

How Can National Policymakers Improve Health Coverage Tax Credits Provided under the Trade Act of 2002?

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About the Economic and Social Research Institute

The Economic and Social Research Institute is a non-partisan, non-profit research organization headquartered in Washington, D.C., and founded in 1987. Specializing in health and social policy research, ESRI conducts research and publishes studies directed at enhancing the effectiveness of social programs, improving the way health care services are organized and delivered, and making quality health care accessible and affordable.

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Executive Summary

Health Coverage Tax Credits (HCTCs) provided under the Trade Act of 2002 are important far out of proportion to the number of qualifying individuals, fewer than 300,000 workers who lost their jobs because of international trade plus early retirees receiving pension payments from the Pension Benefit Guarantee Corporation (PBGC). HCTCs provide the country's first test of whether the uninsured can be helped effectively by fully refundable tax credits that are paid directly to insurers when premiums are due each month. These new credits pay 65 percent of premiums charged by qualified health plans, which primarily consist of COBRA coverage offered by former employers and health plans that have arranged with state officials to serve state residents receiving HCTCs.

In different forms, such "refundable, advanceable" tax credits have won significant support from policymakers in both parties. Before HCTC, analysis of such credits was almost purely theoretical. Now that HCTC has begun, policymakers can use "real world" experience to assess tax credits' potential to cover millions of uninsured Americans. However, for this assessment to be accurate, HCTCs need to be designed as effectively as possible.

Of course, it is early in the implementation of HCTC, which was enacted by legislation signed in August 2002. Moreover, advance payment to insurers did not start until August 2003, less than ten months ago. Nevertheless, problems have already emerged that, earlier this month, prompted 54 Senators in both parties to support reforms that would increase the size of the credit, expedite credit payment to ease beneficiaries' cash flow problems, offer new health plan choices to some beneficiaries, increase the number of beneficiaries receiving consumer protections, and make certain other changes. This proposal failed to garner the 60 votes that were required to overcome budget-related procedural obstacles, but the issue is virtually certain to return. Policymakers wishing to maximize HCTCs' effectiveness may thus wish to consider program changes like the following:

1. **Increasing take-up by raising the amount of the tax credit.** By the end of February 2004, only 4 percent of individuals potentially eligible for HCTCs were enrolled in advance payment. Some contend that a major obstacle to take-up is that many eligible workers cannot afford to pay 35 percent of health insurance premiums. To address this problem, policymakers could:
 - Increase the size of HCTCs for all eligible workers.
 - Increase the size of HCTCs for the lowest-income eligible workers. To determine income, policymakers could:
 - Follow the model of advance payment of the Earned Income Tax Credit, through which an eligible household first determines the size of the advanceable credit by projecting its total annual income and later reconciles any differences between projected and actual income when it files year-end tax forms; or
 - Use the model of low-income subsidies for Medicare prescription drug coverage, through which state agencies that are accustomed to means-testing determine whether a household's income is low enough to qualify for extra assistance.
2. **Increasing take-up by starting subsidies more rapidly.** Another obstacle is that beneficiaries must pay one or more months of premiums in full before advance payment begins. Many lack the resources to "front" these amounts. To address this problem, policymakers could:
 - Give beneficiaries the option to delay coverage until advance payment begins.

