strategies to avoid similar problems with broader tax credits in future reform proposals.

Improving participation in the HCTC program

Affordability

Congressional proposals would make coverage considerably more affordable, increasing the percentage of premium covered by HCTC from the current 65 percent to a higher amount between 80 and 95 percent, depending on the bill. The broad consensus that tax credits paying 65 percent of premiums are insufficient to make coverage affordable to displaced workers and early retirees suggests that future tax credits must pay more than 65 percent of premiums for most low-income uninsured to enroll.[24]

Liquidity

Congress has proposed two mechanisms[25] to address workers' need to pay full premiums before the start of HCTC advance payment. The first would require that, once advance payment begins, the IRS must refund HCTCs covering the applicable percentage of initial premium payments. Unfortunately, many displaced workers may remain unable to "front" full premium payments while awaiting even prompt refunds.

The second mechanism would appropriate DOL funds that state workforce agencies can use to provide "bridge" coverage, subsidizing premiums while workers wait for advance payment to start.[26] While it represents a creative solution within the confines of HCTC, the current system of divided responsibility for eligibility determination and payment of premium subsidies across multiple government agencies is inherently awkward and inefficient. A better remedy would eliminate the need for workers to pay full premiums while waiting for advance payment.

This problem's source is that workers cannot apply for HCTC advance payment unless they are already enrolled in a qualified plan. The problem can be solved by giving taxpayers the option to establish, without enrolling in qualified coverage, that they have the individual characteristics needed for eligibility.[27] After taxpayers receive such determinations of individual eligibility, they could enroll in coverage the IRS certifies as qualified. They would then pay the worker's portion rather than 100 percent of premiums. Other health subsidy programs where enrollees make partial premium payments, such as Medicare and the State Children's Health Insurance Program (SCHIP), work this way; only after individual eligibility is established do applicants enroll in qualified coverage and pay their share of premiums, and at no time

must they pay full premiums. A similar structure for determining eligibility may be needed for future credits to avoid serious liquidity problems and, as noted below, to simplify enrollment.

Complex enrollment

One congressional proposal[28] provides state workforce agencies with grants that can fund individual assistance to help workers obtain HCTCs.[29] A second proposal requires federal agencies to develop coordinated application procedures for HCTC.[30] As these proposals suggest, both individual consumer assistance and simplified enrollment procedures are needed to achieve high levels of participation with any tax credit proposal. For example, HCTC enrollment has substantially exceeded national average levels when particular unions became deeply involved providing individual assistance.[31] Even with a much simpler program like child health coverage through Medicaid and SCHIP, intensive consumer assistance has greatly increased enrollment.[32] Experience with the latter programs likewise shows the importance of procedural simplifications,[33] which helped 79 percent of eligible children enroll, according to recent data.[34]

With tax credits, however, the IRS's understandable commitment to privacy means that, for application assistance to be effective, policy-makers must establish consumer-friendly procedures through which taxpayers can grant permission for consumer assistance programs to access the consumer's otherwise-confidential information.[35] In addition, people who potentially qualify for credits need routine and convenient opportunities to request assistance, as happened with an IRS pilot project that achieved unparalleled success enrolling eligible workers into HCTC.[36]

Moreover, enrollment simplification allowing workers to apply by filing one form with a single agency might be possible if the IRS let applicants seek individual eligibility determinations before enrolling in qualified coverage, as discussed above.[37] Combining effective consumer assistance and simpler application procedures could increase enrollment significantly, with both HCTC and broader tax credits.

Limited coverage

Congressional proposals would greatly reduce the number of workers exposed to preexisting condition exclusions. Coverage gaps between job loss and notice of potential HCTC eligibility would be disregarded in determining whether workers had continuous coverage. So long as workers with continuous coverage before job loss sought to enroll in HCTC within 63 days of receiving notice of eligibility, preexisting conditions could not be excluded.[38] However, the other benefit limitations described above would remain.

