

# LIMITED TAKE-UP OF HEALTH COVERAGE TAX CREDITS AND THE DESIGN OF FUTURE TAX CREDITS FOR THE UNINSURED

## **Stan Dorn**

Senior Policy Analyst  
Economic and Social Research Institute

## **Janet Varon**

Executive Director  
Northwest Health Law Advocates

## **Fouad Pervez**

Policy Analyst  
Economic and Social Research Institute

*Revised November 3, 2005*

**ABSTRACT:** The Trade Act of 2002 created federal tax credits to subsidize health coverage for certain early retirees and workers displaced by international trade. Though small, this program offers the opportunity to learn how to design future tax credits for larger groups of uninsured. During September 2004, the most recent month for which there are data about all forms of Trade Act credits, roughly 22 percent of eligible individuals received credits. The authors find that health insurance tax credits are more likely to reach their target populations if they: 1) limit premium costs for the low-income uninsured and do not require full premium payments while applications are pending; 2) provide access to coverage that beneficiaries value, including care for pre-existing conditions; 3) are combined with outreach that uses easily understandable, multilingual materials and proactive enrollment efforts; and 4) feature a simple application process involving one form filed with one agency.

Support for this paper was provided by The Commonwealth Fund. The views presented here are those of the authors and should not be attributed to The Commonwealth Fund or the Fund's directors, officers, or staff.

## ABOUT THE AUTHORS

**Stan Dorn, J.D.**, is a senior policy analyst at the Economic and Social Research Institute (ESRI). He has been involved in health policy at the state and national levels for almost 20 years, focusing on low-income consumers, Medicaid, the State Children’s Health Insurance Program (SCHIP), and the uninsured. Previously, Dorn served as director of the Health Consumer Alliance, a consortium of legal services groups in California that help low-income consumers obtain necessary health care. He also directed the Health Division of the Children’s Defense Fund, where he led the health policy team in CDF’s campaign that helped enact SCHIP in 1997. Before his work at CDF, Dorn directed the Washington, D.C., office of the National Health Law Program and served as a staff attorney in its Los Angeles headquarters.

**Janet Varon, J.D.**, is the Executive Director of Northwest Health Law Advocates, which she started in 1999. From 1983 to 1996, Janet was a staff attorney at Evergreen Legal Services. Her work focuses on health benefits for low-income, uninsured, and underinsured people in Washington State and nationally. She chairs Washington’s Medical Assistance Advisory Committee.

**Fouad Pervez, M.P.H.**, is a policy associate at ESRI. He has worked primarily on health care coverage, financing, and access issues affecting low-income populations, at both the state and national levels. Prior to joining ESRI, Pervez was a researcher at the Georgetown University Health Policy Institute, where he focused on Medicaid and SCHIP policy, poverty trends, budget cuts, low-wage workers, and immigrant health. Before his work at Georgetown, Pervez conducted research into racial and ethnic health disparities at the Latin-American Health Institute in Boston. Pervez holds a graduate degree in health policy from the University of Michigan.

## ABOUT THE ECONOMIC AND SOCIAL RESEARCH INSTITUTE

Founded in 1987, ESRI is a nonpartisan, nonprofit research organization headquartered in Washington, D.C. Specializing in health and social policy research, ESRI conducts studies aimed at enhancing the effectiveness of social programs, improving the ways in which health care services are organized and delivered, and making high-quality health care accessible and affordable.

## ABOUT NORTHWEST HEALTH LAW ADVOCATES

Northwest Health Law Advocates (NoHLA) is a nonprofit consumer health advocacy organization based in Seattle, Washington. NoHLA’s mission is to promote increased access to health care and to advance basic health rights for all individuals through legal and policy advocacy, education, and support to community organizations.

## ACKNOWLEDGMENTS

The authors are grateful to The Commonwealth Fund, whose financial support made this study possible. The authors would also like to thank: Stephen Finan of the U.S. Treasury Department; David R. Williams and Marilyn J. Smith of the Internal Revenue Service; Jack A. Meyer of ESRI; and JoAnn Lamphere of The Lewin Group for reviewing earlier drafts of this report. Neither The Commonwealth Fund nor our reviewers are responsible for the views expressed in this report, which are solely the authors’.

# CONTENTS

<b>Executive Summary</b>	<b>iii</b>
<b>Introduction</b>	<b>1</b>
<b>I. Enrollment in HCTC – less than originally hoped, more than frequently believed</b>	<b>2</b>
<b>II. While affordability of the worker’s 35 percent premium share may be the most significant factor limiting HCTC enrollment, other factors also play an important role</b>	<b>5</b>
<b>III. Could HCTC’s take-up problems affect future tax credits focused at other groups of uninsured?</b>	<b>9</b>
<b>A. Distinctive characteristics of HCTC-eligible households that affect take-up</b>	<b>10</b>
<b>B. Subsidy size and take-up rates</b>	<b>12</b>
<b>C. Enrollment obstacles other than affordability</b>	<b>19</b>
<b>Conclusion</b>	<b>23</b>
<b>Appendix A: National HCTC rules</b>	<b>24</b>
<b>Appendix B: Enrollment into advance payment</b>	<b>26</b>
<b>Appendix C: Analysis of contact information on IRS website</b>	<b>28</b>
<b>Notes</b>	<b>40</b>

## Executive Summary

The Trade Act of 2002 created Health Coverage Tax Credits (HCTCs) to subsidize health coverage for two groups: certain early retirees who receive assistance from the Pension Benefit Guaranty Corporation (PBGC) and workers who are displaced by international trade and receive Trade Adjustment Assistance (TAA). The tax credits pay 65 percent of premiums for qualified health coverage, which primarily consists of COBRA plans sponsored by former employers and private insurance offered by state arrangement. The federal income tax credits are fully refundable—that is, they are available in full to eligible households, including those with little or no tax liability. At the beneficiary’s option, the credit is either paid in advanceable form directly to the insurer each month, when premiums are due, or goes to the taxpayer after the end of the year, based on the taxpayer’s federal income tax form. (For readers who are unfamiliar with the HCTC program, Appendices A and B to this report describe the program’s basic elements.)

Although HCTCs target a relatively small group, the program offers a unique opportunity to glean lessons about the design of tax credits for other uninsured populations. This issue brief analyzes a well-known problem with the HCTC program—namely, that many eligible individuals have not participated—and explores how future tax credits could be designed to overcome this problem. In the past, a broad range of leaders, including both major presidential candidates in 2004, have proposed using tax credits to subsidize coverage for millions of low- and moderate-income uninsured. The effectiveness of such proposals may hinge in large part on policymakers’ ability to learn from the HCTC experience and improve the design of future tax credits.

### *Enrollment into HCTCs: Less than expected, more than sometimes portrayed*

Based on tax expenditure data, enrollment in HCTCs is about one-third of the level anticipated when the Trade Act passed. In July 2002, the Congressional Joint Committee on Taxation (Joint Tax) estimated that credits would total \$399 million in 2004, \$452 million in 2005, \$470 million in 2006, and increasing amounts in later years. In February 2005, the U.S. Office of Management and Budget (OMB) gave actual and estimated totals for the HCTC program at roughly one-third the projected levels: \$120 million in 2004, \$150 million in 2005, \$140 million in 2006, etc.

Despite this gap between expectations and performance, the take-up rate for HCTCs is higher than is sometimes stated. In July 2005, out of an estimated 234,000 potentially eligible workers and retirees, only 15,640, or 6.7 percent, were enrolled in advance payment. Although a number of respected analysts have suggested a corresponding take-up rate in the neighborhood of 6 percent, the actual take-up rate for HCTC is significantly above that level, for two reasons. First, while 234,000 individuals were identified as *potentially eligible* because they received PBGC or TAA assistance, many were *actually ineligible* because they had other health coverage that precludes HCTC eligibility, such as Medicare or insurance heavily subsidized by a spouse’s employer. Based on the Gov-

ernment Accountability Office's (GAO) description of Internal Revenue Service (IRS) survey results, such disqualification may affect roughly half of individuals who do not enroll in advance payment despite their identification as potentially eligible for credits. Second, individuals who take up HCTCs include, in addition to advance payment recipients, households that receive the credits only after the end of the year, through claims on their federal income tax forms.

To take into account these two factors, an adjusted take-up estimate can be derived as follows. September is the most recent month in 2004 for which advance payment data are publicly available. In that month, nearly 13,600 households received advance payment. In addition, approximately 11,900 households may have received end-of-year HCTCs for 2004 without participating in advance payment, based on recent IRS data. Accordingly, as many as 25,500 workers may have received the credit in some form applicable to September 2004. For that month, IRS received the names of 222,000 workers who received TAA or PBGC assistance and so potentially qualified for the credit. If, as suggested by GAO, roughly half of those workers who did not enroll in advance payment were ineligible for the credit because they were receiving disqualifying coverage, then approximately 118,000 households qualified for the credit. With 25,500 households obtaining the credit in some form, the rough HCTC take-up rate was 22 percent.

In assessing the significance of this number, two caveats are important. First, it is only a rough approximation; GAO's survey description is the only known evidence of the proportion of names sent to IRS that is ineligible for the program. The underlying survey has not been made publicly available, so it is impossible to assess its reliability.

Second, the HCTC program, which is quite novel in its approach to health coverage, is still relatively new. Advance payment began operation in August 2003, slightly more than two years ago. Over time, advance payment enrollment has increased from 8,374 in December 2003 to 13,562 in September 2004 to 15,640 in July 2005. As health plans, government officials, and eligible individuals grow increasingly familiar with the credit, enrollment could continue to increase in the future. Nevertheless, if the program continues on its current course, a dramatic spike in future enrollment would be surprising.

By contrast, the State Children's Health Insurance Program (SCHIP) was less novel, because it built on earlier program infrastructure developed by Medicaid. It is therefore unclear whether SCHIP can fairly be used as a benchmark for HCTC enrollment. SCHIP had a 43.5 percent take-up rate in its first year (1998), 53.9 percent by its third year (2000), and 60.4 percent by its fifth year (2002).

### *Key causes of low take-up*

Many factors impede enrollment into the HCTC program. According to many state officials and stakeholders, however, the most important obstacle to enrollment is that many potentially eligible workers and retirees cannot afford to pay their 35 percent share of premiums.

Another important reason for relatively low take-up is that applicants are frequently required to pay one to three months of premiums, in full, before the start of advance payment. That is because, under the statute, enrollment in a qualified plan is required for HCTC eligibility, and IRS typically requires one to three months to process applications for advance payment. As of September 2005, only 12 states, which together included 39 percent of potentially eligible workers, operated “gap-filler” programs that paid 65 percent of premiums while workers waited for their HCTC advance payments to start.

In addition, many potentially eligible beneficiaries experience coverage gaps of 63 days or more before attempting to enroll in a state-based HCTC plan. Under the HCTC statute, state-based plans can deny coverage of such beneficiaries’ preexisting conditions for up to 12 months. According to observers in a number of states, laid-off workers and early retirees with preexisting conditions almost always regard coverage that excludes those conditions as providing little value and thus choose not to enroll.

Enrollment has also been hindered by limitations in IRS’s approach to outreach. To their credit, officials have taken important steps to educate potential beneficiaries. For example, the IRS sent three mailings to encourage end-of-year HCTC claims for 2003; federal officials have participated in HCTC educational events across the country; and IRS regularly mails HCTC Program Kits, which explain the program in detail, to everyone identified by PBGC or a state workforce agency as potentially qualifying for the credit.

However, several factors have limited the effectiveness of these efforts. According to a recent analysis of outreach to individuals eligible for new Medicare prescription drug subsidies, consumer education materials should be written at no more than a fifth-grade reading level. The HCTC Program Kit, the main educational tool for advance payment, is written at an eighth-grade reading level, making it difficult for some to understand. In addition, the kit is not mailed in languages other than English.

Even if outreach materials were improved, another key barrier remains: namely, the IRS’ two-step enrollment process, in which the agency first provides potentially eligible individuals with HCTC information and then hopes that those receiving the information will later submit an application. This is a traditional approach used by most other health coverage programs, like Medicaid and the State Children’s Health Insurance Program (SCHIP). Much more effective, however, would be a more proactive, one-step process where IRS (or an agency working with IRS) affirmatively contacts potentially eligible individuals about available benefits and allows such individuals to submit a complete application during that initial contact. To illustrate the importance of such proactive strategies, the IRS National Taxpayer Advocate Service (TAS) found that when staff initiated telephone contact to assist individuals with challenging IRS audits of Earned Income Tax Credit claims, as many as 67 percent of these individuals received favorable awards. By contrast, when TAS staff provided assistance without making such proactive telephone calls, only 38 percent obtained favorable awards.

In-person outreach events could likewise be structured to help potentially eligible individuals apply and enroll on the spot. The early months of the HCTC program saw Maryland achieve dramatically higher take-up rates than any other state, largely be-

cause a list of all the state's PBGC recipients was loaded onto health plan officials' laptops, allowing in-person registration and immediate enrollment at consumer information events. Since then, federal officials' application of privacy requirements has prevented further use of this strategy in Maryland and other states. Instead, in-person events can only educate potential beneficiaries, who must later apply on their own.

Another barrier to enrollment is that the process is complex and time-consuming. To qualify for advance payment, workers must apply to between three and five public and private entities and frequently must deliver to one or more of these entities hard-copy documents issued by the others.

At an equally basic level, applicants may have difficulty identifying the state-qualified plans for which the credits can be used. Such difficulties can prevent otherwise eligible households from receiving HCTCs, since IRS does not pay the credit unless an applicant demonstrates enrollment in a qualified health plan.

To learn about state-qualified plans, HCTC applicants are directed to the IRS web site, which lists all such plans and provides their telephone numbers and (in some cases) Web addresses. The IRS Web site, however, includes incomplete information and broken links. Between May 24 and June 16, 2005, researchers from the Economic and Social Research Institute (ESRI) found the following:

- For 57 insurers then listed as offering state-qualified coverage, 21 listings (37%) did not include Web addresses, and one had a non-functioning Web address.
- Out of 35 insurers with a direct link from the IRS site:
  - Only five (or 15%) included any information about HCTC on the Web page called up by following the link.
  - For 20 insurers (57%), a viewer could not identify the HCTC-qualified health plan despite viewing all potentially pertinent links visible from that initial Web page and searching the plan's Web site for all terms related to HCTC.

When researchers called phone numbers for the 57 insurers listed on the IRS site:

- For only 20 of the 57 insurers (35%), the person answering the phone could identify the HCTC-qualified plan.
- For 12 insurers (21%), two or more transfers were needed to find such an employee.
- For 10 plans (18%), no employee could be found to identify the insurer's HCTC-qualified plan.

This problem, which policymakers did not anticipate while they were adopting the Trade Act, highlights the importance of providing program administrators with the flexibility and capacity necessary to address unforeseen problems. If, for example, the HCTC statute had given federal agencies broad authority to impose reasonable conditions on health plan participation, officials could have required state-qualified insurers to give IRS a link to a Web page identifying the insurer's HCTC-qualified plan.

## *Characteristics of Potential HCTC Beneficiaries*

Certain characteristics of HCTC-eligible individuals, as well as the HCTC program itself, influence enrollment. The following factors make it less likely that eligible individuals will enroll, compared with other uninsured populations that could become the focus of future tax credit expansion efforts:

- Many laid-off workers, probably including some TAA beneficiaries, believe that they will soon be rehired and thus do not need health coverage assistance.
- Many HCTC-eligible workers, particularly those receiving TAA, have recently experienced significant drops in income. Some of these individuals must continue paying for fixed financial obligations they incurred while employed. This can lower the amount of discretionary income that is available to pay their share of insurance premiums, compared to other low-income people who did not previously have significantly higher incomes.
- Many eligible individuals, especially early retirees receiving PBGC payments, are older adults. Premium costs (hence the beneficiary's 35 percent premium share) rise with age, which lowers participation.
- HCTC operates in a complex institutional setting because of the credit's interaction with TAA and PBGC, which are run by different state and federal agencies, each with its own complicated rules, procedures, and policy objectives. A future tax credit without such linkages could perhaps be simpler.