- Once advance payment starts, provide an immediate “rapid refund” to pay 65 percent of the first few months of premiums. Currently, beneficiaries must wait until after filing annual tax forms before they receive such refunds.
 - Create revolving loan funds for early payments. Using federal grants, a state or private, charitable agency would pay 65 percent of a beneficiary’s premiums pending the start of advance payment. In effect, this would be a loan. Once advance payment starts, the agency running the revolving loan program would receive the beneficiary’s “rapid refund” directly from IRS (in effect, repaying the “loan”). In turn, that refund would fund a similar “loan” to help cover another beneficiary’s first few months of premiums.
 - Establish a presumptive eligibility system, modeled after a Medicaid program that three-fifths of the states now use for pregnant women. Under this system, once a qualified health plan, a state workforce agency, PBGC, IRS, or the IRS’ designee found that an individual paid his or her share of the first month’s premium and met key eligibility requirements, subsidies would begin immediately and continue until the IRS completed its eligibility determination for standard advance payment.
- 3. Improving the quality and availability of the plans for which HCTCs may be used.** On this issue, perspectives vary greatly. Some believe that more safeguards are required to provide all necessary benefits and to prevent substantial premium variation based on age, gender, and health history. Others believe that regulations need to be loosened to increase plan participation and expand beneficiary choice; and that HCTC beneficiaries have, if anything, too little access to low-cost alternatives with modest benefits. To help the nearly 25 percent of HCTC beneficiaries who live in states without qualified health plans (other than COBRA coverage), some suggest empowering federal agencies to provide “fall-back” coverage that would be comprehensive and community-rated; and others note that if any state-licensed plan could accept HCTCs, qualified coverage would be available nationwide. Policymakers could move in many different directions on these issues, with alternatives that include the following:
- Limit HCTCs to comprehensive, community-rated plans.
 - Permit any state-licensed plan to accept HCTCs.
 - Require each participating state to offer high-deductible options.
 - While permitting each state to offer any plan that qualifies under current rules, also require each participating state to include in its offerings at least one high-deductible option and at least one comprehensive, community-rated plan.
- 4. Increasing the number of beneficiaries receiving consumer protections.** HCTC beneficiaries are guaranteed coverage without any exclusion of preexisting conditions only if they have at least three months of continuous coverage, without any break lasting 63 days or longer, immediately before they enroll in a qualified health plan. As a result, if beneficiaries are uninsured while several months pass between job loss and the start of HCTC, they lose consumer protections. Accordingly, some have proposed disregarding lapses in coverage between job loss and the start of HCTC advance payment. However, under that approach, beneficiaries could wait to get sick before they use HCTCs to enroll in a health plan. To prevent such adverse selection, policymakers could adjust this proposed policy to:
- Limit HCTCs to individuals who enroll within a defined period (such as 60 days) of receiving notice of potential eligibility.
 - Count coverage gaps after the beneficiary receives notice of potential eligibility.
 - Permit insurers to exclude preexisting conditions that first develop after job loss.
 - More closely align federal consumer protections with current state insurance markets.

How Can National Policymakers Improve Health Coverage Tax Credits Provided Under the Trade Act Of 2002?

Introduction

On August 6, 2002, when President Bush signed into law the Trade Act of 2002, the country began its first experiment in a decade with federal income tax credits to cover the uninsured. Since then, a remarkable partnership of federal and state officials, private contractors, health plans, unions, employers, and others have established the infrastructure of the new program more rapidly and effectively than many observers predicted would be possible. Nevertheless, as with any new program, problems have emerged that may require correction. This Issue Brief focuses on three key issues: the proportion of eligible individuals who take up HCTCs; the quality and extent of coverage provided by state-based health plans for which HCTCs may be used; and the range of beneficiaries covered by consumer protection requirements. As to each issue, this paper identifies various policy options and trade-offs facing federal policymakers who wish to improve Trade Act health coverage through legislative change. The appendix to this Issue Brief analyzes some additional policy ideas that may be relatively uncontroversial but could help HCTCs achieve their goals more effectively.

The HCTC program has national policy importance far beyond the roughly 200,000 to 300,000 workers (plus their dependents) who qualify for assistance. With this small and discrete population, the HCTC program tests the effectiveness and potential structure of federal income tax credits for health insurance, the policy mechanism that has been included, perhaps more than any other, in proposals by both Democrats and Republicans to cover millions of uninsured Americans. For example, both President Bush and Senator Kerry include such tax credits (albeit in very different forms) in their proposals for the uninsured. To accurately assess tax credits' potential as one element of a broader, bipartisan strategy to expand health coverage, it is critically important for HCTCs to be designed as effectively as possible.

National policymakers have already been working hard to improve this program. The administrative policies governing HCTC have been adjusted on an ongoing basis to address emerging problems. Moreover, during the recent legislative debate over modifying corporate tax policy to respond to sanctions imposed by the World Trade Organization, 54 Senators voted to change HCTCs in important ways. Although the amendment failed because 60 votes were needed to overcome a point of order, serious interest in program improvement is evident. To help policymakers further analyze available options for improving HCTCs, this Issue Brief summarizes key features of the current program; describes the amendment that was recently considered on the Senate floor; and analyzes various possible approaches to addressing the most prominent concerns that have emerged thus far.

The HCTC program, in brief

Comprehensive descriptions of Trade Act health coverage and its operation to date are available elsewhere.¹ Following are some highlights of the program:

- **Tax credit structure.** Trade Act HCTCs pay 65 percent of health insurance premiums. These credits are fully refundable, so they go to all eligible individuals,

including those who owe little or no federal income tax. For coverage in December 2002 and later months, taxpayers can claim credits on year-end tax forms to reimburse their qualified premium costs. Beginning in August 2003, beneficiaries have had the option to claim credits “in advance” and have them paid directly to insurers when monthly premiums are due, rather than wait until the end of the year for a refund. Individuals electing advance payment pay their 35 percent monthly premium share to IRS, which adds the 65 percent credit and makes full monthly premium payments to the insurer. This is the first time federal income tax credits have been used to make advance payments directly to health insurers.