In addressing those limitations, policy-makers need to decide the types of coverage for which they want tax credits to be used. Some policy-makers may seek to assure access to relatively comprehensive plans typical of employer-sponsored insurance; others may prefer high-deductible plans; still others may wish to ensure that each beneficiary has a choice between more comprehensive and high-deductible coverage.[39] For simplicity of exposition, the following discussion assumes that policy-makers want each beneficiary to have the latter choice, but the main point is to illustrate three methods for giving tax credit recipients access to whatever types of coverage policy-makers support:

- *Nationally available coverage options*. Adding several plans that are available throughout the country (for example, national plans in the Federal Employees Health Benefits Program, or FEHBP) to the roster of automatically qualified coverage could offer both comprehensive and high-deductible insurance to all HCTC beneficiaries, supplementing the plans arranged by each state.[40] To protect existing FEHBP enrollees, HCTC premiums could be based on a distinct risk pool comprised entirely of HCTC beneficiaries.[41]
- *State coverage requirements*. Policy-makers could require each state, as a condition of the tax credit being available to its residents, to arrange at least one qualified plan in each category. Comprehensive plans could be defined in terms of either particular covered benefits or actuarial value.[42]
- *State coverage options*. Each state could have the option of either offering a choice between comprehensive and high-deductible coverage or allowing the federal government to provide the coverage type not arranged by the state. Faced with similar options under other federal laws, most states make such arrangements themselves rather than allow a "federal fallback" to operate.[43]

If policy-makers wish to avoid the problems that have emerged under HCTC, a broad-based health insurance tax credit needs to take explicit account of the type of coverage and the range of consumer choices that policy-makers prefer. Once coverage goals are defined, policy-makers can provide access to that coverage through federal fall-back options if the requisite plan type is not otherwise available; an organized purchasing entity offering insurance; or state obligations to arrange specific types of coverage.

Reducing administrative costs

HCTC's administrative costs involving non-group coverage can be reduced by limiting tax credits to plans outside the non-group market. Moreover, a tax credit with more enrollees could realize economies of scale. The IRS estimates that, if HCTC served three times as many taxpayers, total administrative costs would increase by only 40 percent[44]—in other words, per capita administrative costs would fall by more than 50 percent. TAA reauthorization proposals would achieve some of these efficiencies by increasing the number of people eligible for HCTC.[45]

With a new tax credit serving a much larger population, or with a major HCTC expansion, IRS administrative costs could be further lowered by

cutting the number of monthly transactions per beneficiary. Advance payment could be restructured so health plans first billed beneficiaries each month for their premium share and then invoiced the IRS for credits covering the remainder of premium costs.[46] The IRS would engage in a single monthly or quarterly[47] transaction to pay advance credits for all tax credit enrollees in a given plan.[48] The Centers for Medicare & Medicaid Services (CMS) take that approach today in delivering monthly, low-income premium subsidies to health plans that provide Medicare Part D prescription drug coverage.[49] To effectively use this Medicare-type approach with tax credits, the IRS needs to establish mechanisms that, at the point of enrollment, confirm to both health plan and enrollee that the other qualifies for credits.[50] In this way, a future tax credit serving large numbers of people could have a significantly more efficient advance payment system.

Conclusion

Congressional proposals would make real progress addressing some of the most significant causes of low HCTC participation. Additional refinements could make those proposals even more effective. Larger changes will be needed, however, if broad national reforms extend tax credits to a much bigger group.

Notes

[1] Kaiser Family Foundation, *2008 Presidential Candidate Health Care Proposals: Side-by-Side Summary*, available at http://www.health08.org/sidebyside.cfm.

[2] General Accounting Office (GAO), "Tax Credits: Health Insurance Tax Credit Participation Rate Was Low," GAO/GGD 94/99, April 1994.

[3] House Ways and Means Committee, Subcommittee on Oversight, "Report on Marketing Abuse and Administrative Problems Involving the Health Insurance Component of the Earned Income Tax Credit." WMCP: 103-14, 103rd Cong., 1st Sess., June 1, 1993.