On the other hand, several factors make enrollment more likely for HCTC-eligible individuals than for many other groups of uninsured:

- Eligibility for HCTC is not limited to low-income households. Many displaced workers and early retirees have working spouses, for example; and many PBGC recipients supplement their pensions with earnings from new employment.
- Potential HCTC beneficiaries may attach a particularly high value to health coverage, compared with some other groups of uninsured individuals. HCTC-eligible individuals (particularly PBGC-related HCTC beneficiaries, who are 55 to 64 years old) tend to be older than most American workers, and many have had longstanding prior coverage. By contrast, only 24 percent of the uninsured are over age 44. Moreover, 75 percent of individuals uninsured at any particular time have been without coverage for 12 months or longer.
- IRS receives the name and address of all potential HCTC beneficiaries, making it possible to target outreach to a defined and limited group of individuals.

## *Lessons for Future Tax Credit Design*

To inform the future design of health insurance tax credits, can policymakers draw useful lessons from the HCTC Program's experience thus far? Are HCTC's take-up problems unique to this particular set of beneficiaries and institutions? Or could the causes of

low enrollment in HCTC also inhibit take-up among other groups of uninsured? As the following analysis of other programs and populations suggests, the kinds of barriers apparent in the operation of HCTC could probably affect many other groups of insured.

### *Premium Requirements*

Perhaps the most important obstacle to HCTC enrollment has been that beneficiaries are required to pay 35 percent of their premiums. The effect of similar cost-sharing requirements on future tax credit proposals would vary, depending on the group being targeted. By definition, the higher-income uninsured tend to have more ability to pay, compared with those who earn less. But two-thirds (65%) of the uninsured have incomes below 200 percent of the federal poverty level (FPL). If future tax credits seek to cover the low-income uninsured, premium costs like those imposed by HCTC are likely to deter participation by most potential beneficiaries. Analyses of take-up rates for health coverage programs serving low-income households have found that when premium payments consume even 5 percent of household income, take-up rates fall below 25 percent. Based on this research, the average monthly HCTC premium share for a one-person policy, \$144 a month in mid-2004, would be expected to yield a take-up rate of less than 30 percent among households with incomes as high as 250 to 300 percent of FPL.

For example, with Washington State's Basic Health Program, which has provided premium subsidies to low-income, uninsured workers since the early 1990s, small changes in premium levels have frequently been followed by large changes in enrollment. When average household premium payments fell from 21 to 16 percent of premiums, enrollment rose by 146 percent. When average household payments were raised from 16 to 19 percent of premiums, demand for coverage fell by 45 percent. Several peer-reviewed, published studies have found a strong causal relationship between Basic Health Program premium requirements and enrollment levels.

In recent years, program administrators in many states have likewise found that even modest premium requirements can noticeably affect enrollment in low-income health coverage programs. Here are some examples of since January 2002:

- When a Massachusetts health coverage program for laid-off workers began charging \$20 weekly premiums, enrollment declined by nearly 50 percent.
- After Oregon's Medicaid program raised monthly premiums for low-income adults (for example, from \$6 to \$9 for the very poor), 44 percent of enrollees left the program.
- In Texas, when an annual \$15 fee for children's coverage changed to a monthly fee for near-poor families, 35 percent of affected families left the program.
- When Washington State dropped 28,000 low-income immigrants from Medicaid, which did not charge premiums, and offered them Basic Health coverage with premiums charged on a sliding scale starting at \$10 a month, 57 percent dropped state-subsidized insurance.

The impact of apparently modest premium requirements on enrollment in low-income health coverage programs is not hard to understand. Many low-income households have such little discretionary income that money for premiums would come from cutting back other necessities. To pick one example from a recent study of low-wage workers in 10 U.S. communities, a single-parent family in Philadelphia with a school-aged child and a preschooler needs income equivalent to 230 percent of FPL, supplemented by the Earned Income Tax Credit, to pay for housing, child care, food, transportation, taxes, and the like (excluding any money for entertainment, carry-out or fast food, savings, credit card debt, or emergency expenses).

In August 2005, the Congressional Budget Office (CBO) released a new study of individual coverage, with findings that are consistent with the analysis presented here. CBO concluded that “modest premium subsidies...would have a small potential impact on reducing the ranks of the uninsured.” According to CBO, paying even 50 percent of health insurance premiums would cause individual coverage among the otherwise uninsured to rise by only 3.5 percentage points.

### *Other factors*

Even if future tax credits increased premium subsidies well above HCTC levels, other barriers could severely limit program enrollment unless policymakers make additional modifications to the HCTC model. Tax credit programs are likely to reach few low-income people if they must pay full premiums while their subsidy applications are being processed. Many low-income households lack the discretionary income to “front” premium payments while awaiting refunds. A different approach worth serious consideration would be to model health insurance tax credit statutes on Medicare, Medicaid, and SCHIP, none of which make enrollment in qualified coverage an element of eligibility. Under this approach, applicants would not be required to pay premiums while they wait for their applications to be processed.

Another deterrent to HCTC enrollment—the exclusion of preexisting conditions for beneficiaries with recent coverage gaps—could dissuade many uninsured with known health problems from taking up coverage in similarly structured, future tax credit programs. A comprehensive review of take-up studies across a broad range of public and private programs concluded that a key determinant of enrollment rates is the value of the benefit offered to eligible individuals. Policymakers need to find strategies that, while protecting health insurers from disproportionate enrollment by very sick individuals, nevertheless offer health insurance that potential beneficiaries regard as valuable because it covers their known health problems.

In terms of outreach strategies, the practices needed to reach potential beneficiaries may vary with the population being targeted for coverage. The need for multilingual materials depends on the proportion of individuals with limited English proficiency. The importance of easily readable materials also depends to some degree on the population targeted, although this would likely be important to most coverage expansions. Nearly two-thirds of the uninsured (63%) either did not complete high school or stopped their formal education after receiving a high school degree.

By contrast, almost any target population is likely to enroll in much larger numbers if the administering agency and its community partners employ proactive approaches that use a single interaction to educate potential beneficiaries and sign them up. The broad applicability of this approach is illustrated by a study of British physicians who were encouraged to enroll in certain training programs. When researchers called the physicians, informed them about the training, and allowed them to register during the call, 82 percent enrolled, compared with 22 percent of similar physicians who were mailed written materials that described the training and urged the physicians to enroll.

As applied to health insurance tax credits, a similar approach could be efficient only if available data allowed such proactive, “one-step outreach and enrollment” to be targeted narrowly on good candidates for subsidy eligibility. Even if such outreach included careful targeting, however, policymakers considering this approach would first need to weigh likely enrollment gains against the increased cost of this outreach strategy.

Finally, cumbersome and complex application procedures have proven to be a significant barrier to enrollment in programs other than the HCTC. For example, take-up of retirement security accounts with identical levels of tax savings can vary from 10 percent to 86 percent, depending on the amount of work required to enroll. Similarly, take-up of various Medicare benefits ranges from 96 percent to 33 percent, depending in significant part on ease of enrollment. The HCTC experience is one more reminder that designers of future tax credits will need to incorporate simple application procedures, at a minimum allowing people to apply for assistance by filing one form with one public or private agency.

## *Conclusion*

Taking into account enrollment patterns in other programs, the HCTC program’s lower-than-expected take-up rate seems to be due to its failure to meet four basic goals:

1. *Affordable premiums.* For low-income households to enroll in large numbers, their premium payments need to be small. In addition, they cannot be required to pay full monthly premiums while their applications are pending.
2. *Coverage that beneficiaries value.* Take-up rates are likely to be much higher when health plans cover care that beneficiaries need to treat their known health problems.
3. *Effective outreach.* Enrollment will be considerably greater if officials use a proactive outreach strategy that includes easily understandable, multilingual materials and opportunities for consumer education and enrollment during a single encounter.
4. *Customer-friendly intake.* High take-up requires simple application procedures that allow the determination of eligibility after one form is filed with one agency.

In designing future tax credits to cover large groups of uninsured, or in seeking to improve the HCTC program, decision-makers who want the majority of eligible individuals to use the credits and obtain coverage should consider incorporating policy design strategies that achieve these four goals.

# LIMITED TAKE-UP OF HEALTH COVERAGE TAX CREDITS (HCTCs) AND THE DESIGN OF FUTURE TAX CREDITS FOR THE UNINSURED

## Introduction

When President Bush signed into law the Trade Act of 2002 and created Health Coverage Tax Credits (HCTCs) for certain displaced workers and early retirees, the nation began its second experiment with using the federal income tax system to subsidize health coverage for the otherwise uninsured. The first such policy – the so-called “Bentsen child health tax credit” – was repealed in the early 1990s on a bipartisan basis, following reports of limited use by eligible families and widespread marketing fraud by certain insurers.<sup>1</sup>

Even though the HCTC program serves a relatively small group, its enactment was a significant development in national health policy. In effect, HCTC serves as a pilot program that illustrates some of the potential opportunities and pitfalls of one particular approach to using refundable, advanceable federal income tax credits for covering the otherwise uninsured. Such credits have played an important role in many health reform proposals sponsored by leaders across the political spectrum, including both major Presidential candidates in 2004. Studied carefully, the HCTC program offers a unique opportunity to glean practical lessons about the future design of tax credits to cover large numbers of uninsured, should policymakers wish to pursue such a strategy.

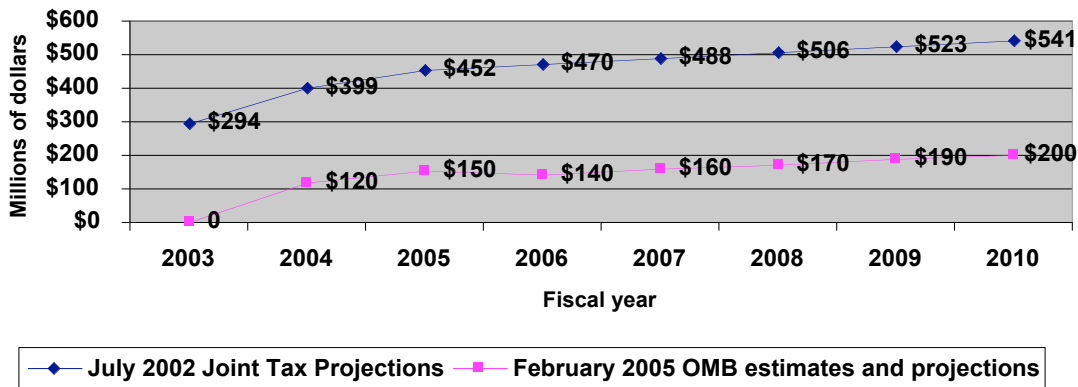
Several years after enactment, the HCTC program remains a work in progress. However, it has encountered a number of problems, the best known of which is the credits’ use by only a small proportion of eligible households. This paper seeks to analyze the problem of limited take-up, first noting that, while enrollment has fallen well short of original hopes, take-up rates are nevertheless significantly higher than is sometimes portrayed. We then explore some of the reasons why fewer enrollees have taken advantage of the credits than policymakers originally expected. We conclude that, for future tax credits to reach more than a small portion of their intended beneficiaries, such credits need to be designed carefully to avoid creating barriers to enrollment like those that have apparently limited the success of HCTC.

Note: for readers who are unfamiliar with the HCTC program, Appendices A and B to this report describe the basic elements of the program.

## I. Enrollment in HCTC – less than originally hoped, more than frequently believed

One measure of program performance is the total dollar volume of subsidies. The following chart compares the HCTC tax expenditures projected by the Congressional Joint Committee on Taxation in July 2002,<sup>2</sup> shortly before the legislation passed, with the Office of Management and Budget's (OMB) February 2005 statement of actual and projected HCTC tax expenditure costs.<sup>3</sup> HCTC subsidy expenditures, both actual and projected, are now roughly a third of originally anticipated levels (Figure 1).

**FIGURE 1. HCTC TAX EXPENDITURE COSTS: JULY 2002 PROJECTIONS VS. FEBRUARY 2005 ESTIMATES AND PROJECTIONS**



Sources: Congressional Joint Tax Committee, July 2002;<sup>4</sup> OMB, February 2005.<sup>5</sup> Calculations by ESRI, May 2005. Note: the February 2005 numbers combine the revenue and outlay effects identified by OMB.

Despite this gap between original expectations and program performance,<sup>\*</sup> HCTC enrollment is higher than experts have sometimes stated. In July 2005, the most recent month for which information about advance payment is available, out of an estimated 234,000 potentially eligible workers and retirees, only 15,640, or 6.7 percent, had completed registration and were receiving advance benefits or would receive advance benefits when they made a payment.<sup>6</sup> Based on similar numbers, several respected health policy analysts have suggested that the credit's take-up rate is approximately 6 percent.<sup>7</sup>

\* Another measure of initial expectations was set out in a February 14, 2003 letter from three Cabinet Secretaries – Treasury Secretary Snow, Labor Secretary Chiao, and Health and Human Services Secretary Thompson – to the nation's governors. Explaining the new HCTC program, the Cabinet Secretaries wrote: "We estimate that these provisions could help over 500,000 Americans each year ... continue or obtain health insurance." Letter from John W. Snow, Secretary of the Treasury, Elaine L. Chao, Secretary of Labor, and Tommy G. Thompson, Secretary of Health and Human Services, to Virginia Governor Mark Warner, February 14, 2003.

Unfortunately, HCTC participation has been far below these levels. From August 2003 (when advance payment began) through July 2005 (the most recent month for which data are available about advance payment participation), fewer than 50,000 workers and dependents have received either advance payment or year-end HCTCs – less than one-tenth the estimated amount. Marilyn J. Smith, IRS, personal communication, September 2005. Of course, this gap may be a function of imprecise language in the letter to the nation's Governors, rather than HCTC program performance. That is, the letter may have been referring to the number of *eligible individuals* rather than *projected enrollees*.

Nevertheless, the actual take-up rate for HCTC is well above this level, for several reasons:

- Many fewer than 234,000 workers qualify for HCTC. That number includes *all* workers who were (a) identified by the Pension Benefit Guarantee Corporation (PBGC) as 55-to-64-year-old recipients of PBGC payments; or (b) identified by State Workforce Agencies (SWAs) as either (i) recipients of Trade Adjustment Assistance (TAA) income support or Alternative Trade Adjustment Assistance; or (ii) recipients of unemployment insurance (UI) who would qualify for TAA income support but for their receipt of UI. Their names were sent to the Internal Revenue Service (IRS) because they met the qualifications for HCTC that were known to PBGC and SWAs. Put differently, each worker on the list met *some* of the eligibility requirements for HCTC. However, many workers on the list did not meet other eligibility requirements, most commonly because they may have received health coverage from other sources. According to the Government Accountability Office (GAO), when IRS in October 2003 surveyed individuals who were identified by PBGC or an SWA as potentially eligible but who did not enroll in HCTC advance payment, “about half were in fact ineligible because they had other coverage, such as Medicare or through a spouse’s employer.”<sup>8</sup> Regrettably, IRS has not made this or other surveys publicly available for further analysis.
- While approximately 15,640 workers used HCTC advance payment during the most recent month for which data are available (namely, July 2005), other workers receive HCTC only after they file their end-of-the year tax returns. As of May 2004, 12,594 tax filers had received end-of-year (EOY) HCTCs for January through December 2003, based solely on their tax returns, without any advance payment.<sup>9</sup> With advance payment beginning in August but annual refunds available for qualified coverage purchased at any time from January through December, 2003 was a unique year for the HCTC program. IRS has not yet made public the number of individuals receiving EOY HCTCs for 2004, the first calendar year for which HCTC advance payment was available from January through December. However, IRS recently published data showing that the number of tax returns claiming HCTCs for 2004 was 5.5 percent below the comparable number at the identical point in the previous year (that is, the end of August).<sup>10</sup> Several factors may be responsible for this drop: first, IRS sent three mailings to potentially eligible individuals encouraging them to file for 2003 EOY HCTCs, but IRS did not send any such mailings for 2004; second, advance payment was available for the entire year, not just five months; and third, state “gap filler” programs reached many more workers in 2004.