- **Eligibility.** Two main groups qualify for HCTCs: early retirees, age 55 through 64, who receive payments from the Pension Benefit Guaranty Corporation (PBGC);* and displaced workers who lost their jobs because of international trade and either receive Trade Adjustment Assistance (TAA) cash payments through the U.S. Department of Labor or would qualify for such payments but for their receipt of unemployment insurance. Dependents of these workers also qualify for HCTCs. However, neither workers nor their dependents are eligible if they are enrolled in Medicare or certain other types of health coverage.
- **Health plans.** HCTCs may be used for two types of qualified plans: “Automatically” qualified plans that are available in every state (without any action by state government), and which generally consist of COBRA coverage provided by former employers; and state-qualified plans, which must be arranged by a state, and which include high-risk pools, nongroup plans with premiums that vary based on the insurer’s assessment of individual risk, and plans with community-rated premiums that are not based on individual assessment of risk within the group.
- **Consumer protections.** For beneficiaries who had three months of continuous coverage without any gap lasting 63 days or longer immediately before seeking to enroll in a state-based plan, the insurer must guarantee issue of coverage and may not exclude preexisting conditions.
- **Federal Trade Act grants to states** fall into two categories: grants to support the establishment and operation of high-risk pools; and National Emergency Grants (NEG) from the Department of Labor, which fund certain state costs associated with HCTCs.

The Wyden/Coleman amendment: proposed changes to HCTC

On May 3, 2004, Senators Wyden (D-OR), Coleman (R-MN), Baucus (D-MT), Rockefeller (D-WV), Brownback (R-KS), and Snowe (R-ME) proposed an amendment to pending corporate tax legislation that would have modified Trade Adjustment Assistance in many ways.² In addition to extending TAA to service workers and making other broad changes to TAA, the amendment would have modified the HCTC program as follows:

- **Expedited payment.** When advance payment begins after a beneficiary has paid one or more months of full premiums for qualified coverage, the beneficiary (or the beneficiary’s designee) would receive an immediate HCTC reimbursing the applicable percentage of those full monthly premiums. Currently, beneficiaries must wait until after they have filed annual tax returns before they obtain such reimbursement.

* PBGC makes lump-sum or periodic payments to retirees from certain companies that experienced financial reversals and no longer pay promised defined-benefit pensions.

- **Consumer protections.** For individuals who qualify for HCTCs through TAA, gaps in coverage would not prevent the application of federal consumer protections if such gaps occur between job loss and five days after IRS has mailed such individuals notice that they qualify for advance payment.
- **Medicare spouses.** When an otherwise-eligible individual is disqualified from HCTC because of Medicare enrollment, the individual's spouse would remain eligible for HCTC.
- **Credit size.** The credit would increase to cover 75 percent of health insurance premiums.
- **NEG grants.** Such grants would be authorized and appropriated in the amount of \$200 million for fiscal years 2004 through 2005. They would pay three months of premiums for coverage of PBGC-related beneficiaries, to help them meet continuous coverage requirements for federal consumer protections. In addition, such grants could be used for outreach, for direct assistance to help potentially eligible individuals enroll, and for other purposes.
- **Group coverage.** Within two years of statutory enactment, a state's qualified plans would be required to include at least one option that is either a high-risk pool, an insurance program for state employees, a health plan that resembles plans serving state employees, or a group health plan. If a state does not meet that deadline, the Office of Personnel Management (which runs the Federal Employees Health Benefits Program) would be authorized to establish a group health option for state residents.
- **IRS notices of eligibility for advance payment** would include contact information for state officials who provide enrollment assistance, a list of coverage options, and information about the need to enroll quickly to avoid coverage gaps and to retain federal consumer protections.
- **Information provided to Congress** would include annual HCTC reports from the Treasury Department and notices from the Department of Labor whenever state applications for NEG grants are not addressed within the statutory time limit of 15 days.

Ultimately, Senator Nickles (R-OK) objected that the amendment as a whole (including provisions unrelated to HCTC) violated the Budget Act. The motion to waive this objection received 54 votes,³ but 60 were needed, so the amendment did not succeed.

The remainder of this paper takes a step back from this recent legislative debate and analyzes a range of options for modifying the HCTC program, including both proposals in the Wyden/Coleman amendment and other alternatives.

Analysis of possible approaches to modifying HCTC

Issue 1: Increasing HCTC take-up

In February 2004, HCTC advance payment covered 10,246 workers and retirees, or 4 percent of approximately 250,000 individuals who were identified as potentially eligible and were mailed outreach materials.⁴ Including dependents, nearly 15,000 were enrolled by the end of January 2004.⁵

It is far too soon to come to any final conclusions about take-up. Operational since August 2003, advance payment is less than one year old. Officials are at an early point on a steep learning curve, and word of mouth about the new program has not spread fully among eligible

workers. Moreover, published data do not yet show the number of additional families who claimed HCTCs on their year-end tax forms for 2003.