[4] See, for example, IRS Oversight Board, *FY2006 IRS Budget: Special Report,* March 2005; R.J. King-Shaw and A. Dobson, *Implementing the New Health Insurance Tax Credit: A Model for Implementation*, U.S. Treasury Department and The Lewin Group, May 21, 2003; R.E. Moffit and N. Owcharenko, *An Examination of the Bush Health Care Agenda*, The Heritage Foundation, October 12, 2004; L. Etheredge, *Trade Act Tax Credits: A Path to Broader Health Care Coverage?* Alliance for Health Reform, August 1, 2003 (transcript available at http://www.kaisernetwork.org/health_cast/uploaded_files/080103_alliance_tradeact_trans.pdf).

[5] The IRS web site contains additional information about HCTC. See "HCTC: Frequently Asked Questions," available at http://www.irs.gov/individuals/article/0,,id=109956,00.html.

[6] HCTC also subsidizes non-group coverage that is not arranged by a state when a worker received such coverage during at least the last 30 days before job loss.

[7] The Consolidated Omnibus Budget Reconciliation Act (COBRA) requires companies with 20 or more employees to do a number of things, including continuing to offer coverage to laid-off workers and their families who formerly received insurance from the company. Workers must pay 102 percent of premiums.

[8] In addition, state-qualified plans may not charge higher premiums or provide less coverage to HCTC enrollees than to others. All these consumer protections apply to workers with continuous coverage for a total of three months before enrolling in HCTC coverage, without a gap lasting 63 days or longer.

[9] See for example, R. Pear, "Sluggish Start for Offer of Tax Credit for Insurance," *New York Times*, January 25, 2004.

[10] S. Dorn, "Take-Up of Health Coverage Tax Credits: Examples of Success in a Program with Low Enrollment," prepared by the Urban Institute for the Commonwealth Fund, December 2006.

[11] This includes both advanceable and year-end HCTCs. Crystal Philcox, IRS, personal communication, November 2007; Internal Revenue Service (IRS), *HCTC Background Briefing*, April 2, 2007.

[12] Dorn, op cit.; Government Accountability Office (GAO), "Trade Adjustment Assistance: Changes to Funding Allocation and Eligibility Requirements Could Enhance States' Ability to Provide Benefits and Services," GAO-07-702, May 2007; GAO, "Trade Adjustment Assistance: Changes Needed to Improve States' Ability to Provide Benefits and Services to Trade-Affected Workers," GAO-07-995T, June 14, 2007; S. Dorn, J. Varon, and F. Pervez, "Limited Take-Up Of Health Coverage Tax Credits And The Design Of Future Tax Credits For The Uninsured," prepared by the Economic and Social Research Institute and Northwest Health Law Advocates for The Commonwealth Fund, revised November 3, 2005.

[13] DOL Office of Inspector General, "Performance Audit Of Health Coverage Tax Credit (HCTC) Bridge And Gap Programs," Report Number: 02-05-204-03-330, September 30, 2005; GAO, "Trade Adjustment Assistance: Most Workers in Five Layoffs Received Services but Better Outreach Needed on New Benefits," GAO-06-43, January 2006; GAO, "Health Coverage Tax Credit: Simplified and More Timely Enrollment Process Could Increase Participation," September 2004, GAO-04-1029. Although this affordability problem affects workers in every state, it is exacerbated in states that have arranged forms of state-qualified coverage that make enrollment particularly costly. For example, 20 states use high-risk pools to offer coverage, with premiums that generally reflect the high average cost of non-HCTC enrollees who qualify for such pools because of their elevated health risks. Similarly, nine states allow premiums to vary by the beneficiary's individual characteristics such as age, gender, health history, current health status, and area of residence. F. Pervez and S. Dorn, "Health Plan Options Under the Health Coverage Tax Credit Program," Health Management Associates and the Urban Institute for the Commonwealth Fund, December 2006. While this individual variation lowers costs for young, healthy men, coverage becomes even less affordable for those with the greatest expected health care needs, impeding their participation while raising serious questions of equity.