For the first time, publicly available data allow calculation of a single take-up rate for HCTC that both (a) subtracts individuals from the pool of potential eligibles based on their enrollment in other health coverage and (b) adds to the number of beneficiaries a

count of individuals receiving EOY HCTCs who did not obtain advance payment. To be specific:

- September 2004 is the most recent month for which data are available concerning both advance payment enrollment and EOY HCTCs. During that month, 221,716 workers were identified as receiving the pertinent type of PBGC or TAA assistance. Of those workers, 13,562 workers received advance payment<sup>11</sup> and 208,154 did not.
- Based on the GAO's description of IRS preliminary survey results, about half of these 208,154 may have received other health coverage that disqualified them from HCTC, leaving 118,000 as the approximate number of potential eligibles.
- If the 5.5 percent drop from 2003 to 2004 claims for EOY HCTCs described above is reflected in the number of EOY claims eventually found to be valid for households not participating in advance payment, and the May 2004 count of such claims for 2003 is largely complete, then as many as 11,900 households who did not participate in advance payment may have received EOY HCTCs for 2004.<sup>†</sup>

This analysis suggests that approximately 25,500 households may have received HCTCs in some form for September 2004, out of roughly 118,000 eligibles, yielding an estimated take-up rate of 22 percent.

In assessing this number, two caveats are important. First, this is merely a rough approximation. As noted above, an IRS survey summarized by GAO is the only extant evidence of the proportion of individuals whose identities were sent to IRS by PBGC or state workforce agencies but who were ineligible for HCTC because of enrollment into Medicare or spousal coverage. Because that survey has not been made publicly available, it is impossible to assess its reliability. A much more satisfactory point-in-time estimate could be developed if the following numbers were calculated by officials and made publicly available: reliable survey results showing the proportion of identified PBGC and TAA recipients who in fact are ineligible for the credit based on enrollment in other health coverage or additional factors; the number of valid EOY HCTC claims for 2004 by households not participating in advance payment; the average duration of quali-

---

<sup>†</sup> This analysis likely overestimates the number of such recipients, for two reasons. First, a much higher percentage of EOY claims for 2004 may have involved households receiving advance payment; in 2004, advance payment was available the entire year, but in 2003, it did not begin until August. Second, even among workers not participating in advance payment, many valid EOY HCTC claims for 2004 involved only months other than September. For example, during July, August, and September 2004 (the last three months for which full advance payment enrollment data are publicly available), an average of 5.8 percent of total advance payment enrollees during a given month were experiencing their first month on the program. HCTC Program, *Monthly Executive Scorecard September 2004 – v 1.0*, October 13, 2004; HCTC Program, *Monthly Executive Scorecard August 2004 – v 1.0*, September 14, 2004; HCTC Program, *Monthly Executive Scorecard July 2004 – v 1.0*, August 11, 2004. If that same rate of monthly program qualification applied to EOY HCTCs, then approximately 17.4 percent of EOY HCTCs would be received by households whose eligibility began after September 2004. Additional households no doubt received EOY HCTCs only for months before September. More than likely, these two factors outweigh a countervailing concern that some beneficiaries of HCTC in 2004 are included in neither group described in the text: namely, individuals whose advance payment applications were pending in September 2004 but for whom advance payment began in a later month that year. Because they received advance payment during a later month, these individuals who were not enrolled in advance payment during September 2004 would not be counted among households who received only EOY HCTCs but not advance payment.

fied coverage for such claims; and the average proportion of advance payment applications that ultimately result in advance payment.

Second, the HCTC program, which is quite novel in its approach to health coverage, is still relatively new. Advance payment began operation in August 2003, slightly more than two years ago. Over time, advance payment enrollment has increased from 8,374 in December 2003<sup>12</sup> to 13,562 in September 2004<sup>13</sup> to 15,640 in July 2005.<sup>14</sup> As health plans, government officials, and eligible individuals grow increasingly familiar with the credit, enrollment could continue to increase in the future. Nevertheless, if the program continues on its current course, a dramatic spike in future enrollment would be surprising.

By contrast, the State Children's Health Insurance Program (SCHIP) was less novel, because it built on earlier program infrastructure developed by Medicaid. It is therefore unclear whether SCHIP can fairly be used as a benchmark for HCTC enrollment. SCHIP had a 43.5 percent take-up rate in its first year (1998), 53.9 percent by its third year (2000), and 60.4 percent by its fifth year (2002).<sup>15</sup>

## **II. While affordability of the worker's 35 percent premium share may be the most significant factor limiting HCTC enrollment, other factors also play an important role**

As noted in an earlier report, stakeholders and observers in some (but not all) states report that potential beneficiaries' inability to afford their 35 percent premium share may be the most important single factor limiting HCTC enrollment.<sup>16</sup> However, potential HCTC beneficiaries also face other important obstacles to enrollment, including the following:

- HCTC applicants are frequently required to pay one to three months of premiums, in full, before advance payment begins. While they can claim end-of-year HCTCs to reimburse 65 percent of those early months' payments, many households lack the disposable income needed to make such full premium payments even temporarily. As of September 2005, 12 states, which together included 39 percent of potentially eligible workers, operated so-called "gap-filler" programs that paid 65 percent of premiums while workers waited for IRS to start their advance payment.<sup>17</sup>
- Many potentially eligible HCTC beneficiaries experience coverage gaps of 63 days or more before attempting to enroll in a state-based HCTC plan. Accordingly, they are outside the ambit of federal consumer protections, and state-based plans can (for up to 12 months) deny coverage of their preexisting conditions. According to observers in a number of states, HCTC enrollment in such circumstances rarely takes place, since workers with preexisting conditions almost always view coverage that excludes those conditions as not worth the required 35 percent premium payment.<sup>18</sup>

- Problems with the IRS outreach strategy have contributed to low take-up. It is to IRS' credit that, as noted above, the agency sent three separate mailings to potential eligibles urging them to file claims for EOY HCTCs for 2003 (although that effort was not repeated for 2004). Moreover, officials from both IRS and the U.S. Treasury Department participated in many local outreach events across the country. In addition to those commendable steps, IRS regularly mails the full HCTC Program Kit to every potentially eligible individual in the country. Nevertheless, HCTC's outreach strategy failed to employ several best practices identified by a recent, comprehensive study of outreach involving the new low-income subsidy for Medicare coverage of prescription drugs.<sup>19</sup>
  - First, according to this study, the most effective outreach involves materials that are readable at no more than the Fifth Grade level. The HCTC Program Kit,<sup>20</sup> which explains the HCTC program in detail and asks recipients to call the HCTC Call Center to enroll, is at an Eighth Grade reading level,<sup>21</sup> suggesting that the program's main outreach vehicle may not be understood by a number of recipients.
  - Second, materials ideally are provided in multiple languages, according to the recent Medicare analysis. By contrast, the HCTC Kit is mailed in English only.<sup>22</sup>
  - Third, the most effective outreach involves a single, proactive contact with likely eligibles, in which consumers are both educated about potential coverage and immediately helped to enroll. The more traditional "two-step" IRS strategy of mailing materials that encourage recipients to call for help or apply on their own is much less effective. In its 2004 Report to Congress, the IRS National Taxpayer Advocate Service (TAS) came to a similar conclusion after analyzing outcomes when recipients of Earned Income Tax Credits (EITC) challenged IRS audits that disallowed some or all of their EITCs. According to the report, "taxpayers received dramatically better results when the Taxpayer Advocate Service contacted them by telephone to request documentation.... Overall, only 38 percent of taxpayers who went through the TAS-assisted audit reconsideration process but received no phone calls were awarded EITC. This percentage increased to 67 percent for taxpayers who received three or more calls[, 64 percent for taxpayers who received two calls, and 45 percent for those who received one call.] This finding suggests that the IRS needs to take a fresh look at the way it communicates with taxpayers to get the right answer in many of its programs, including the EITC."<sup>23</sup> Obviously, this setting is not precisely analogous to HCTC, but it does reinforce the general principle that proactive contact rather than reactive processing of inquiries can yield powerful results in the utilization of no-cost services that benefit low-income individuals.
- Finally, the process of applying for HCTC advance payment is complex and time-consuming. To enroll, workers must apply to between two and five public and private entities and frequently must deliver to one or more of these entities hard-copy documents issued by the others (Table 1).

**TABLE 1. APPLICATIONS REQUIRED FOR VARIOUS HCTC BENEFICIARIES TO ENROLL IN ADVANCE PAYMENT**

Applicant's Circumstances			Place/Purpose of Required Applications						
Basis of eligibility	Was the layoff certified as trade-impacted?	Does state run a gap-filler program?	U.S. Dept. of Labor (for a finding of trade-impacted layoffs)	PBGC (to start PBGC payments)	State workforce agency (for finding the worker TAA-eligible)	State gap-filler program (to receive gap-filler subsidies)	IRS (to start advance payment)	Health plan (to enroll into qualified coverage)	Total number of public and private agencies
PBGC	n/a	Yes		X		X*	X*	X*	4
		No		X			X*	X*	3
TAA	Yes	Yes			X	X*	X*	X*	4
		No			X		X*	X*	3
	No	Yes	X		X	X*	X*	X*	5
		No	X		X		X*	X*	4

\*As part of these particular applications, hard copies of documents issued by other agencies listed in this table are required in some or all states.

Source: ESRI, October 2005. Note: applications to gap-filler programs are required only if workers seek gap-filler assistance before the start of advance payment.

One aspect of the application process involves additional challenges that have not been discussed in prior publications. Before IRS can process an application for HCTC advance payment, the applicant must first be enrolled in a qualified health plan. But many workers may find it difficult or in some cases impossible to identify the qualified plans that are available in their state. IRS' education materials as well as the HCTC consumer call center refer potential tax credit beneficiaries to the IRS website for a list of state-qualified plans.<sup>24</sup> Although this list includes insurers' phone numbers and links to their websites, in many states it does not provide the basic information consumers need to learn which health plan qualifies for HCTCs. Between May 24 and June 16, 2005, researchers at the Economic and Social Research Institute attempted to contact each plan on the IRS list via both the internet and the telephone. As explained in Appendix C to this report, our survey found the following:

- Out of 57 insurers listed on the IRS web site as offering state-qualified coverage, 22 (or 39 percent) either had no web links or (in one case) had only a broken link. Most of this problem could be easily solved, since 12 out of these 22 insurers in fact operated web pages that identified their HCTC-qualified plans.
- Out of 35 insurers with a direct link from the IRS website:
- Only 5 (or 15 percent) included any information about HCTC on the web page called up by clicking the IRS link.
- For 20 insurers (57 percent), a viewer could not identify the HCTC-qualified health plan or plans despite doing all of the following: (a) looking at the web page called up by clicking the IRS link; (b) clicking all potentially pertinent links visible from that initial web page; and (c) searching the plan's website for all

terms related to HCTC (“HCTC”, “Trade Act”, “TAA”, “PBGC”, and the name of the state’s HCTC plan or program).

When researchers called the phone numbers for the 57 insurers listed on the IRS web site:

- 1 insurer could not be reached, because the listed phone number was only for state residents;
- For 20 insurers (or 35 percent), the person answering the phone identified the HCTC-qualified plan or plans;
- For 13 insurers (23 percent), one transfer was needed to find an employee who identified the HCTC-qualified plan or plans;
- For 12 insurers (21 percent), two or more transfers were needed to find such an employee; and
- For 10 out of 57 plans (18 percent), either (a) repeated calls were not returned; or (b) after between two and five transfers, no employee could be found who would identify the insurer’s HCTC-qualified plan or plans.

*Key lesson learned: tax credit proposals need policy mechanisms that promote adaptability*

Several years ago, Wharton School Professor Mark V. Pauly noted that, since the country had “no experience with ... a large-scale system of [health insurance] tax credits,” policymakers were faced with “substantial and (currently) irreducible uncertainty” about the potential impact and ideal configuration of such credits. Accordingly, he recommended “a plan that deals with uncertainty and learns from its resolution,” incorporating an “embed[ded] ... scheme to learn from [initial tax credit implementation] to alter aspects of the program according to a fixed, transparent, and comfortable process.”<sup>25</sup>

The country’s experience with HCTCs illustrates the wisdom of Professor Pauly’s recommendation. Numerous issues have arisen that were not anticipated by policymakers. For example, when the Trade Act was adopted, there is no evidence that policymakers considered the practical problems that would result from the statute’s drafting that made enrollment in an HCTC-qualified plan an element of tax credit eligibility. Similarly, policymakers did not contemplate that workers might be unable to learn which plan was state-qualified and could therefore be unable to enroll in HCTCs. As the lead author of this report has suggested in earlier work,<sup>26</sup> policymakers could be well-served by incorporating into tax credit legislation substantial administrative discretion to reconfigure credits in response to unforeseen developments, perhaps building on the model provided by experimental waivers under Section 1115 of the Social Security Act. Policymakers could also consider a broad grant of authority to impose reasonable conditions on health plan participation, thereby empowering officials to address emerging problems. If the HCTC statute had given such authority to IRS, for example, the agency could have required each state-qualified insurer to provide a link to a web page identifying the insurer’s HCTC-qualified plans.

The disadvantage of these approaches, of course, is that broad discretion can be abused. To minimize the potential for abuse, policymakers could incorporate regular reporting requirements and independent evaluations to inform the public and policymakers about how health insurance tax credits are unfolding, allowing sensible mid-course corrections and enabling strong Congressional oversight. Alternatively, policymakers could follow the HCTC model and enact in statute what they believe to be the optimal policy design, frequently requiring later statutory changes if serious problems emerge. In sum, policymakers designing future tax credits need to resolve the trade-off between the benefits of administrative flexibility that permits unforeseen contingencies to be addressed promptly and the risks that such flexibility can be abused.

### **III. Could HCTC’s take-up problems affect future tax credits focused at other groups of uninsured?**

Policymakers designing future credits for the uninsured would be wise to consider whether and, if so, how to address the obstacles to enrollment that have surfaced with HCTC. A central question facing such policymakers is whether the take-up problems experienced by HCTC are primarily a result of the unique characteristics of this particular beneficiary group or whether they result mostly from factors that are likely to affect other groups of uninsured as well.

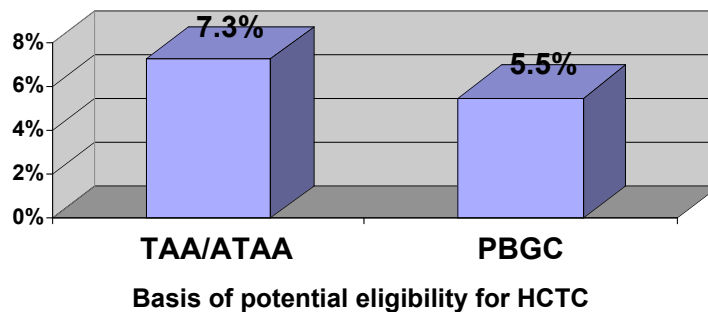
Of course, the answer to that question depends in part on which new group of uninsured is the focus of future tax credits. For example, financial challenges that represent insuperable obstacles for low-income uninsured could represent only minor annoyances for higher-income uninsured. On the other hand, non-financial obstacles may present a problem for individuals of all income levels.