Despite the preliminary nature of concerns about take-up, several obstacles are apparent that may need to be addressed for HCTCs to reach most of their intended beneficiaries. The two barriers analyzed below are the size of the credit and the speed with which advance payment begins.

Some analysts suggest that take-up is also significantly impeded by limits on available, state-based plans, either because (as some claim) excessive regulations in the Trade Act have prevented many affordable, state-licensed, non-group plans from participating or (as others suggest) state-qualified plans frequently have benefits that are so limited that few HCTC-eligible workers view them as valuable. While changes to the federal rules that govern state-based plans may be worthwhile for other reasons, they are unlikely to have a major impact on take-up. Currently, state-based HCTC plans exhibit extraordinary variety in their costs, benefits, and risk-rating rules, but no state has enrolled more than 10 percent of its residents who have been individually identified as potentially eligible for HCTCs.⁶ At least a few states would have much higher enrollment if the key to increased take-up were offering a particular type of state-based coverage.

A. Credit size

The beneficiary's 35 percent premium share appears to be unaffordable for many unemployed workers and early retirees. Workers using advance payment of HCTCs in December 2003 purchased coverage with an average, annualized premium of \$4,896 for single coverage, so their 35 percent share amounted, on average, to \$1,713.⁷ In that same year, actively employed workers made annual premium payments of only \$508, on average, for single coverage available from their employers.⁸ HCTCs thus presuppose that many workers will pay substantially more for health insurance precisely when unemployment (even accompanied by unemployment insurance payments) causes family income to fall by an average of 40 percent.⁹

This \$1,713 would consume 13 percent of average unemployment insurance or TAA income support payments¹⁰ or 5 percent of all income for a four-person family with earnings at 200 percent of the Federal Poverty Level (FPL). Studies of state-based health coverage programs and the nongroup market conclude that, when health insurance payments require 5 percent of income, fewer than 25 percent of eligible individuals enroll; and that even if such payments account for as little as 3 percent of income, fewer than 40 percent of eligible individuals enroll.¹¹

Policymakers can choose from several approaches to this problem, including the following:

Option #1: Increase the credit size for all beneficiaries.

This approach would be easy to administer. It would also help a number of middle-income beneficiaries, such as those with spousal income, who are nevertheless unable to afford large premium payments because they recently suffered job loss and have high fixed costs that spousal income alone cannot easily cover. On the other hand, this option would spread limited federal dollars among both those who need extra help and those who do not. If resource constraints mean that the increase in credit size is modest (for example, to 70 or 75 percent of premiums), the effect on take-up is likely to be modest as well. Many unemployed workers and early retirees who cannot afford to pay 35 percent of premiums will be unable to pay 25 or 30 percent of premiums.

If policymakers pursue this option, they will need to decide the appropriate credit size. One set of benchmarks is provided by employer-sponsored insurance. On average in 2003, employers paid 85 percent of premiums for worker-only coverage and 74 percent of premiums for family insurance.¹²

Option #2: Increase the credit size for low-income beneficiaries.

This approach would increase credit size substantially for the neediest beneficiaries. Household premium costs could be reduced to affordable levels for families who qualify for increased credits, with a potentially significant effect on take-up. While the income distribution of HCTC beneficiaries is currently unknown, among the involuntarily unemployed in general, two-thirds of the uninsured have low family incomes – that is, below 200 percent of the FPL.¹³

However, designing an efficient and effective approach to income determination may not be easy, particularly given the significant income fluctuations and uncertainty about future earnings experienced by workers who have lost their jobs and are seeking re-employment. One approach to administration would hold IRS ultimately responsible for income determinations. IRS would make advance payments based on a household's projection of annual income, with reconciliation when tax forms are filed after the end of the year if actual income turns out to differ from projections. However, when tried with the Earned Income Tax Credit (EITC), this approach had dismal results; fewer than 1 percent of EITC recipients claim the tax credit in advance,¹⁴ in part because, after a family receives advance EITCs, unexpected income can endanger tax refunds or create tax debts when annual income tax forms are filed and final household income for the year is determined.