[14] GAO May 2007, op cit.

[15] Many beneficiaries also find it difficult to identify which health plans qualify for HCTC. Pervez and Dorn, op cit. Complexity is a different kind of problem in the broader TAA program. Workers are asked to absorb large amounts of information about multiple benefits during the stressful period following job loss, which is one reason why many laid-off workers do not know about HCTC. GAO 2006, op cit.

[16] Depending on what happens to their former employers, PBGC enrollees may or may not experience gaps in coverage like those that are typical for many TAA-eligible workers. Philcox, IRS, op cit.

[17] Under federal law, such gaps also permit state-qualified plans to deny issue. However, according to one early survey, roughly half of state-qualified plans issued policies to workers with coverage gaps. By contrast, nearly every state-qualified plan excluded preexisting conditions. S. Dorn and T. Kutyla, *Health Coverage Tax Credits Under The Trade Act Of 2002: A Preliminary Analysis Of Program Operation*, prepared by the Economic and Social Research Institute for The Commonwealth Fund, April 2004. Some plans waive their right to exclude preexisting conditions for enrollees with coverage gaps. Philcox, op cit.

[18] Pervez and Dorn, op cit.

[19] During 2006, the IRS incurred $20 million in administrative costs to deliver $80 million in advanceable credits and $19 million in end-of-year credits. Philcox, op cit.

[20] Pervez and Dorn, op cit.

[21] S. Dorn, "Administrative Costs for Advance Payment of Health Coverage Tax Credits: An Initial Analysis," prepared by the Urban Institute for the Commonwealth Fund, March 2007.

[22] On the subject of TAA reauthorization, H.R. 3920 has passed the House. Pending Senate bills include S. 1848, which has 23 co-sponsors, including the Chairman of the Senate Finance Committee, S. 1652, and S.1739.

[23] H.R. 3920 and S. 1848 would raise the subsidy to 85 percent. S. 1652 and S. 1739 would raise the HCTC subsidy percentage to 80 percent and 95 percent, respectively.

[24] Accompanying this increase in the subsidy percentage, pending legislation would narrow the range of premium variation permitted for state-qualified coverage. For example, S. 1848 limits premium variation to the amount permitted in each state's small group market, and H.R. 3920 specifies that the highest rate-band for a given plan cannot exceed the plan's standard premium by more than 50 percent. While both proposals allow significant variation, they narrow the range, lowering premiums for older adults and the chronically ill while increasing premiums for the young and healthy. Increasing the percentage of premium paid by the credit would protect individuals in the latter group from unaffordable cost increases to some degree. However, the impact of rating changes on premiums will depend on the beneficiary's traits, the number and health status of enrollees with whom HCTC beneficiaries are grouped in determining premiums, and the state's rating rules. Also, because plans may leave HCTC if new rules diverge greatly from current market practices, policy-makers may need to provide such plans' enrollees with transitional coverage.

[25] These mechanisms are set forth in S. 1848.

[26] This approach lets each state decide whether to make bridge payments. Federal policy-makers instead could require all states to provide such assistance. Of course, requiring any particular use of DOL funds may reduce states' provision of other services.

[27] Under the HCTC statute, this means that the taxpayer satisfies the requirements of IRC Section 35 (b)(1)(A)(i), (iii), and (iv). Even with the new procedure offered as an option to taxpayers, the IRS would not begin advance payment until it finds that both the taxpayer and plan qualify.

[28] S. 1848.

[29] However, as with the above-described bridge payments, some states may choose not to provide this assistance.

[30] S. 1652.

[31] Dorn 2006, op cit., citing examples from West Virginia and Bethlehem Steel.