The first section below explores the ways in which take-up is affected by the unique characteristics of individuals who are potentially eligible for HCTC. The second section discusses whether the affordability problems that have surfaced with HCTC are likely to affect other groups of uninsured, in which case larger premium subsidies will be required for significant take-up. The third and final section analyzes whether the obstacles other than affordability that have affected HCTC are likely to affect other uninsured individuals as well, in which case policymakers may need to devise more effective methods of delivering health insurance tax credits.

### *A. Distinctive characteristics of HCTC-eligible households that affect take-up*

Two very different groups comprise the HCTC target population: displaced workers who lost their jobs because of foreign competition and who remain unemployed; and early retirees receiving pension payments from PBGC. Enrollment into advance payment is slightly more likely among the former group, as the following chart illustrates.

**FIGURE 2. ENROLLMENT INTO HCTC ADVANCE PAYMENT AMONG WORKERS IDENTIFIED AS POTENTIALLY ELIGIBLE, TAA- VS. PBGC-BASED ELIGIBILITY: SEPTEMBER 2004**



Source: IRS, October 13, 2004, calculations by ESRI, May 2005.<sup>27</sup>

Unfortunately, relatively little data has been published about the characteristics of these two groups. However, even in qualitative terms, several features of these two groups make take-up less likely than for many other groups of uninsured Americans:

- Historically, laid-off workers have often believed that they soon would be re-hired and so have seen little need for health coverage assistance, according to Massachusetts officials administering the Medical Security Plan, that state's long-standing health coverage program for recipients of Unemployment Insurance.<sup>28</sup> Accordingly, as of 1996, only 10 percent of that program's estimated eligible individuals were enrolled, according to one analysis.<sup>29</sup>
- Particularly in the case of TAA-related eligibility, many HCTC beneficiaries have experienced significant short-term reductions in income. Some retain financial obligations that were incurred based on a higher, previous level of earnings. This

leaves less discretionary income in household budgets than would be present in households with unchanging income levels, where ongoing costs are more likely to reflect current earnings.<sup>30</sup>

- Especially with PBGC-related eligibility, which is limited to individuals age 55 to 64, HCTC beneficiaries are much older than average American workers. This raises premiums, hence the amount of the worker's 35 percent share, reducing affordability.
- The complexity of HCTC's institutional context makes it difficult to run a simple and straightforward program. The credit interacts extensively with TAA and PBGC, which are independent benefit systems run by different state and federal agencies, each with its own complicated rules, procedures, and policy goals. A future tax credit without such linkages could perhaps be structured more simply.

On the other hand, several factors make enrollment more likely for HCTC beneficiaries than for many other groups of uninsured who could be the focus of future reforms:

- Eligibility for HCTC is not limited to low-income households. Many displaced workers and early retirees have working spouses, for example. Some early retirees from one company now work at another, earning paychecks to supplement PBGC payments. Either way, extra income makes coverage more affordable.
- HCTC beneficiaries may tend to value health insurance more highly than some other populations, for several reasons. First, as noted above, many are older adults; such adults, who frequently know they need health care, are somewhat more likely than younger adults to take-up available health coverage.<sup>31</sup> By contrast, only 24 percent of the uninsured are over age 44.<sup>32</sup> Second, before they separated from employment, many HCTC beneficiaries worked in industries where employer-based coverage was common. Accordingly, they are more accustomed to health insurance than are some other groups of uninsured, who have been without coverage for long periods of time. According to one national survey, 75 percent of individuals who were uninsured at the time of the survey had been uninsured long-term, going without coverage for 12 months or longer.<sup>33</sup>
- IRS receives the name and address of all potential HCTC beneficiaries. Each potential beneficiary thus becomes the target of a direct-mail effort, with IRS sending an HCTC enrollment kit. Put simply, HCTC beneficiaries are an identified, almost captive population, which should greatly simplify the task of outreach and enrollment, compared to other populations whose members are not individually known to any government agency.

As is true for every potential eligibility group that could benefit from incremental health coverage expansions, HCTC eligibles have some traits that inhibit and others that increase take-up. The question facing policymakers is whether these characteristics, taken as a whole, reduce take-up so greatly that low HCTC enrollment levels are best seen as an unusual result that would not apply to other groups of uninsured if they were given

comparable, 65 percent premium subsidies furnished through administrative systems like HCTC. The following sections analyze each obstacle to HCTC enrollment in turn to assess its potential applicability to new groups of uninsured.

### *B. Subsidy size and take-up rates*

Whether premium obligations like those in the HCTC program would pose a serious barrier to enrollment for other uninsured Americans surely depends on which group of uninsured is being subsidized. Uninsured Americans with moderate or high incomes may not find a 35 percent premium payment to be a major obstacle to coverage. However, two-thirds (65.4 percent) of the uninsured<sup>34</sup> are low-income individuals with earnings at or below 200 percent of the Federal Poverty Level (FPL).<sup>‡</sup> To predict the likely take-up rates among these low-income uninsured if they were provided tax credits that required consumer premium payments like those in HCTC, we first examine the larger track record of subsidies to help low-income people obtain health coverage. Second, we analyze the budgets of low-income households to assess whether discretionary income typically is sufficient to cover modest monthly premium payments. We conclude that an inability or unwillingness to make premium contributions like those required by HCTC seems to be a common and understandable characteristic of low-income populations.

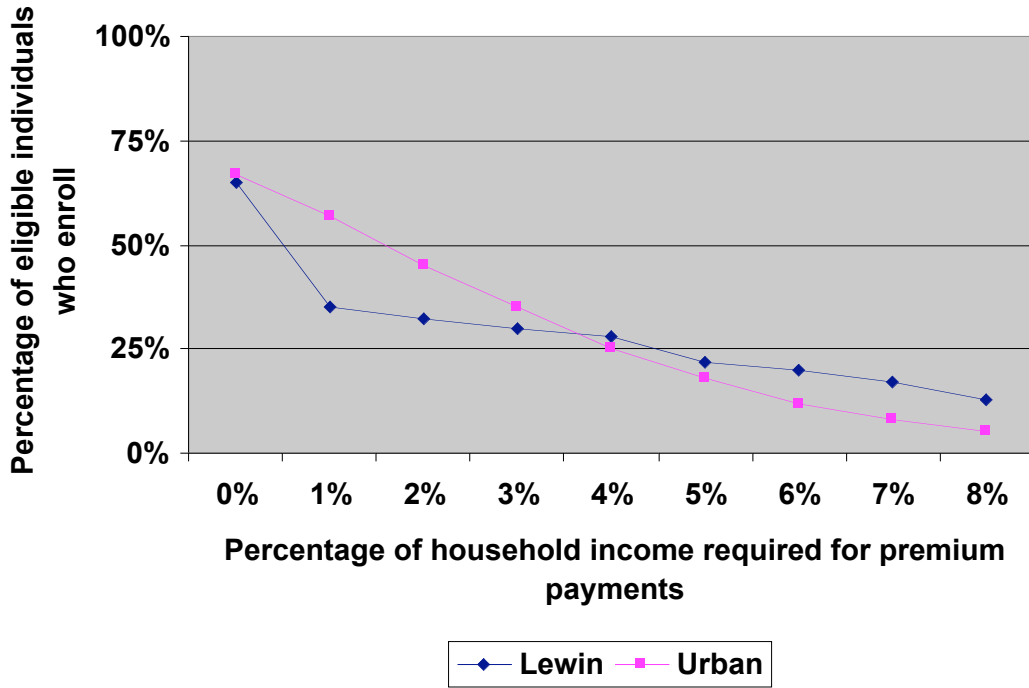
#### *1. The impact of premium payment levels on participation in low-income health coverage programs*

Various health policy analysts have examined take-up rates in low-income health coverage programs that assisted uninsured individuals with incomes up to 200 percent of the FPL or even higher levels. These programs involved states like Washington (which covered individuals up to 200 percent FPL), Minnesota (275 percent FPL), Hawaii (300 percent FPL), and Tennessee (no upper bound at the time of the study). Each researcher found that, when required premium payments consumed even small proportions of household income, enrollment fell to very low levels. For example, when premiums cost 5 percent of household income, enrollment fell below 25 percent of eligible individuals (Figure 3).

---

<sup>‡</sup> In 2005, the FPL is \$9,570 a year for a one-person household; \$12,830 for a two-person household; \$16,090 for a three-person household; \$19,350 for a four-person household; etc.

**FIGURE 3: RELATIONSHIP BETWEEN TAKE-UP AND PERCENTAGE OF HOUSEHOLD INCOME REQUIRED FOR PREMIUM PAYMENTS: STUDIES BY THE LEWIN GROUP AND THE URBAN INSTITUTE OF ENROLLMENT INTO LOW-INCOME HEALTH PROGRAMS**



Source: The Lewin Group, October 2003,<sup>35</sup> the Urban Institute, 1999/2000.<sup>36</sup>

The following table applies these findings to estimate, for various percentages of FPL, take-up rates for households of three that are offered subsidized coverage with a range of required premium payments.

**TABLE 2: PREDICTED TAKE-UP RATES FOR A FAMILY OF THREE, BY MONTHLY PREMIUM REQUIREMENTS AND PERCENTAGE OF POVERTY: 2005**

Household income	\$20 per month	\$50	\$100	\$150	\$200	\$250
100% FPL in 2005 (\$1,341 per month)	51% take-up	30%	15%	9%	5%	1%
200% FPL (\$2,682)	60%	47%	30%	20%	15%	11%
300% FPL (\$4,032)	62%	54%	40%	30%	20%	19%

Sources: The Lewin Group and The Urban Institute (see previous figure), calculations by ESRI, June 2005.  
 Notes: (1) Whenever Lewin and Urban estimates of take-up differ for a given level of premium contribution, this table shows the higher of the two take-up estimates. (2) Of the two analyses, only Lewin's reports take-up rates for individuals asked to pay more than 8% of income in premiums. However, based on both groups' reported take-up rates at levels between 4 and 8%, it seems likely that Lewin's take-up rate would be higher than Urban's, if Urban's were extrapolated to higher premium payments.

How to read this table: In 2005, a three-person family earning \$1,341 per month has income at 100 percent of the FPL. If offered a subsidy that required household premium payments of \$20 per month, 51 percent of such families would use that subsidy to enroll in coverage; if offered a subsidy that required household premium payments of \$50 a month, 30 percent would use that subsidy to enroll; etc.

This analysis is generally consistent with the HCTC experience of limited take-up. The average monthly premium for a one-person HCTC policy purchased through advance payment in June 2004 (the most recent month for which such premium data are publicly available) was \$411,<sup>37</sup> with the beneficiary's 35 percent share equaling \$144 per month, on average. Even for individuals with household incomes in the range of 250 to 300 percent of the federal poverty level, such payments would be expected to limit take-up to approximately 20 to 30 percent of eligible individuals.

This picture is further confirmed by both longstanding and recent experience in a number of states operating health coverage programs for low-income residents. Since the early 1990s (the mid-1980s, in some counties), Washington State has operated a state-funded Basic Health Program (BHP) that subsidizes commercial-type coverage for adults and children with incomes up to 200 percent of the FPL. Because the state can revise program rules without any federal constraint, beneficiary premium requirements have been modified many times. Throughout the program's history, even modest changes in beneficiary premiums have triggered large changes in enrollment. For example:

- From 1995 to 1996, the average BHP enrollee's monthly premium share was cut from \$23 (21 percent of premiums) to \$17 (16 percent of premiums). Enrollment rose by 146 percent.
- Policymakers later reversed direction, increasing average premium payments from \$18 (16 percent of premiums) in December 1997 to \$24 (19 percent of premiums) in December 1998. Demand for BHP coverage, measured by the number of enrolled individuals plus those on BHP waiting lists, fell by 45 percent.

- In 1999, policymakers again reversed course, cutting minimum premium payments to 1997 levels for enrollees with incomes above 125 percent FPL. Demand for BHP eventually rose by 27 percent.

In the case of Washington's well-studied, longstanding program, this descriptive evidence is supplemented by rigorous studies published in peer-reviewed journals that analyzed the causal relationship between BHP premium requirements and enrollment levels. One such study found that each \$5 increase in BHP family premium costs caused a 6 percent decline in overall enrollment.<sup>38</sup> Another concluded that reducing monthly premiums from \$50 to \$25 would increase BHP enrollment by 62 percent; and cutting premiums from \$50 to \$10 would more than double BHP participation.<sup>39</sup>

Across the country, more recent changes in health policy have provided additional examples of the impact of premium charges on enrollment in low-income health coverage programs. Depending on the income level of the individuals involved and the size of the premium charge, take-up has declined significantly, in many (but not all) cases. For example:

- In September 2003, a subsidized health insurance program for Massachusetts residents receiving unemployment insurance began to charge premiums of \$20 and \$30 a week for individuals and families, respectively. One month later, enrollment had dropped by 34 percent.<sup>40</sup> By February 2004, enrollment had declined by a total of nearly 50 percent. At that point, the Legislature intervened, lowering premiums to \$15 a week.<sup>41</sup> Since then, premium requirements have been abolished for unemployed workers with incomes below 200 percent of the FPL.<sup>42</sup>
- In 2003, Oregon's Medicaid program made significant policy changes for non-elderly adults with income below 100 percent of the FPL, lowering benefits, increasing co-payments, and raising premiums. For example, monthly premiums increased from \$6 to \$9 for single adults between 11% and 50% of the FPL. For couples, premiums nearly doubled (for example, from \$18 to \$30 at 50% of the FPL).<sup>43</sup> Stricter premium payment policies were also imposed. In a study of the impact of the program's increased cost-sharing, researchers surveyed over 2,700 people affected by the changes.<sup>44</sup> Most enrollees said that they had difficulty coming up with the increased premium payments. Some reported delaying rent payments or skipping meals to afford premiums; others relied on relatives or community organizations to pay their premiums. In the six months following the changes, 44 percent of previous enrollees lost coverage for all or part of that period. More than two-thirds remained uninsured, and 44 percent said that premiums and co-payments were among the main reasons for losing coverage. These changes also caused 59 percent of people with no income, who had to pay only \$6 per month in premium costs, to lose coverage.<sup>45</sup>
- In 2003, Utah surveyed persons disenrolled from the Primary Care Network (PCN), a program for uninsured adults with income below 150 percent of FPL.

Of 6,275 PCN enrollees, 1,709 (27.2%) left the program during July through September 2003.<sup>46</sup> Among survey respondents, 29 percent said they disenrolled because of financial barriers. Of this group, 63 percent could not afford the \$50 annual enrollment fee, and 78 percent had no health insurance after leaving the program.