Another approach would determine income eligibility for increased tax credits based on the findings of non-tax agencies that regularly determine recent income, such as those administering the State Children's Health Insurance Program (SCHIP). This follows the model of Medicare prescription drug legislation, under which Medicaid or Social Security agencies determine eligibility for low-income subsidies.[†] Such an approach has several salient features that would simplify HCTC administration:

- Unless the beneficiary affirmatively applies for and receives a certification of low income, the standard tax credit percentage would apply.
- IRS would not determine income eligibility for the enhanced credit. Rather, IRS would rely on the income certification of the SCHIP agency, just as it currently relies on certifications by state workforce agencies and PBGC that particular beneficiaries qualify for TAA and PBGC, respectively.
- The SCHIP agency could use whatever procedures and time frames it ordinarily follows in making income determinations.

Of course, the state agencies making these income determinations would need to be reimbursed for their reasonable administrative costs.

As with the first option, a critical question here is the size of enhanced subsidies for low-income beneficiaries. Rather than create a new subsidy scale from scratch, federal policymakers could rely on existing models. For example:

- As under Medicare prescription drug legislation, credits could cover 100 percent of premiums for individuals with incomes at or below 135 percent of the FPL, with subsidies phasing down to standard levels as income rose to 165 percent of the FPL.

[†] In this context, SCHIP agencies have several advantages over Medicaid and Social Security agencies, which the Medicare bill requires to develop new, streamlined application procedures. For example, SCHIP does not have the same tradition of stigma that some ascribe to Medicaid, and most SCHIP programs already use streamlined, relatively family-friendly application procedures. See, e.g., Donna Cohen Ross and Laura Cox. *Preserving Recent Progress On Health Coverage For Children And Families: New Tensions Emerge*. Center on Budget and Policy Priorities, for the Kaiser Commission on Medicaid and the Uninsured. July 2003. <http://www.cbpp.org/7-30-03health.pdf>.

- Low-income credits could be based on common state practices under SCHIP.[‡] For example, HCTC beneficiaries with incomes at or below 200 percent of the FPL could receive an enhanced credit reducing the worker’s premium costs to levels typical of SCHIP programs. In 2003, the median SCHIP program charged \$240 a year to a low-income family with two children and income at 200 percent of FPL.¹⁵ Premium charges have increased since then in a number of states.¹⁶

B. Prompt start of advance payment

To qualify for advance payment today, a worker must first enroll in an HCTC-qualified health plan, provide the IRS with a bill from the insurer, and pay premiums in full for one or more months while the IRS determines the worker’s HCTC eligibility. Many workers report that they cannot afford to pay even one or two months of full health insurance premiums without help, and so they do not join the HCTC program. A small number of states use NEG grants to pay 65 percent of premiums before advance payment starts, but most states have not taken this approach, and only limited amounts of NEG funding remain. Following are several potential approaches to this problem:

Option #1: Delayed coverage.

Under this approach, eligible workers would have the option to ask their HCTC plan for delayed coverage until IRS advance payment began. For such a request to take effect, the worker would need to make a 35 percent initial premium payment to the HCTC program. Workers found ineligible would have that initial payment refunded.

While this approach would eliminate any requirement of paying full premiums, it would delay the start of health coverage until advance payment began. To reduce the resulting harm, the period between the initial payment and the start of coverage would need to be disregarded in determining whether a beneficiary had continuous coverage and therefore would be covered by Trade Act consumer protections.[§]

Option #2: Rapid refunds.

As soon as advance payment begins, this approach would refund to beneficiaries the HCTC-covered share of full premium payments made while waiting for advance payment to start. While it appears administratively feasible, and it would considerably shorten beneficiaries’ wait for HCTC refunds, this approach would still require beneficiaries to “front” full monthly premiums, which averaged \$408 a month for single HCTC coverage in December 2003.¹⁷ For the laid-off workers and early retirees who lack such disposable income, HCTC coverage would remain unaffordable.

Option #3: Revolving loan funds.

This option incorporates but goes beyond rapid refunds. States or private, charitable organizations could use NEG funds or other federal grants to pay the HCTC share of

[‡] Another approach would base enhanced subsidy amounts, not on actual SCHIP practice, but on the federal SCHIP statute. Under that statute, children with incomes at or below 150 percent of the FPL may be charged only the nominal premiums permitted under the Medicaid program. Children with incomes between 151 and 200 percent of the FPL can be charged premiums that, when combined with out-of-pocket health costs, do not exceed 5 percent of family income. That approach has two major disadvantages: potential administrative complexity; and the likelihood, as indicated above, that even if premiums are limited to 5 percent of income, very few low-income families will enroll.