[32] Flores, G. et al. "Randomized, Controlled Trial of the Effectiveness of Community-Based Case Management in Insuring Uninsured Latino

Children" *Pediatrics*. December 2005. Vol. 116, No. 6, pp. 1433-1441.

[33] See, e.g., J. Wooldridge, G. Kenney, C. Trenholm, *Congressionally Mandated Evaluation of the State Children's Health Insurance Program: Final Report to Congress*, Mathematica Policy Research, Inc., and The Urban Institute, October 26, 2005; D. Cohen Ross, L. Cox, and C. Marks, *Resuming the Path to Health Coverage for Children and Parents: A 50 State Update on Eligibility Rules, Enrollment and Renewal Procedures, and Cost-Sharing Practices in Medicaid and SCHIP in 2006*, Center on Budget and Policy Priorities and Kaiser Commission on Medicaid and the Uninsured, January 2007.

[34] J. L. Hudson, and T.M. Selden, "Children's Eligibility and Coverage: Recent Trends and a Look Ahead." *Health Affairs*, Web Exclusive, August 16, 2007.

[35] Without such access, only the taxpayer can receive information from the IRS about the status of his or her tax credit application, making it much harder for the assistance program to diagnose and resolve problems expeditiously. IRS Form 8821 currently allows taxpayers to authorize third-parties to obtain otherwise confidential information for specific purposes. However, it is not realistic to expect this form to be used systematically to help HCTC applicants unless the IRS shares with qualified health plans, state workforce agencies, unions, and others specific examples of how the form can be used for HCTC.

[36] The HCTC call center operated this program from March through July 2004. Asked if they wanted their contact information shared with their state, 83 percent of Virginia callers consented to disclosure. The state then contacted these individuals, enrolling more than 90 percent into health coverage. Dorn 2006, op cit. With both HCTC and future tax credits, Congress could direct the IRS to give all taxpayers who contact the tax credit program the option to share their contact information with an IRS-approved consumer assistance agency, as under the above-described pilot. That pilot ended because of a generalized institutional concern about confidentiality, despite the absence of any privacy breaches. Such concerns are likely to prevent similar efforts in the future unless Congress specifically directs the IRS to take these steps.

[37] With HCTC, a single form filed with either PBGC or a state workforce agency could initiate an application for both (a) TAA or PBGC and (b) an IRS determination of individual eligibility for HCTC.

[38] This proposal applies to TAA workers. With PBGC-eligible workers, the House bill applies consumer protections so long as workers enroll in HCTC-qualified coverage within 90 days of the last day of the month in which they first become PBGC eligible. Under S. 1848, appropriated NEG grants must be used to provide health insurance coverage for PBGC-eligible individuals for three months before they enroll in HCTC-qualified plans. This provides eligible workers with continuous coverage, so when they shift to HCTC-qualified plans, consumer protections apply.

[39] Congressional proposals to substantially increase the percentage of premium covered by HCTC would help spread health care risk across both comprehensive and high-deductible plans, promoting the sustainability of each option. Large percentage subsidies in FEHBP have prevented significant risk segmentation. B. M. Gray, T.M. Selden, 2002, "Adverse Selection And The Capped Premium Subsidy In The Federal Employees Health Benefits Program," *The Journal of Risk and Insurance*, Vol. 69, No. 2, 209-224. In broader proposals, subsidized reinsurance and risk-adjusted payments to plans that do not affect premiums charged to consumers can further lessen adverse selection and risk of destabilization.

[40] Offering such nationwide qualified plans would yield many other benefits. Such offers would address the difficulty that workers face in identifying which plans qualify for the credit. Administrative costs would fall if enrollees shifted into nationwide and out of non-group plans, with their high administrative costs. If numerous HCTC beneficiaries enrolled in a small number of national plans, the IRS could negotiate a more efficient approach to delivering advance payment, potentially reducing program administrative costs, particularly if HCTC were limited to coverage purchased through the federal plans. Federally-arranged plans could be prohibited from varying premiums based on age, gender, health status, or other individual characteristics, as with FEHBP today.