- In Texas, an annual \$15 fee for coverage offered by the State Children's Health Insurance Program (SCHIP) was changed in October 2003 to a monthly \$15 premium for families with incomes between 100% and 150% of the FPL; office visit co-payments were also increased from \$2 to \$5, and dental and vision benefits were dropped.<sup>47</sup> In the nine-month period after the changes, 35 percent of families in this income group disenrolled. Many of them told interviewers that they could not afford the monthly premiums. The 35 percent disenrollment rate in this income group was in marked contrast to the simultaneous 7 percent *increase* in enrollment among families with income between 150% and 185% of federal poverty, whose premiums, previously \$15 per month, were increased less drastically to \$20 per month.<sup>48</sup>
- In January 2002, Rhode Island's Medicaid program began charging families with incomes above 150 percent of FPL premiums on a sliding scale of \$43 to \$58 per month. During the first three months this policy was in effect, nearly one in five (18 percent) affected families disenrolled.<sup>49</sup>
- When Virginia imposed premiums of \$15 per month<sup>50</sup> on children with family incomes above 150 percent of the poverty line, and then-Governor James Gilmore learned in late 2001 that coverage for approximately 3,000 children would be terminated due to non-payment of premiums, the Governor established a moratorium to keep these children on the SCHIP program.<sup>51</sup> Newly elected Governor Mark Warner took this action one step farther when he suspended premiums effective April 15, 2002 and permanently eliminated them from cost-sharing requirements effective September 1, 2002.<sup>52</sup>
- In October 2002, 28,000 immigrants in Washington State were dropped from state-funded Medicaid, which did not charge premiums, and offered coverage through the state's Basic Health Program (BHP), which charged premiums of \$10 per month for those below 125 percent of FPL and between 2 percent and 7 percent of income for those earning between 125 and 200 percent of FPL.<sup>53</sup> Roughly half of these immigrants never enrolled in BHP, and many who initially enrolled quickly withdrew once BHP's higher costs and more limited benefits came clearly into focus. By April 2003, only 12,000 of the original 28,000 (or 43 percent) remained in BHP. Focus groups and interviews conducted with families and social service workers confirmed that BHP premiums had severe impacts on many people's household budgets, making such premiums unaffordable. As one enrollment outreach worker explained, "Some [families] don't have \$10 to pay . . .

The rent dominates their lives. They don't even try to rent on their own, but share with others and still don't have enough to pay rent."<sup>54</sup>

Looking outside the confines of low-income subsidy programs, a number of other studies have come to similar conclusions about the impact of premium costs on take-up. For example, the Congressional Budget Office (CBO) recently found that paying 50 percent of health insurance premiums would cause take-up rates for individual coverage among the otherwise uninsured to rise only slightly, from 16.3 percent to 19.8 percent.<sup>55</sup> CBO noted that this conclusion was consistent with other academic research about subsidies and take-up of individual coverage, as well as observed use of HCTC advance payment.<sup>56</sup>

## *2. Low-income household budgets*

The significant impact of apparently modest premium requirements on enrollment into low-income health coverage programs is not hard to understand. Many low-income households have such little discretionary income that money for premiums must come from other necessities. Higher premium payments require an increasing trade-off of other household priorities. Fairly soon, the trade-off reaches a level that the household is unwilling to make.

A recent Urban Institute study of low-wage workers in ten U.S. communities found that a typical family needs from \$27,660 per year (in New Orleans, before Hurricane Katrina) to \$59,544 per year (in Boston) just to meet basic needs.<sup>57</sup> In none of the ten communities studied was a minimum-wage job sufficient to make ends meet for a single-parent family. A \$10 per hour full-time job allowed a single parent with two young children to cover 61% of basic expenses on average, and as low as 42% in a high-cost city like Boston.

The study used a measure called the "Self-Sufficiency Standard," which calculated the amount of income it takes for working families to meet their basic needs, using the actual cost of goods in the market, without public or private assistance of any kind. The calculated household budget did not allow for entertainment, carry-out or fast food, savings, credit card debt, or emergency expenses such as car repairs. It was based on government data sources and a consistent national methodology, so it showed variation across states and family types. In one fairly typical example, the Self-Sufficiency Standard showed that, for a family in Philadelphia that (a) had income at or below 230 percent of the FPL and (b) included a parent, a school-age child, and a preschooler, money spent on health insurance premiums would probably need to come from other necessities, such as child care or transportation (Table 3).

**TABLE 3: AMOUNTS REQUIRED FOR VARIOUS MONTHLY EXPENSES (NOT INCLUDING HEALTH CARE COSTS), THREE-PERSON FAMILY IN PHILADELPHIA, PA: 2004**

Type of expense	Minimum amount required for working parent plus two children
Housing	791
Child Care	977
Food	411
Transportation	106
Miscellaneous	251
Taxes	752
Tax Credits [-]	-282
<b>Monthly total</b>	<b>\$3,005</b>
Percentage of FPL	230%

Source: Wider Opportunities for Women, 2004. Calculations by ESRI, June 2005. Notes: (1) The Self Sufficiency Standard, in effect, raised family income above 230 percent of FPL by adding to family earnings the designated amount of Earned Income Tax Credit to help pay household costs. (2) The analysis published here excludes from the minimum household budget all out-of-pocket health care costs, to determine the maximum level of income at which premium payments would not be offset by lower out-of-pocket health care costs and so could be financed only through cutting non-health-related household expenditures. This is a conservative estimate, considering that health insurance plans generally require enrollees to pay some out-of-pocket health care costs in addition to premiums.

Another analysis, by researchers at the University of Washington and Mercer, Inc., used a different method but came to similar results. Focused on Washington State’s Basic Health Program (BHP), described in the previous section, this study estimated the minimum income needed, in eight diverse counties, to make BHP payments and still meet other basic needs, such as shelter, food, utilities, transportation, child care, and clothing. In each county, researchers developed separate budgets for twelve family types, three health status categories, and possible receipt or non-receipt of certain public benefits (food stamps and child care subsidies). These analysts developed a total of 576 minimum household budgets, in eight counties. They concluded that, for households to pay BHP premium contributions (typically \$10 a month) and average point-of-service cost-sharing and still meet their other basic needs, their income needed to exceed 104 percent of FPL for the best-case household (a large, healthy family, living in a rural county and receiving various kinds of public assistance) and 278 percent of FPL for the worst-case household (a large family in poor health, living in an urban county and not receiving public assistance). Most minimum budgets easily exceeded 150 percent FPL.<sup>58</sup>

While these amounts vary geographically and by family type, the numbers above suggest that many low-income families may find it difficult or even impossible to simultaneously meet other basic needs and pay more than nominal amounts for health insurance premiums. It is therefore understandable that many health subsidy programs, including but going far beyond HCTC, have found that even modest premium payment requirements can greatly lower enrollment among eligible, low-income households.

### *C. Enrollment obstacles other than affordability*

Four problems are discussed in turn below: the required payment of full premiums before the start of advance payment; preexisting condition exclusions; sub-optimal outreach strategies; and complex application procedures. We conclude that, for future tax credits to achieve significant take-up among low-income, uninsured Americans, beneficiaries cannot realistically be asked to pay full monthly premiums while their subsidy applications are being processed. For tax credits to help either the low-income or the higher-income uninsured, available coverage must be valued by the target group, outreach may need to be proactive and individualized, and the application process needs to be simple and straightforward.

#### *1. Full premium payments required before the start of advance payment*

Few low-income households will benefit from tax credits if they are required to make full monthly premium payments while their subsidy applications are being processed. The budgets of many such households do not have the discretionary income to “front” premium payments while awaiting later refunds, as is discussed above. “Gap-filler” programs run by state workforce agencies and funded by grants from the Department of Labor have been a remarkable and creative solution that helps workers without disposable income obtain subsidized coverage immediately, while IRS is processing their advance payment application. However, in designing a broader tax credit system serving a larger group of uninsured, providing the first few months of a worker’s subsidy through a program entirely distinct from tax credits, run by a separate government agency funded from a different revenue stream, could raise serious questions of efficiency, coordination, and seamlessness of coverage.

Underscoring these concerns is the troubling fact that, in states operating gap-filler programs, funding for such programs to cover the first one to three months of enrollees’ coverage exceeded by more than 20 percent all the remaining months of annualized HCTC coverage provided through advance payment from IRS. By September 2004, “gap-filler” programs were operating in five states, funded by \$22.4 million in grants from the U.S. Department of Labor (DOL).<sup>59</sup> Not all of those grant funds were necessarily spent during the year of their award, however; at least some states have received a number of extensions of time within which to distribute these resources to eligible workers.<sup>60</sup> That said, this funding level apparently exceeded the amount HCTC spent in those states for advance payment during the rest of the year, after the conclusion of the “gap filling” period. At the highest, publicly known monthly pace of the HCTC advance payment system – namely, for September 2004 - \$5.1 million in federal credits were provided by the national HCTC program, resulting in an annualized spending level of \$61.6 million. Allocating a pro rata share to the five states then operating bridge programs (which together enrolled 30.2 percent of all advance payment enrollees nationally), an estimated \$18.6 million in annualized advance payments would have gone to workers in these states – \$3.8 million less than the \$22.4 million in gap-filler funding provided by DOL. Before tax credits are expanded to a broader, low-income population, a more effi-

cient and integrated mechanism may be needed to begin subsidies promptly for eligible individuals.

One factor that distinguishes HCTC from programs like Medicare, Medicaid, and SCHIP is that, under the HCTC statute, enrollment into qualified coverage is an element of HCTC eligibility. As a result, individuals must pay for qualified coverage on their own while HCTC eligibility is being determined; but in these other health programs, eligibility is defined purely in terms of underlying household characteristics, so applicants can wait until they have been found eligible before they enroll, without any resulting reduction in the scope of benefits. While delays in processing applications for Medicaid, Medicare, and SCHIP are unfortunate because they slow the start of coverage, they do not force applicants to pay premiums in the meantime. In the future design of advanceable health insurance tax credits, an approach to eligibility modeled after these long-standing public programs could prevent processing delays from posing an insuperable obstacle for enrollment by potential beneficiaries with limited liquidity.

## *2. Preexisting condition exclusions*

A “meta-analysis” of hundreds of take-up studies, across a range of public and private programs, came to the unsurprising conclusion that one of the most important factors determining enrollment levels is the value of the benefit at stake.<sup>61</sup> Obviously, to an individual with chronic illness, health insurance is significantly less valuable if it excludes coverage of that illness.

On the other hand, preexisting condition exclusions can play an important role keeping insurance markets operational. In subsidy programs where insurers fear that sicker individuals may be disproportionately likely to enroll, preexisting condition exclusions can be essential to health plan participation. Similarly, such exclusions can play an important role in discouraging individuals from remaining uninsured until they get sick. That said, policymakers designing future coverage expansions may need to develop other mechanisms to address those legitimate concerns without imposing preexisting condition exclusions that make health coverage significantly less valuable, hence significantly less likely to be taken up.<sup>§</sup> If those concerns are not addressed successfully, tax credits may be effective only for individuals without preexisting health problems – precisely those for whom health coverage would have the least average impact on health outcomes.

## *3. Sub-optimal marketing strategies*

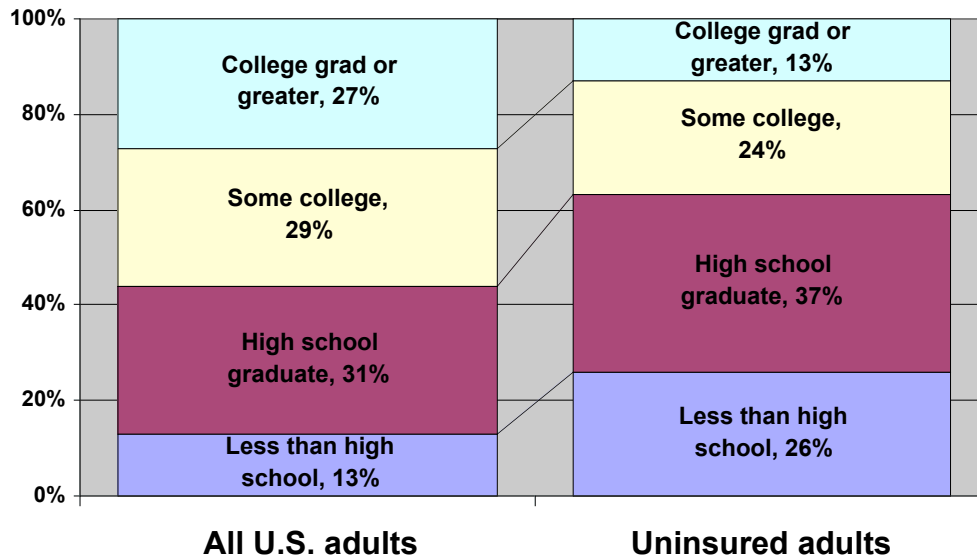
A number of marketing principles will be much more relevant to some groups of uninsured than to others. Multilingual consumer education materials will obviously be most important if the target group of uninsured includes many individuals with limited Eng-

---

<sup>§</sup> For example, the HCTC statute could be revised to exclude from the determination of whether individuals lost continuous coverage (and so are subject to preexisting condition exclusions) two periods of time: a) between loss of employment or employer-funded pension and notice of potential HCTC eligibility; and b) between application for and start of HCTC advance payment.

lish proficiency. However, simplicity of materials are likely to be important for effective outreach to most uninsured. Nearly two-thirds of the uninsured (63 percent) either never completed high school or ended formal education with their high school degree (Figure 4).

**FIGURE 4: DISTRIBUTION OF INDIVIDUALS WITH VARIOUS LEVELS OF EDUCATION, AMONG NON-ELDERLY ADULTS GENERALLY VS. NON-ELDERLY, UNINSURED ADULTS: 2003**



Source: The Kaiser Commission on Medicaid and the Uninsured, November 2004 (using data from March 2004 CPS).<sup>62</sup>

More fundamentally, proactive strategies that, during a single encounter, both educate likely eligibles and enroll them will secure much higher take-up rates than more traditional, passive, “two-step” strategies, for almost every population, even the most highly educated. One study, for example, found that when General Practice physicians in Great Britain were given information and urged to participate in training for a certain method of screening and brief intervention related to patients’ alcohol use, 22 percent of those who were mailed materials agreed to participate, compared to 68 percent of individuals who were contacted in-person and 82 percent who were contacted through proactive telephone calls and enrolled during these conversations.<sup>63</sup>

Several caveats on this issue are important. First, it would be important to design such strategies to safeguard consumer privacy. For example, forms could permit tax credit applicants to request help from a consumer assistance program and to authorize disclosure of otherwise private, automated information that is potentially pertinent to their eligibility. Such programs could then call individuals who requested help and who appear reasonably likely to qualify.

Second, this approach is novel in its application to health coverage subsidies. It has been used only rarely by Medicaid or SCHIP.<sup>64</sup> While the strategy may need to be considered for inclusion in future tax credit efforts, it would not be fair to criticize IRS or the Treasury Department for failing to employ this approach in the past.

Finally, this strategy would be more costly than traditional outreach approaches, even if the “target list” is carefully screened and limited to individuals who are likely to qualify. For example, telephoning Medicare beneficiaries to enroll them in low-income prescription drug subsidy programs is estimated to cost approximately \$66 per successful enrollee.<sup>65</sup> If comparable outreach to potential HCTC beneficiaries involved similar expenses, the resulting cost per successful HCTC enrollee would be nearly 2 percent of the average annual HCTC subsidy for a one-person policy.<sup>66</sup> Before deciding to implement such an approach to HCTC outreach, policymakers would need to weigh this administrative cost against the likely increase in enrollment.

#### *4. Complex and cumbersome application procedures*

HCTC is only one of many programs in which application procedures have had a significant impact on enrollment levels. For example, different administrative arrangements to promote retirement savings yield sharply different take-up rates for accounts that provide the identical tax benefit. Among individuals who must sign-up on their own for Individual Retirement Accounts (IRAs), only 10 percent of eligible households enroll.<sup>67</sup> When employers include an opportunity to establish 401(k) accounts within the routine process for new hires, 37 percent of eligible workers enroll. And when employers automatically enroll newly hired workers in such accounts unless they affirmatively opt out, enrollment increases to 86 percent, with the most significant effects coming among the lowest-income workers.<sup>68</sup>

Health coverage contains similar examples. For example, 96 percent of eligible seniors enroll in Medicare Part B,<sup>69</sup> in which individuals who do not “opt out” within a certain period after turning 65 are automatically enrolled, with premium payments taken out of their Social Security checks. By contrast, only one-third (33.4 percent) of eligible, poor Medicare recipients sign up for the Medicare Savings Program (MSP), which pays Medicare cost-sharing; to enter MSP, Medicare beneficiaries must apply through the Medicaid program and show that their income and assets are low enough to qualify.<sup>70</sup>

All of this suggests that, in designing future health insurance tax credits, policymakers need to provide an easy and convenient means of enrollment. At a minimum, potentially eligible individuals will need the ability to apply for assistance by filing one, simple form with a single agency.