[§]In addition, policymakers pursuing this approach would need to decide whether: (a) to *require* qualified plans to delay coverage upon request, which may (or may not) cause some plans to cease offering state-qualified coverage, and which would increase administrative costs slightly for COBRA third-party administrators serving HCTC beneficiaries; or (b) to *permit* qualified plans to reject requests for delayed coverage, which would mean that some beneficiaries would not have access to this option.

premiums for the first few months of coverage, before advance payment begins. In effect, this would be a loan to the beneficiary. In exchange for such assistance, the beneficiary would agree that the state or private agency would be repaid by receiving, directly from IRS, the beneficiary's rapid refund for the months covered by the "loan." The state or private agency would then use the refund to help another beneficiary with his or her first months of coverage, before advance payment begins.

By giving state agencies and private, charitable groups the assurance of rapid reimbursement, this approach would permit HCTC-level subsidies to begin immediately. However, beneficiaries would need to apply, not just to IRS for HCTC, but also to the state or private agency administering the loan fund. This would add one more step to an already complex process, potentially causing some loss in coverage. In addition, revolving funds seem best fitted to systems where a relatively steady stream of beneficiaries seeks assistance, and the volume of incoming repayments roughly matches the need for outgoing assistance. By contrast, with HCTC health coverage, large numbers of individuals often seek assistance over brief periods as a company shuts down. In addition, this approach would need a clear allocation of financial responsibility if, for a given individual, the refund never materializes. Finally, this option may require clear national standards to ensure that the local revolving fund operator uses federal funding for its intended purpose.

Option #4: Presumptive eligibility.

This option is based on Medicaid's presumptive eligibility program, which more than three-fifths of states have chosen to extend to low-income, pregnant women.¹⁸ Medicaid presumptive eligibility provides short-term health coverage, pending the Medicaid agency's final eligibility decisions, for applicants whom qualified entities (such as participating doctors and clinics) find meet specific requirements that indicate likely eligibility. If the presumptively eligible individual fails to complete the application process for full Medicaid coverage, or the state ultimately finds the individual ineligible, coverage ends, but the individual is not asked to repay Medicaid's presumptive eligibility costs.

With HCTCs, this model could work as follows. Presumptive eligibility would start for a particular individual once HCTC, a state-qualified plan, a state workforce agency, PBGC, or another qualified entity selected by IRS made three determinations: (a) that the individual requested enrollment in a qualified plan; (b) that the individual paid his or her share of premiums for the first month of coverage; and (c) that the individual was certified as eligible by PBGC or a state workforce agency. At that point, the HCTC program would start making full, monthly premium payments to the individual's health plan, billing the individual for his or her share of premiums under standard procedures starting with the second month.^{**} Presumptive eligibility would continue until the HCTC program determined whether the individual met all requirements for advance payment. At that point, either standard advance payment would begin or assistance would cease.

This approach would involve some complexity, and a small number of individuals who are ultimately found ineligible for HCTCs would nevertheless receive short-term tax credits that would not be repaid. On the other hand, in the Medicaid program, presumptive eligibility has a track record of success in starting coverage rapidly, which, for HCTC recipients, could avoid any need to make full, monthly premium payments.

^{**} If presumptive eligibility is established during the middle of the insurer's standard coverage month, at least three approaches are possible to starting coverage: coverage could begin retroactively, effective on the first day of that month; coverage could start mid-month, with the premium pro-rated; or coverage could begin at the start of the following coverage month. From the standpoint of maximizing coverage and minimizing barriers to enrollment, the first approach is preferable. Its administrative feasibility is not yet clear, however, and it would be slightly more costly than the alternatives.

Issue 2: Adequacy and availability of state-based health coverage

Some observers have expressed concerns about state-based HCTC plans that limit benefits tightly or vary premiums significantly based on the beneficiary's age, gender, area of residence, or prior health history. For example, a survey of states' HCTC coverage conducted by the Economic and Social Research Institute found that, in 11 of 15 surveyed states, the most generous state-based plan excluded or severely limited maternity care, mental health care, prescription drugs, or preventive care. The survey also found that, in the median surveyed state that allowed risk-rating, women were charged 53 percent more than men for the same coverage; healthy, 60-year-old men were charged 238 percent more than healthy, 25-year-old men for the same plan; and the insurer's classification of an individual in the highest rather than the lowest risk level increased premiums by 480 percent.¹⁹

Others have noted that, although more than three-fourths of beneficiaries live in states with state-qualified plans, potentially eligible workers in other states who lack access to COBRA or other automatically-qualified plans cannot use HCTCs to buy any available coverage. Still other analysts worry that, because the Trade Act's consumer protections are out of step with state insurance rules, most state-licensed, non-group insurers offering low-cost products have been deterred from participating in HCTC. For example, even though 9 of 15 states in the survey described above gave HCTC beneficiaries at least five different coverage options, most options consisted simply of a choice of deductible, and 10 out of the 15 states had only one insurer offering state-based coverage.²⁰

Policymakers could approach these issues in numerous ways, including the following:

Option #1: Limit HCTCs to community-rated plans, without preexisting condition exclusions or coverage denials, that meet minimum benefits standards.