[41] However, if a plan has few HCTC enrollees, and some of them have major health problems, HCTC premiums could be high. Large premium subsidies would provide some protection, as would limiting the number of qualifying FEHBP plans, thus increasing the number of HCTC members per plan. Nevertheless, especially if healthier beneficiaries disproportionately enroll elsewhere, affordability may remain a problem.

[42] For example, Medicaid requires each state to provide children with a federally-specified set of benefits, but SCHIP requires coverage with an actuarial value based on the state's choice among the FEHBP standard Blue Cross/Blue Shield plan, state employee coverage, and the most highly-subscribed Health Maintenance Organization in the state. "Actuarial value" is a measure of the global comprehensiveness of a given package of benefits and out-of-pocket cost-sharing rules, reflecting the expected average claims costs of a standardized population.

[43] For example, the Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires each state to arrange individual insurance for people with expiring COBRA coverage. If a state does not make its own arrangements, a "federal fallback" applies. Only 9 states and D.C. use this fallback. Kaiser Family Foundation, "Non-Group Coverage Rules for HIPAA Eligible Individuals, 2006," *Statehealthfacts.org*, data as of December 2006.

[44] S*tatement of David R. Williams*, Director of Electronic Tax Administration and Refundable Credits, Internal Revenue Service, Testimony Before the House Committee on Ways and Means, June 14, 2007.

[45] For example, the Congressional Budget Office (CBO) estimates that, by extending TAA to service-sector workers and allowing industry wide certification of trade-related, adverse effects, H.R. 3920 would increase the number of TAA recipients by roughly 50 percent. CBO, *Cost Estimate: H.R. 3920, Trade and Globalization Assistance Act of 2007*, October 29, 2007.

[46] Of course, this would increase plans' administrative costs and delay payment. While that might create difficulties with a relatively small program like the current HCTC, such costs and delays need not deter policy-makers from using this administrative structure if the HCTC-eligible population expands significantly or if a new credit serves a much larger group. Health plans already accept such administrative expenses and delays with Medicare Part D, presumably building the resulting costs into their premiums. If policy-makers wish to avoid similar cost-shifts with future tax credits, insurers could receive supplemental credits, perhaps equaling 1 or 2 percent of premiums. The latter approach is borrowed from COBRA, which requires enrollees to pay 102 percent of premiums, with the extra 2 percent covering employers' administrative costs.

[47] If credits were paid quarterly, plans would need interest payments compensating for resulting delays.

[48] Alternatively, CMS could adapt its current infrastructure to administer advance payment for IRS.

[49] When enrollees receive low-income subsidies, Part D plans bill them for the applicable, reduced premium amount. At the end of the month, CMS makes adjustments for each plan, including payments that compensate for all premium reductions provided to subsidized enrollees. Kim Miegel, Technical Advisor, CMS Division of Enrollment and Payment Operations, "Beneficiary Premium Payment," *Medicare Advantage and Prescription Drug Plans Enrollment and Payment Conference*, August 30 – September 1, 2005, available at http://www.cms.hhs.gov/MedicareMangCareSys/Downloads/Day1PDPEnrollmentConference.zip. Suggesting this mechanism's general effectiveness in delivering subsidies, in 2006 less than 1 percent of CMS' total year-end corrections to monthly payments made to Part D plans involved low-income subsidies. CMS, *2006 Part D Payment Reconciliation*, downloaded on November 27, 2007 from http://www.cms.hhs.gov/MCRAdvPartDEnrolData/Downloads/2006%20Part%20D%20Payment%20Recon.pdf.

[50] With this approach, it is critically important for the tax credit statute to make clear that either the health plan or the taxpayer can be liable to the IRS for wrongful advance payments, depending on the circumstances surrounding the error. Without such a provision, taxpayers could be subjected to significant penalties based on health plan actions over which the taxpayers have no control.

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