## Conclusion

Some advocates of federal income tax credits to cover the uninsured suggest that the enrollment problems experienced by HCTC result from unique characteristics of the program's beneficiaries or institutional context. In their view, future tax credits may have much higher take-up rates even if such credits are no larger than HCTC and even if the structure for administering the future credits resembles HCTC.

It is true that some unusual features of this population inhibit enrollment – but other characteristics promote take-up. Placing the HCTC experience into context with broader patterns involving other programs, the simplest explanation for HCTC's enrollment problems seems to be that HCTC has not reached the following objectives, which appear crucial to the effectiveness of virtually any program that seeks to cover the low- to moderate-income uninsured:

- For low-income households with little disposable income, very limited premium payment requirements and subsidies that avoid any need for beneficiaries to “front” full monthly premium payments;
- Health coverage that beneficiaries value because it covers care that beneficiaries need to treat their known health problems;
- A proactive outreach strategy that includes easily understandable, multi-lingual materials as well as opportunities, during a single encounter, for individuals to learn about credits and to complete an application; and
- A simple application process for subsidies, with one form that can be filed with one public or private agency.

For future tax credits (or a re-designed HCTC program) to reach more than a small proportion of their target population, policymakers may need to restructure health insurance tax credits so they have a good chance of achieving these goals.

## Appendix A: National HCTC rules

Comprehensive explanations of the Health Coverage Tax Credits (HCTC) program are available elsewhere.<sup>71</sup> For the purposes of this report, however, the following brief summary may be helpful:

**Eligibility.** Several groups qualify for HCTCs:

1. Displaced workers whose layoffs have been certified by the U.S. Department of Labor (DOL) as trade-related and who therefore receive Trade Adjustment Assistance (TAA) cash payments or would qualify for such payments but for their receipt of unemployment insurance (UI);
2. Certain adults aged 55 through 64 who are paid by the Pension Benefit Guaranty Corporation (PBGC), which assists retirees from companies that have suffered severe financial reversals and so no longer pay promised defined benefit pensions;
3. Adults aged 50 through 64 who receive Alternative Trade Adjustment Assistance (ATAA) payments because they suffered trade-related job loss and then shifted to a new line of work for lower pay; and
4. Dependents of individuals in the three previous categories.
5. Individuals must also meet other criteria for eligibility, including absence of health coverage through Medicare, Medicaid, or employer-based plans (either as a worker or dependent) for which the firm pays 50 percent or more of premiums.

**Health coverage.** HCTCs pay 65 percent of premiums for qualified health plans, which fall into two categories:

1. State-qualified coverage, which is established by state action (through arrangements with an insurer or certain other methods) and which must meet the consumer protection requirements described below; and
2. Automatically qualified plans, which are available for HCTC use throughout the country (without any required action by state government) and which include: (a) COBRA plans offered by former employers; and (b) nongroup coverage in which the HCTC beneficiary was enrolled during at least the final 30 days before job loss or other qualifying event.

**Consumer protection requirements.** For individuals with at least three months of continuous coverage immediately before enrolling in an HCTC plan, without any gap in coverage of 63 days or more, state-qualified insurers must guarantee issue and may not exclude coverage of preexisting conditions.

**Modes of obtaining HCTC.** An eligible individual may either claim the HCTC on annual tax returns (for reimbursement of insurance premiums paid during the year) or have the HCTC paid in advance to the insurer, each month, as premiums are due.

**HCTC-related grants to states.** These grants, made by DOL and the Centers for Medicare and Medicaid Services (CMS), fall into two categories: CMS grants to support the establishment and operation of high-risk insurance pools; and National Emergency Grants (NEGs) from DOL, which include funding for infrastructure development and certain transitional state costs associated with HCTCs.

## Appendix B: Enrollment into advance payment

While each state tailors the process in accord with its own infrastructure, and the national program makes adjustments on an ongoing basis with the goal of improving outcomes for beneficiaries, taxpayers, and health plans, enrollment into HCTC payment generally includes the following steps:

- 1) Each State Workforce Agency (for TAA and ATAA beneficiaries) and the Pension Benefit Guaranty Corporation (for its beneficiaries) send the HCTC program lists of individuals who may qualify for HCTC. Transmitted electronically, such lists are provided daily by SWAs and monthly by PBGC.
- 2) The HCTC program mails HCTC Program Kits to each individual listed by the PBGC or a SWA as potentially eligible. These kits contain detailed explanations of eligibility, qualified coverage, application procedures for HCTCs, and related topics. They are available in English and Spanish.
- 3) The individual enrolls in qualified health coverage. Unless the potential beneficiary lives in a state offering so-called “bridge” or “gap-filler” assistance, he or she must pay each month’s premium in full, pending completion of the HCTC registration process and the start of advance payment. If the individual turns out to be eligible for HCTCs, the Internal Revenue Service (IRS) reimburses such full-premium payments at the end of the year, after the individual files annual income tax forms.
- 4) The health plan sends an invoice to the individual showing the full premium amount. (The plan can continue sending these full, premium invoices even after advance payments begin and the consumer makes 35 percent premium payments to the HCTC program, rather than pay full premiums to the plan.)
- 5) The individual contacts the HCTC call center to enroll in advance payment, while mailing the health plan’s invoice to the HCTC program. The HCTC program then uses that invoice to confirm enrollment in qualified coverage and to determine the proper dollar amount of the credit and the regular, monthly due date for payment to the plan.
- 6) The HCTC program determines whether the individual is eligible and, if so, registers him or her for advance payment.
- 7) For each month of advance payment, the following process applies:
  - a) Precisely 27 days before the plan needs to receive its full premium payment, the HCTC program bills the individual for his or her 35 percent premium share. The consumer’s payment is due at the HCTC program 21 days after the bill is mailed.

- b) If the HCTC program receives the full 35 percent payment by that date, the IRS provides a 65 percent advance credit. The HCTC program then combines that credit with the beneficiary's payment, sending the full premium payment electronically to the health plan.
- c) If the beneficiary pays less than the full 35 percent amount, the HCTC program combines that payment with a proportional matching credit from IRS, forwards the combined payment to the health plan, and reminds the beneficiary of the additional amount that must be paid to the plan to retain coverage. The plan is then responsible for collecting such additional amounts.
- d) If no payment is received from the beneficiary by the due date, the HCTC program sends the consumer a notice stating that HCTC neither received a payment from the consumer nor made a payment to the health plan on the consumer's behalf—and that to maintain coverage the consumer must pay the full premium amount to the plan. As long as it continues to receive eligibility records from PBGC or an SWA, HCTC continues sending advance-payment invoices to the consumer requesting 35 percent of the next month's full premium amount. It is up to the individual and the plan to work out issues regarding past amounts due and whether coverage continues. Eligible individuals who are enrolled in qualified plans and who make premium payments that are not covered by advance payment may use their annual tax returns to claim HCTC reimbursement for such payments.

## **Appendix C: Analysis of contact information on IRS website**

From May 24 to June 16, 2005, researchers at the Economic and Social Research Institute investigated the information provided by the IRS website concerning state-qualified HCTC plans.\*\* We examined every state-qualified insurer, except for mini-COBRA plans. This left 57 insurers to investigate. Our goal was to assess the ease with which individuals in each state could learn precisely which plan or plans qualified for HCTCs.

To reach this goal, we called each phone number and visited each web site listed by IRS. We were unable to call one listed insurer (in Illinois), because the phone number accepted only in-state calls and we could not obtain a different number accessible from out-of-state. Sometimes, after we first called an insurer, as we were being transferred to a new staff person, we were given another number to call. We also followed each web-link on the IRS web site, except for one link, which was broken. If the IRS did not provide a link to a particular insurer, we conducted a search of the internet via Google and, more than half of the time, were able to find the insurer's web page. We also searched via Google when the IRS link took us somewhere other than the listed plan; this happened in three states, where the IRS link connected to either the general state government's web site or a web site for a large, multi-state insurer with a name not listed on the IRS site.

When we reached the pertinent insurer's web site, either through the web link on the IRS website or our own Google search, we tried to find the identity of the HCTC-qualified plan, as follows. First, we examined the main page (that is, the page linked directly from the IRS site or Google search results). Second, we followed links from the main page to what was described as the health plans page, the premiums page, the eligibility page, or the benefits page. Third, we took advantage of available search options to locate HCTC information. We did this by searching for "HCTC", "health coverage tax credit", "TAA", "Trade Act", "PBGC", and the name of the plan as listed on the IRS web site. The following tables show what we found.

---

\*\* <http://www.irs.gov/individuals/article/0,,id=110016.00.html>

**Appendix Table 1: HCTC plan information obtained from the IRS website, for plans with a web link from the IRS site**

State	Plan Name	Link from IRS?	HCTC information on main page?	Any locatable HCTC information on website?	Search Options?	Any HCTC-terms or the plan name result in search hits?
AL	BlueCross Blue Shield AL	Yes	No	No	Yes	No
AK	Alaska Comprehensive Health Insurance Association	Yes	No	Yes (implicitly states plan)	No	N/A
AZ	HealthCareGroup of Arizona	Yes	No	No	No	N/A
CA	Kaiser Permanente	Yes	No	No	Yes	No
CO	CoverColorado	Yes	No	Yes (implicitly states plan)	Yes	Yes (implicitly states plan)
DC	Carefirst BlueCross BlueShield	Yes	No	No	Yes	No
FL	Anthem Blue Cross Blue Shield	Yes	No	No	Yes	No (no plan)
ID	States General Life Insurance Company	Yes	No (no info on website)	No (no info on website)	No (no info on website)	N/A
	Blue Cross of Idaho	Yes	No	No	Yes	No
	Regence BlueShield of Idaho	Yes	No	No	Yes	No (no plan)
	Assurant Health	Yes	No	No	Yes	No
IL	Comprehensive Health Insurance Plan	Yes	No	Yes (explicitly states plan)	No	N/A
	Indiana Comprehensive Health Insurance Association	Yes	Yes (implicitly states plan)	Yes (implicitly states plan)	Yes	Yes (implicitly states plan)
IA	Iowa Comprehensive Health Association	Yes (but later link to different web-	No	Yes (implicitly states plan)	Yes	Yes (implicitly states plan)

State	Plan Name	Link from IRS?	HCTC information on main page?	Any locatable HCTC information on website?	Search Options?	Any HCTC-terms or the plan name result in search hits?
			site)			
KS	Kansas Health Insurance Association	Yes	No	Yes (implicitly states plan)	No	N/A
LA	Louisiana Health Plan	Yes	No	No	No	N/A
MD	Maryland Health Insurance Plan	Yes	No	Yes (implicitly states plan)	No	N/A
	Carefirst BlueCross BlueShield	Yes	No	No	Yes	No
MN	Minnesota Comprehensive Health Association	Yes (links to multi-state insurer) not on IRS website)	No	No	Yes	No
MT	Montana Comprehensive Health Association	Yes	Yes (implicitly states plan)	Yes (implicitly states plan)	No	N/A
NE	Nebraska Comprehensive Health Insurance Pool	Yes (links to NE govt. website)	No	No	Yes	No (no plan)
NJ	Aetna New Jersey HCTC Discretionary Plan	Yes	No	Yes (explicitly states plan)	Yes	No (need password to search)
NY	Healthy New York	Yes	Yes (explicitly states plan)	Yes (explicitly states plan)	No	N/A

State	Plan Name	Link from IRS?	HCTC information on main page?	Any locatable HCTC information on website?	Search Options?	Any HCTC-terms or the plan name result in search hits?
	HCTC Healthy New York	No (link doesn't work)	N/A	N/A	N/A	N/A
	Direct pay HMO and POS	Yes	No	Yes (explicitly states plan)	Yes	Yes (explicitly states plan)
NC	Blue Cross Blue Shield of North Carolina	Yes	No	No	Yes	Yes (implicitly states plan)
RI	BlueCross BlueShield of Rhode Island	Yes	No	No	Yes	No
TN	Blue Cross Blue Shield of Tennessee	Yes	No	No	Yes	Yes (implicitly states plan)
TX	Texas Health Insurance Risk Pool	Yes	No (no plan)	Yes (implicitly states plan)	No	N/A
	BlueCross BlueShield of Texas	Yes	No	No	No	N/A
UT	State of Utah Department of Workforce Services	Yes (links to multi-state insurer not on IRS website)	No	No	Yes	No
VT	MVP Health Plan, Inc.	Yes	No	No	Yes	No
	Blue Cross Blue Shield of Vermont	Yes	No	No	Yes	No
VA	Anthem BlueCross BlueShield	Yes	No	No	Yes	No
	Carefirst BlueCross BlueShield	Yes	No	No	Yes	No
WA	Washington State Basic Health Plan	Yes	Yes (explicitly states plan)	Yes (explicitly states plan)	Yes	Yes (explicitly states plan)

State	Plan Name	Link from IRS?	HCTC information on main page?	Any locatable HCTC information on website?	Search Options?	Any HCTC-terms or the plan name result in search hits?
TOTALS	36	35	4 Yes (2 Implicit, 2 Explicit) 31 No	13 Yes (8 Implicit, 5 Explicit) 22 No	24 Yes 11 No	7 Yes (5 Implicit, 2 Explicit) 17 No 11 N/A

Notes: (1) For HCTC information to be locatable on a website, it would have to be either on the main website page, the health plans page, the premiums page, the eligibility page, or the benefits page. (2) The search terms used to find information about HCTC-qualified plans were HCTC, health coverage tax credit, TAA, trade act, and PBGC. Also, for Minnesota, Nebraska, and Utah, where the IRS links went to entities other than the plan name listed on the IRS site, the search included the IRS-listed plan name as well. (3) “Explicitly states plan,” means that the website stated exactly which plan and/or option qualified for HCTC (e.g., “HCTC recipients are eligible for every deductible for Plan X,” or “only the \$300 deductible for Plan X”) (4) “Implicitly states plan”, means that the website showed the general plan but not the specific option that qualified for HCTC, (e.g., “HCTC recipients are eligible for Plan X”, which has several different deductibles). (5) “No” means that the website did not mention the HCTC program at all. (6) “No (No Plan)” means that the website had general information about the HCTC program but did not specify the plan for which HCTCs could be used.