While pursuing this approach, policymakers could incorporate existing standards to avoid creating new benefits standards out of whole cloth for this small population. For example, plans could be asked to meet the minimum benefit requirements of the SCHIP statute, which limits participating plans to those with actuarial values at least as high as certain benchmark plans. While leaving considerable state flexibility, such requirements assure the broad coverage that many experts associate with increased receipt of appropriate health care services and improved health outcomes.²¹ Such an approach would also eliminate disparities in premiums and coverage based on factors over which individuals have no control, such as age, gender, and certain prior health conditions. It would also eliminate the tragic irony of charging unaffordable amounts, failing to cover essential benefits or limiting them severely, or denying all coverage for the very individuals who most need insurance because they have health problems that require treatment.

On the other hand, some laid-off workers may prefer less generous (hence less costly) coverage that protects them against catastrophic financial loss and helps the chronically ill with high annual medical bills. Some policymakers also support higher-deductible policies that they believe will make enrollees more cost-conscious, permit finite federal subsidies to cover more people, and reduce the interposition of third-party intermediaries between the consumer and his or her health care provider. Moreover, younger workers may be less likely to participate if they are asked to subsidize coverage for older workers, who (in many cases) may have more income and assets. In addition, high-cost health care users may disproportionately enroll in community-rated health plans, which could ultimately raise premiums and make coverage even less affordable to beneficiaries. Also, in state insurance markets where risk-rating is generally allowed, mandatory community-rating of HCTC plans could reduce the participation of insurers, many of which have already been reluctant to join the HCTC program. As a result, some beneficiaries could lose access to qualified plans.

In addition to these substantive trade-offs, this option would reopen the emotionally charged, highly ideological debate over the merits of non-group versus group insurance markets. Although controversy dogged its creation, the current policy has turned out to be a compromise that gives states the ability to choose among very different coverage models and rating rules. The resulting diversity of state models can provide information about the consequences of various group and non-group coverage strategies, laying the groundwork for better-informed future policies.

Option #2: Permit HCTCs to be used both for coverage arranged by states and for any other health coverage available under state law (including in the nongroup market).

This approach would ensure that a significant variety of health plan options are available for HCTC beneficiaries in every state. This would give each beneficiary access to qualified coverage and permit many laid-off workers and early retirees to choose plans that meet their individual needs, taking into account both cost and coverage.

On the other hand, middle-aged or older workers, women, and people with past health problems can find coverage extremely expensive in the non-group market, even coverage with high deductibles and strict limits on covered services. The medical care that such individuals need to address their conditions is frequently excluded on an individual basis. Furthermore, when it comes to services like mental health care, prescription drugs, or maternity care, many non-group plans do not cover them for anyone or greatly restrict the coverage they provide.

As with Option #1, this approach would re-open the highly contentious question of the merits of group versus nongroup coverage, making legislative progress difficult. That question played a major role in preventing Congress from including health coverage in economic stimulus legislation debated in 2001 and 2002, and in summer 2002, many observers feared that this same question could be the greatest challenge to passage of the entire Trade Act.

Option #3: Require each state to offer high-deductible options.

Such options could be defined, for example, to have deductibles of at least \$1,000 per individual and \$2,000 per family. This would ensure that relatively low-cost products are available in each state with state-qualified options. As noted above, experts disagree about the desirability of such high-deductible coverage, compared to traditional employer-based insurance, which is more comprehensive. As a practical matter, however, this option would not make a substantial difference in the operation of the HCTC program, since most states already offer high-deductible plans. The above-described survey of HCTC plans in 15 states²² found that only two states did not offer any plan with high cost-sharing.^{††}

Option #4: While giving HCTC beneficiaries access to both high-deductible options and comprehensive, community-rated plans, retain current state flexibility to offer beneficiaries additional choices of other state-qualified plans.

Under this approach, both high-deductible options and community-rated, comprehensive plans (as described in Options 1 and 3, above) would be offered in each participating state, but states would be free to supplement such plans with other qualified coverage. The advantage of this approach is that it would give beneficiaries access both to comprehensive plans that resemble traditional employer-based coverage and to insurance with low premiums and high deductibles, without limiting beneficiaries to either type of plan or narrowing the choices available to states. In theory, the disadvantage of varied health plan choices is that sicker

^{††} In 5 of the 15 states, beneficiaries had access to plans with individual deductibles of \$5,000 or more; in another 5 states, beneficiaries could enroll in plans with individual deductibles up to \$1,500 or \$2,500; 2 other states offered plans with \$1,000 individual deductibles; and another state had a plan with low nominal deductibles but 50 percent coinsurance.

enrollees may disproportionately enroll in the comprehensive, community-rated options, raising the premiums of such options to unsustainable levels. In practice, however, adverse selection among varied plans has sometimes failed to materialize when generous, proportional subsidies have been available.²³ Moreover, adverse selection could be reduced through such measures as reinsurance or risk adjustments that do not affect the premiums charged to beneficiaries,²⁴ both of which could be funded through NEG or other federal grants.