**Appendix Table 2: HCTC plan information obtained from websites via Google searches for plans without links from the IRS website**

State	Plan Name	HCTC information on main page?	Any locatable HCTC information on website?	Search Options?	Any HCTC-terms result in search hits?
AR	Arkansas Comprehensive Health Insurance Pool	No	Yes (implicitly states plan)	No	N/A
CT	Health Reinsurance Association of CT	No	Yes (implicitly states plan)	No	N/A
ID	The MEGA Life and Health Insurance Company	No	No	No	N/A
	Mid-West National Life Insurance Company of Tennessee	No	No	No	N/A
IN	Anthem Blue Cross Blue Shield	No	No	Yes	No
KY	Anthem Blue Cross Blue Shield	No	No	Yes	No
ME	State of Maine Employee Health and Benefits Department	No website	No website	No website	No website
MI	Blue Cross Blue Shield of Michigan	No	No	Yes	No (no plan)
MN *	Minnesota Comprehensive Health Association	No	Yes (implicitly states plan)	No	N/A
NH	New Hampshire Health Plan	Yes (implicitly states plan)	Yes (implicitly states plan)	Yes	Yes (implicitly states plan)
NY	HCTC Healthy New York	No	Yes (explicitly states plan)	Yes	Yes (explicitly states plan)
NE	Nebraska Comprehensive Health Insurance Pool	No	No	Yes	No (no plan)
ND	Comprehensive Health Association of North Dakota	No	Yes (implicitly states plan)	No	N/A

State	Plan Name	HCTC information on main page?	Any locatable HCTC information on website?	Search Options?	Any HCTC-terms result in search hits?
OH	Anthem Blue Cross Blue Shield	No	No	Yes	Yes (explicitly states plan)
	Kaiser Permanente	No	Yes (explicitly states plan)	Yes	Yes (explicitly states plan)
OK	Oklahoma Health Insurance High Risk Pool	No website	No website	No website	No website
PA	Highmark Blue Cross Blue Shield	No	Yes (explicitly states plan-BUT VERY HARD TO FIND)	Yes	No (no plan)
	Highmark Blue Shield	No	Yes (explicitly states plan)	No	N/A
	Pennsylvania Blue Shield (now same as Highmark Blue Shield)	No website	No website	No website	No website
	Independence Blue Cross	No	No	Yes	No
	Blue Cross of Northeastern Pennsylvania	No	No	No	N/A
	Capital Blue Cross	No	Yes (explicitly states plan)	Yes	Yes (explicitly states plan)
SC	South Carolina Health Insurance Pool	No website	No website	No website	No website
UT *	State of Utah Department of Workforce Services	Yes (neither implicitly or explicitly states plan)	Yes (neither implicitly or explicitly states plan)	Yes	No (no plan)
WV	Mountain State Blue Cross and Blue Shield	No	No	No	N/A
TOTALS	25	2 Yes (1 Implicit, 1 Neither)	11 Yes (5 Implicit, 5 Explicit, 1 Neither)	12 Yes	5 Yes (1 Implicit, 4 Explicit)

State	Plan Name	HCTC information on main page?	Any locatable HCTC information on website?	Search Options?	Any HCTC-terms result in search hits?
		19 No	10 No	9 No	7 No
		4 No Website	4 No Website	4 No Website	4 No Website
					9 N/A

\* For both Minnesota and Utah, the links from the IRS website led to organizations not named on the IRS site. However, when searching for the Minnesota Comprehensive Health Association and the State of Utah Department on Workforce Services on the internet, one can link directly to the websites for HCTC program information.

Notes: (1) For HCTC information to be locatable on a website, it would have to be either on the main website page, the health plans page, the premiums page, the eligibility page, or the benefits page. (2) The search terms used to find information about HCTC-qualified plans were HCTC, health coverage tax credit, TAA, trade act, and PBGC. Also, for Minnesota, Nebraska, and Utah, where the IRS links went to entities other than the plan name listed on the IRS site, the search included the IRS-listed plan name as well. (3) "Explicitly states plan," means that the website stated exactly which plan and/or option qualified for HCTC (e.g., "HCTC recipients are eligible for every deductible for Plan X," or "only the \$300 deductible for Plan X") (4) "Implicitly states plan", means that the website showed the general plan but not the specific option that qualified for HCTC, (e.g., "HCTC recipients are eligible for Plan X", which has several different deductibles). (5) "No" means that the website did not mention the HCTC program at all. (6) "No (No Plan)" means that the website had general information about the HCTC program but did not specify the plan for which HCTCs could be used. (7) For Utah, the website stated that the IHC plan was qualified as an HCTC plan, but there is no one IHC plan. There are several, and the one specified for HCTC is not clear, nor is it clear that all the plans are for HCTC recipients; hence its marking as neither explicit nor implicit.

**Table 3: HCTC plan information provided over the phone**

State	Plan Name	# of Transfers	Unreturned Messages or email	Did you find out which plan qualifies for HCTCs?
AL	BlueCross Blue Shield AL	0	0	Yes
AK	Alaska Comprehensive Health Insurance Association	0	0	Yes
AR	Arkansas Comprehensive Health Insurance Pool	0	0	Yes
AZ	HealthCareGroup of Arizona	2	0	Yes
CA	Kaiser Permanente	2	0	Yes
CO	CoverColorado	0	0	Yes
CT	Health Reinsurance Association of CT	0	0	Yes
	<i>Mini-COBRA</i>			
DE	<i>NO PLAN</i>			
DC	Carefirst BlueCross BlueShield	2	0	Yes
FL	Anthem Blue Cross Blue Shield	2	0	Yes
	<i>Mini-COBRA</i>			
GA	<i>NO PLAN</i>			
HA	<i>NO PLAN</i>			
ID	States General Life Insurance Company	3	0	No
	Blue Cross of Idaho	2	1	No
	Regence BlueShield of Idaho	2	0	Yes
	Assurant Health	4	0	No
	The MEGA Life and Health Insurance Company	3	0	No
	Mid-West National Life Insurance Company of Tennessee	4	0	No
IL	Comprehensive Health Insurance Plan			N/A
IN	Anthem Blue Cross Blue Shield	0	0	Yes
	Indiana Comprehensive Health Insurance Association			Yes
IA	Iowa Comprehensive Health Association	1	0	Yes

State	Plan Name	# of Transfers	Unreturned Messages or email	Did you find out which plan qualifies for HCTCs?
KS	Kansas Health Insurance Association	0	0	Yes
KY	Anthem Blue Cross Blue Shield <i>Mini-COBRA</i>	0	0	Yes
LA	Lousiana Health Plan	1	0	Yes
ME	State of Maine Employee Health and Benefits Department	0	0	Yes
MD	Maryland Health Insurance Plan Carefirst BlueCross BlueShield	1 3	0 0	Yes Yes
MA	<i>NO PLAN</i>			
MI	Blue Cross Blue Shield of Michigan	1	0	Yes
MN	Minnesota Comprehensive Health Association	2	0	Yes
MS	<i>NO PLAN</i>			
MO	<i>Mini-COBRA</i>			
MT	Montana Comprehensive Health Association	0	0	Yes
NE	Nebraska Comprehensive Health Insurance Pool <i>Mini-COBRA</i>	3	0	Yes
NV	<i>NO PLAN</i>			
NH	New Hampshire Health Plan	1	0	Yes
NJ	Aetna New Jersey HCTC Discretionary Plan <i>Mini-COBRA</i>	5	1	No
NM	<i>NO PLAN</i>			
NY	Healthy New York HCTC Healthy New York Direct pay HMO and POS <i>Mini-COBRA</i>	1 1 1	0 0 0	Yes Yes Yes
NC	Blue Cross Blue Shield of North Carolina	2	0	Yes
ND	Comprehensive Health Association of North Dakota	2	1	No
OH	Anthem Blue Cross Blue Shield	1	0	Yes

State	Plan Name	# of Transfers	Unreturned Messages or email	Did you find out which plan qualifies for HCTCs?
	Kaiser Permanente	2	0	Yes
	<i>Mini-COBRA</i>			
OK	Oklahoma Health Insurance High Risk Pool	0	0	Yes
PA	Highmark Blue Cross Blue Shield	0	0	Yes
	Highmark Blue Shield	0	0	Yes
	Pennsylvania Blue Shield (now same as Highmark Blue Shield)	0	0	Yes
	Independence Blue Cross	2	0	Yes
	Blue Cross of Northeastern Pennsylvania	0	0	Yes
	Capital Blue Cross	0	0	Yes
RI	BlueCross BlueShield of Rhode Island	2	0	No
	<i>Mini-COBRA</i>			
SC	South Carolina Health Insurance Pool	0	0	Yes
SD	<i>NO PLAN</i>			
TN	Blue Cross Blue Shield of Tennessee	1	0	Yes
TX	Texas Health Insurance Risk Pool	0	0	Yes
	BlueCross BlueShield of Texas	2	0	No
UT	State of Utah Department of Workforce Services	2	1	No
	<i>Mini-COBRA</i>			
VT	MVP Health Plan, Inc.	1	0	Yes
	Blue Cross Blue Shield of Vermont	1	0	Yes
	<i>Mini-COBRA</i>			
VA	Anthem BlueCross BlueShield	0	0	Yes
	Carefirst BlueCross BlueShield	5	0	Yes
WA	Washington State Basic Health Plan	0	0	Yes
WV	Mountain State Blue Cross and Blue Shield	1	0	Yes
WI	<i>Mini-COBRA</i>			
WY	<i>NO PLAN</i>			

State	Plan Name	# of Transfers	Unreturned Messages or email	Did you find out which plan qualifies for HCTCs?
TOTALS	Plans (No Mini-COBRA)	Avg. Transfers		Found Out Info
	57	1.3		46
		Two or More Transfers	Unreturned Calls/Messages	Did Not Find Out Info
		22	4	10
		No Transfers		
		21		

## Notes

---

<sup>1</sup> 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.

<sup>2</sup> Joint Committee on Taxation (Joint Tax). *Estimated Budget Effects of the Revenue Provisions Contained in the Conference Agreement for H.R. 3009, The Trade Adjustment Assistance Reform Act of 2002 ('TAA')*, July 29, 2002, JCX-84-02.

<sup>3</sup> U.S. Office of Management and Budget (OMB). *Analytical Perspectives on the Budget, 2006*, February 2005. <http://www.whitehouse.gov/omb/budget/fy2006/pdf/spec.pdf>.

<sup>4</sup> Joint Tax, op cit.

<sup>5</sup> OMB, op cit.

<sup>6</sup> Marilyn J. Smith, IRS, personal communication, September 2005.

<sup>7</sup> Lael Brainard, Robert E. Litan, and Nicholas Warren. "A Fairer Deal for America's Workers In A New Era of Offshoring." The Brookings Institution and the Kauffman Foundation. May 19, 2005. Draft chapter in forthcoming book, Lael Brainard and Susan M. Collins (editors): *Offshoring White-Collar Work—The Issues and Implications*, The Brookings Trade Forum, 2005.

[http://www.brookings.edu/es/commentary/journals/tradeforum/2005btf\\_brainard.pdf](http://www.brookings.edu/es/commentary/journals/tradeforum/2005btf_brainard.pdf). For similar analyses, see Karen Pollitz and Stephanie Lewis, *The Health Coverage Tax Credit for Trade Dislocated Workers and Retirees: Lessons from Maine's Early Experience*, Georgetown University Health Policy Institute and National Academy for State Health Policy prepared for Maine Health Access Foundation, April 2004, [http://www.mehaf.org/pictures/NASHP\\_HCTC\\_paper\\_final\\_4-5-04.pdf](http://www.mehaf.org/pictures/NASHP_HCTC_paper_final_4-5-04.pdf); and Deborah Chollet and Fabrice Smieliauskas, *Indiana's Health Insurance Market (Final Report)*, Mathematica Policy Research, Inc., prepared for Health Evolutions, Inc., MPR Reference No.: 6070, <http://www.in.gov/fssa/programs/chip/insurance/pdf/MarketFinalReport.pdf>.

<sup>8</sup> U.S. Government Accountability Office (GAO). *Health Coverage Tax Credit: Simplified and More Timely Enrollment Process Could Increase Participation*. September 2004. GAO-04-1029. <http://www.gao.gov/cgi-bin/getrpt?GAO-04-1029>.

<sup>9</sup> IRS. *Monthly Executive Scorecard September 2004 – v 1.0*. (September Scorecard) October 13, 2004.

<sup>10</sup> IRS. *Tax Year 2004 Taxpayer Usage Study, Report Number 15* - page 1. Data are for returns received from January 1 through August 26, 2005 - Tax Year 2004 – and January 1 through August 27, 2004 - Tax Year 2003. <http://www.irs.gov/pub/irs-soi/04tp15tb.xls>. Calculations by ESRI, October 2005.

<sup>11</sup> September Scorecard, op cit.

<sup>12</sup> IRS. *Executive Scorecard, December 2003*. January 20, 2004.

<sup>13</sup> September Scorecard, op cit.

<sup>14</sup> Smith, op cit.

<sup>15</sup> Thomas M. Selden, Julie L. Hudson, and Jessica S. Bantlin. "Tracking Changes In Eligibility And Coverage Among Children, 1996–2002," *Health Affairs* September/October 2004. <http://content.healthaffairs.org/cgi/content/full/23/5/39>.

<sup>16</sup> Stan Dorn, Tanya Alteras, and Jack A. Meyer. *Early Implementation of the Health Coverage Tax Credit in Maryland, Michigan, and North Carolina: A Case Study Summary*. ESRI, prepared for The

---

Commonwealth Fund and the Nathan Cummings Foundation. April 2005.

[http://www.cmf.org/usr\\_doc/806\\_dorn\\_earlyimplementationhct.pdf](http://www.cmf.org/usr_doc/806_dorn_earlyimplementationhct.pdf).

<sup>17</sup> Smith, op cit.

<sup>18</sup> See, e.g., Peter Trinidad, Contract Coordinator, United Steel Workers of America, at National Health Policy Forum, May 7, 2004, *Implementing the Health Coverage Tax Credit Program: Model for the Future?*; Dorn, Alteras, Meyer, et al., op cit.

<sup>19</sup> Access to Benefits Coalition. *Pathways to Success: Meeting the Challenge of Enrolling Medicare Beneficiaries with Limited Incomes*. National Council on Aging. June 24, 2005.

<http://www.accesstobenefits.org/library/pdf/ABC%20ReportFNL62305.pdf>.

<sup>20</sup> The kit is available at [http://www.irs.gov/pub/irs-utl/06\\_04\\_program\\_kit.pdf](http://www.irs.gov/pub/irs-utl/06_04_program_kit.pdf).

<sup>21</sup> The kit's text tested out at a 7.9 grade level on the Flesch-Kincaid test that is built into Microsoft Word. ESRI, July 2005.

<sup>22</sup> Smith, op cit.

<sup>23</sup> National Taxpayer Advocate. *2004 Report to Congress: Volume 2, Earned Income Tax Credit (EITC) Audit Reconsideration Study*. December 31, 2004. IRS Publication 2104B (Rev.12-2004) Catalog Number 23655L <http://www.irs.gov/pub/irs-utl/nta2004arcvol2interactive.pdf>.

<sup>24</sup> <http://www.irs.gov/individuals/article/0,,id=110016,00.html>.

<sup>25</sup> Mark V. Pauly. "An Adaptive Credit Plan for Covering the Uninsured." *Covering America: Real Remedies for the Uninsured*. Economic and Social Research Institute, for The Robert Wood Johnson Foundation. June 2001. <http://www.esresearch.org/RWJ11PDF/pauly.pdf>.

<sup>26</sup> Dorn, Alteras, and Meyer, op cit.

<sup>27</sup> September Scorecard, op cit.

<sup>28</sup> For more information on the Medical Security Program, see

<http://www.detma.org/WSmsp.htm>.

<sup>29</sup> Kathryn Haslanger, Robert E. Mechanic, Mary Jo O'Brien, and Kenneth E. Thorpe. *Taking Steps, Losing Ground: The Challenge of New Yorkers without Health Insurance*. United Hospital Fund of New York. 1998. [http://www.uhfny.org/usr\\_doc/UNINSURE.PDF](http://www.uhfny.org/usr_doc/UNINSURE.PDF).

<sup>30</sup> On the other hand, recently laid-off workers may retain savings or other assets that help them afford health insurance premiums more easily than low-income families without such resources.

<sup>31</sup> For example, 80 percent of 19-24 year olds who are offered employer-based insurance accept it – slightly fewer than the 85 percent who accept such offers among workers of all ages. Stan Dorn. *Towards Incremental Progress: Key Facts About Groups Of Uninsured*. Economic and Social Research Institute, prepared for the California HealthCare Foundation. September 2004 (citing research by the Urban Institute). [http://www.esresearch.org/newsletter/facts\\_uninsured.pdf](http://www.esresearch.org/newsletter/facts_uninsured.pdf).

<sup>32</sup> Catherine Hoffman, Alicia Carbaugh, Allison Cook. *Health Insurance Coverage in America: 2003 Data Update*. Kaiser Commission on Medicaid and the Uninsured (KCMU), Urban Institute. November 2004.

<http://www.kff.org/uninsured/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=49550>.

<sup>33</sup> Jennifer Haley and Stephen Zuckerman. *Is Lack Of Coverage A Short- Or Long-Term Condition?* The Urban Institute, prepared for KCMU. June 2003.

[http://www.kff.org/uninsured/upload/45570\\_1.pdf](http://www.kff.org/uninsured/upload/45570_1.pdf).

---

<sup>34</sup> Hoffman, et al., op cit.

<sup>35</sup> John Sheils and Randall Haught. *Cost and Coverage Analysis of Ten Proposals To Expand Health Insurance Coverage*, Appendix A. The Lewin Group, prepared for Covering America, The Robert Wood Johnson Foundation. October 1, 2003.

<http://www.esresearch.org/publications/SheilsLewinall/A-Methodology.pdf>.

<sup>36</sup> Leighton Ku and Teresa A. Coughlin. *The Use of Sliding Scale Premiums in Subsidized Insurance Programs*. The Urban Institute. March 01, 1997. <http://www.urban.org/Template.cfm?Section=ByAuthor&NavMenuID=63&template=/TaggedContent/ViewPublication.cfm&PublicationID=6201>, later revised and published in *Inquiry*, Winter 1999/2000, 36(4):471-480.

<sup>37</sup> The Lewin Group. *Advance Premium Payments: A Snap Shot of Emerging Experience*. Data from June, 2004. (Lewin) Calculations by ESRI, June 2005.

<sup>38</sup> Carolyn Madden, Allen Cheadle, Paula Diehr, Diane Martin, Donald Patrick, Susan Skillman. *Journal of Health Politics, Policy, and Law*. 20(4): 955-972. 1995. "Voluntary Public Health Insurance for Low-Income Families: The Decision to Enroll."

<sup>39</sup> Stephen H. Long and M. Susan Marquis. *Inquiry*. 39:243-257 (Fall 2002). "Participation in a Public Insurance Program: Subsidies, Crowd-Out, and Adverse Selection."

<sup>40</sup> Cindy Mann & Samantha Artiga, *The Impact of Recent Changes in Health Care Coverage for Low-Income People: A First Look at the Research Following Changes in Oregon's Medicaid Program*, KCMU, June 2004

<http://www.kff.org/medicaid/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=36812>. The Massachusetts program is subsidized by a payroll surcharge.

<sup>41</sup> Vicki Pulos. *Chronology of Health Access Cutbacks in 2002-2004*. Massachusetts Law Reform Institute, prepared for Health Care for All. February 2004.

[http://www.masslegalservices.org/docs/Cutbacks\\_2002-04\\_Highlights.doc](http://www.masslegalservices.org/docs/Cutbacks_2002-04_Highlights.doc).

<sup>42</sup> See <http://www.detma.org/wsmssp.htm#Direct> (as of June 9, 2005).

<sup>43</sup> Bill J. Wright, Matthew J. Carlson, Tina Edlund, Jennifer DeVoe, Charles Gallia, and Jeanene Smith, "The Impact Of Increased Cost Sharing On Medicaid Enrollees," *Health Affairs*, July/August 2005. <http://content.healthaffairs.org/cgi/reprint/24/4/1106>; Matthew Carlson and Bill Wright, *The Impact of Program Changes on Enrollment, Access, and Utilization in the Oregon Health Plan Standard Population*, Office for Oregon Health Policy and Research, March 2005, <http://egov.oregon.gov/DAS/OHPPR/RSCH/docs/OHREC.cohortflwup.03.05.rpt.pdf>

<sup>44</sup> Carlson and Wright, op cit.

<sup>45</sup> Mann and Artiga, op cit.

<sup>46</sup> Office of Health Care Statistics. *Utah Primary Care Network Disenrollment Report*. Utah Department of Health. 2004. <http://health.utah.gov/hda/Reports/PCN%20Disenrollment.pdf>

<sup>47</sup> Ann Dunkelberg and Molly O'Malley, *Children's Medicaid and SCHIP in Texas: Tracking the Impact of Budget Cuts*, Center for Public Policy Priorities, prepared for KCMU, July 2004, at 15. <http://www.cppp.org/files/3/Children-s-Medicaid-and-SCHIP-in-Texas-Tracking-the-Impact-of-Budget-Cuts-Report.pdf>. Although not a leading cause of disenrollment, complex administrative procedures also contributed to coverage losses.

<sup>48</sup> Vernon Smith and David Rousseau, *SCHIP Program Enrollment: December 2003 Update*, KCMU, July 2004, at

---

<http://www.kff.org/medicaid/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=44443>.

<sup>49</sup> Artiga and O'Malley, op cit.

<sup>50</sup> The maximum monthly premium chargeable to a family as a whole was \$45. National Governors Association. "Virginia." *NGA Summary, State Children's Health Insurance Program*. <http://www.nga.org/cda/files/VASCHIP.pdf>.

<sup>51</sup> Leighton Ku. *The Effect Of Increased Cost-Sharing In Medicaid: A Summary Of Research Findings*. Center on Budget and Policy Priorities. May 31, 2005. <http://www.cbpp.org/5-31-05health2.htm>.

<sup>52</sup> Center for Medicare and Medicaid Services. *Virginia Title XXI State Plan Fact Sheet*. Last updated September 15, 2004. <http://www.cms.hhs.gov/schip/factsheets/chpfsva.pdf>.

<sup>53</sup> Stan Dorn and Tanya Alteras. *Washington State: Pioneer and Innovator in Covering Low-Income Workers*. ESRI, prepared for KCMU. August 2004.

<http://www.kff.org/medicaid/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=46188>. Ann Dunkelberg and Molly O'Malley, *Children's Medicaid and SCHIP in Texas: Tracking the Impact of Budget Cuts*, Center for Public Policy Priorities, prepared for KCMU, July 2004, at 15. <http://www.cppp.org/files/3/Children-s-Medicaid-and-SCHIP-in-Texas-Tracking-the-Impact-of-Budget-Cuts-Report.pdf>. Although not a leading cause of disenrollment, complex administrative procedures led many persons and families to fall out of coverage.

<sup>54</sup> Mark Gardner and Janet Varon. *Moving Immigrants from a Medicaid Look-Alike Program to Basic Health in Washington State: Early Observations*. University of Washington and Northwest Health Law Advocates for the KCMU. May 2004. <http://www.kff.org/medicaid/7079a.cfm>. The minimum premium has since been raised to \$17.00.

<sup>55</sup> David Auerbach and Sabina Ohri. *The Price Sensitivity of Demand for Nongroup Health Insurance*. Congressional Budget Office. August 2005. <http://www.cbo.gov/ftpdocs/66xx/doc6620/08-24-HealthInsurance.pdf>.

<sup>56</sup> Such studies cited by CBO include Jonathan Gruber, *Tax Policy for Health Insurance*, National Bureau of Economic Research Working Paper No. 10977, December 2004, <http://www.nber.org/papers/w10977>; Susan M. Marquis, et al., "Subsidies and the Demand for Individual Health Insurance in California," *Health Services Research*, vol. 39, no. 5, pp. 1547-1570, 2004; and Susan M. Marquis and Stephen H. Long, "Worker Demand for Health Insurance in the Nongroup Market," *Journal of Health Economics*, vol. 14, no.1, pp. 47-63, 1995. One set of studies that came to very different conclusions about subsidy size and take-up rates was published by Mark Pauly and Bradley Herring in 2001 and 2002. Pauly and Herring estimated that a tax credit paying 66 percent of health insurance premiums would be taken up by between 46 and 79 percent of all eligible uninsured. This conclusion resulted from two different calculations. First, by noting the percentage of workers at each income level who received employer-sponsored insurance, the authors gleaned the level of subsidy needed to induce such workers to enroll into coverage. That subsidy was calculated as the sum of (a) the tax savings to workers resulting from the exclusion of employer premium payments from workers' taxable income, plus (b) the savings in administrative costs obtained by the employers' more efficient "bulk" purchasing for groups of workers. The authors assumed that workers did not count as a subsidy employer payments for health insurance (other than for the tax benefits and administrative efficiency of group purchas-

---

ing), since the authors believed that workers realize over the long-term that such payments lower wages. Put differently, the authors assumed that workers eventually come to believe that (1) employer payments of health insurance premiums provide no net value (other than tax benefits and lower administrative costs), since (2) firms compensate for health insurance premium payments by lowering wages.

In their second method for projecting take-up rates for tax credits of various sizes, the authors determined the savings that reasonably comprehensive coverage would provide to uninsured individuals, taking into account average out-of-pocket health costs, increased receipt of health care resulting from insurance, reduced uncertainty, and the presumed distastefulness of obtaining free or charity care. The authors assumed that if a tax credit reduced the premium price below the anticipated level of savings for a household, the household would take up the tax credit and purchase coverage.

This ingenious analysis projected take-up rates for an HCTC-level tax credit that were quite different from those observed with HCTC in practice. They also differed from many observations of state-based health coverage programs described in the text below as well as the results of CBO's recent study. While the authors may have accurately analyzed how rational workers *should* perceive their self-interest, it is not clear that the authors' behavioral assumptions correspond closely to the actions of such workers receiving subsidies outside the context of employer-sponsored insurance.

Of course, these conclusions by Pauly and Herring were stated in terms of workers as a whole. The authors presumably did not intend them to apply to low-income workers in particular; other, slightly less favorable take-up rates were estimated for low- and moderate-income individuals with incomes at or below 300 percent of the FPL. (Certainly, the analysis was not intended to apply to the unique populations eligible for HCTC – namely, early retirees and displaced workers, whose situation differs greatly from the currently employed.) In any event, policymakers may be unwise to rely on this analysis to predict take-up rates stemming from various subsidy levels, rather than analyses derived from the experience of low-income health subsidy programs, in estimating the likely take-up rates for future tax credits aimed primarily at low-income Americans purchasing coverage without an employer subsidy. Mark V. Pauly and Bradley Herring, "Expanding Coverage Via Tax Credits: Trade-Offs and Outcomes," *Health Affairs*, January/February 2001,

[http://130.94.25.113/1130\\_abstract\\_c.php?ID=/usr/local/apache/sites/healthaffairs.org/htdocs/Library/v20n1/s3.pdf](http://130.94.25.113/1130_abstract_c.php?ID=/usr/local/apache/sites/healthaffairs.org/htdocs/Library/v20n1/s3.pdf); Mark V. Pauly and Bradley Herring, *Cutting Taxes For Insuring: Options And Effects Of Tax Credits For Health Insurance*, American Enterprise Institute, 2002, [http://www.aei.org/docLib/20040217\\_book45.pdf](http://www.aei.org/docLib/20040217_book45.pdf).

<sup>57</sup> Donna R. Lenhoff, *Coming Up Short: A Comparison of Wages and Work Supports in 10 American Communities*, prepared for Wider Opportunities for Women. Summer/Fall 2004.

<http://wowonline.org/docs/dynamic-CTTA-43.pdf>.

<sup>58</sup> Carolyn A. Watts and James Matthisen. *Income Adequacy and the Affordability of Health Insurance in Washington State*. "Appendix D, The Adjusted Self-Sufficiency Standard as a Percent of the

---

Federal Poverty Level for Eight Washington Counties." June 2002.

<http://www.ofm.wa.gov/accesshealth/research/33appendixd.pdf>

<sup>59</sup> GAO, op cit.

<sup>60</sup> Dorn, Alteras, Meyer, op cit.

<sup>61</sup> Dahlia K. Remler and Sherry A. Glied. "What Other Programs Can Teach Us: Increasing Participation in Health Insurance Programs." *American Journal of Public Health*. January 2003, Vol 93, No. 1.

<sup>62</sup> Hoffman, et al., op cit.

<sup>63</sup> C.A. Lock, E.F.S. Kaner E.F., N. Heather, B.R. McAvoy, and E. Gilvarry. "A randomized trial of three marketing strategies to disseminate a screening and brief alcohol intervention programme to general practitioners." *British Journal of General Practice*. Volume 49, Number 446, 1 September 1999, pp. 695-698(4).

<http://www.ingentaconnect.com/content/rcgp/bjgp/1999/00000049/00000446/art00004>.

<sup>64</sup> For example, New Jersey's child health program used targeted telephone follow-up to complete SCHIP applications on behalf of children participating in the National School Lunch Program. Dorothy Gaboda, Sabrina Chase, Sharifa Williams, Carl Schneider, *NJ FamilyCare Express Enrollment: Report on the Pilot Program*. Rutgers Center for State Health Policy. April 2005.

[http://www.expresslaneinfo.org/AM/Template.cfm?Section=Program\\_Examples1&template=/CM/contentDisplay.cfm&contentID=7542](http://www.expresslaneinfo.org/AM/Template.cfm?Section=Program_Examples1&template=/CM/contentDisplay.cfm&contentID=7542).

<sup>65</sup> Access to Benefits Coalition, op cit.

<sup>66</sup> Lewin, op cit. Calculations by ESRI, September 2005.

<sup>67</sup> Lynn Etheredge. *Health Insurance Coverage At Transitions: What Works, What Doesn't Work*. Health Insurance Reform Project of George Washington University, prepared for Maryland State Planning Grant, Health Care Coverage Workgroup. April 11, 2003.

<http://www.dhmf.state.md.us/hrsa/pdf/LynnEtheredge.pdf>.

<sup>68</sup> Brigitte Madrian and Dennis Shea, "The Power of Suggestion: Inertia in 401(k) Participation and Savings Behavior," National Bureau of Economic Research Working Paper No. 7682, May 2000, p. 51. See also Brigitte Madrian and Dennis Shea, "The Power of Suggestion: Inertia in 401(k) Participation and Savings Behavior," *Quarterly Journal of Economics* 116, no. 4 (November 2001): 1149-87; and James Choi and others, "Defined Contribution Pensions: Plan Rules, Participant Decisions, and the Path of Least Resistance," in *Tax Policy and the Economy*, Vol. 16, edited by James Poterba (MIT Press, 2002), pp. 67-113.

<sup>69</sup> National Cancer Institute. *SEER-Medicare: Medicare Enrollment & Claims Data*.

<http://healthservices.cancer.gov/seermedicare/medicare/>.

<sup>70</sup> Alex D. Federman, Bruce C. Vladeck, and Albert L. Siu. "Avoidance Of Health Care Services Because Of Cost: Impact Of The Medicare Savings Program." *Health Affairs*. January/February 2005; 24(1): 263-270. <http://content.healthaffairs.org/cgi/reprint/24/1/263.pdf>. Calculations by ESRI described in Stan L. Dorn, "Situation Even Worse than Stated; Case for Auto-Enrollment Even Stronger," published as an Electronic Letter in Health Affairs on line, 21 January 2005,

<http://content.healthaffairs.org/cgi/eletters/24/1/263>.

<sup>71</sup> Stan Dorn, *The Trade Act of 2002: Coverage Options for States*, Economic and Social Research Institute, for AcademyHealth's State Coverage Initiatives Program, March 2003,

---

<http://www.statecoverage.net/pdf/issuebrief303trade.pdf>. Official, detailed explanations of Trade Act health coverage are available online, including at [http://www.irs.gov/pub/irs-utl/governers\\_letter\\_hctc\\_guidance\\_ltr\\_ammended\\_080803\\_v2.pdf](http://www.irs.gov/pub/irs-utl/governers_letter_hctc_guidance_ltr_ammended_080803_v2.pdf) and <http://www.irs.gov/individuals/article/0,,id=109960,00.html>.