For policymakers pursuing this option, one important design question is whether states would be required to develop and implement these comprehensive and high-deductible options themselves. If so, state participation would become more difficult for states to arrange. Given the small number of affected individuals in many states, some states almost certainly would stop offering qualified plans, leaving many of their residents without access to any coverage that is qualified for HCTCs. To avoid this result, policymakers could give states the option to ask a federal agency to offer their residents both comprehensive and high-deductible options meeting the above-described requirements. The federal agency involved could be the Department of Health and Human Services or perhaps the Office of Personnel Management, which runs the Federal Employees Health Benefits Program (FEHBP), and which could be given the authority to offer HCTC beneficiaries access to one or more FEHBP plans. Under the latter approach, HCTC enrollees would need to be placed in a separate risk pool from current FEHBP enrollees, with separately-calculated premiums for HCTC beneficiaries. Whichever federal agency is used would need to be reimbursed for its administrative costs, perhaps by assigning to such agency the applicable state's share of federal NEG grants. That would give states at least some incentive to develop these coverage options themselves.

Issue 3: Increasing the number of beneficiaries receiving consumer protections

Many HCTC beneficiaries experience gaps in coverage of 63 days or more between job loss and their first eligibility for HCTCs. As a result, state-based plans can exclude these beneficiaries' preexisting conditions or deny coverage outright. That can cause grim consequences, particularly for beneficiaries with chronic illness or other preexisting health problems. By reducing the value of offered coverage, such exclusions can also discourage enrollment by individuals with preexisting conditions.

Many analysts have suggested that the three-month continuous coverage test could apply to the date of job loss or other qualifying event for HCTCs. That would extend consumer protections to workers who maintained continuous health coverage until they simultaneously lost income and employer subsidies for health insurance, making it infeasible for them to continue coverage.

For example, suppose a worker was insured through her job during all of 2003. On January 1, 2004, the worker was laid-off because of trade. Unable to afford COBRA coverage, she became uninsured. On April 1, she learned about HCTCs. She enrolled in a state-qualified HCTC plan on May 1 and applied for advance payment. She was found eligible for HCTCs, and advance payment began on June 1. Under current law, she is not entitled to consumer protections, because she did not have three months of continuous coverage immediately before May 1, when she enrolled in an HCTC plan. Under the modified approach described above, she would be entitled to consumer protections, since she had three months of continuous coverage before her January 1, 2004 separation from employment.

Insurers have expressed the concern that such a revision could expose them to significant adverse selection, with disproportionate enrollment by people with serious health problems. Such adverse selection could include high enrollment by consumers with health conditions that emerged or worsened after job loss. More fundamentally, since lack of health coverage after job loss would not affect the terms on which HCTC-funded insurance is available, relatively healthy individuals who qualify for HCTCs could rationally choose to remain

uninsured indefinitely, planning to use their HCTCs and enroll in coverage only if they got sick and needed health care. Such adverse selection and the resulting potential loss of health plan participation could be forestalled in several ways. For example:

- To qualify for HCTCs, workers and retirees could be required to apply for enrollment in an HCTC plan within a defined period (e.g., 60 days) of receiving notice of potential HCTC eligibility. That would lower adverse selection risks across the board by preventing families from waiting until someone gets sick before they use HCTCs.
- To similar effect, once a worker receives notice of potential HCTC eligibility, any subsequent gaps in coverage could count in determining whether the worker had continuous coverage.
- If a health condition first became present during a gap in coverage lasting 63 days or longer that took place between job loss (or other qualifying event) and the worker's request to enroll in the HCTC plan, a state-based plan could be allowed to exclude treatment of that particular condition.
- The modified continuous coverage requirement could perhaps be coupled with aligning Trade Act consumer protections more closely with state health insurance rules. For example, in states where six months of continuous coverage is generally required to avoid later preexisting condition exclusions, the same six-month period could apply to HCTC coverage. While fewer consumers would be protected, using a familiar set of rules could encourage more health plans to participate in HCTC.

Conclusion

These are just a few potential approaches to modifying Trade Act health coverage. Other options may also be viable. Nevertheless, the approaches described here illustrate a basic point: if policymakers wish to adjust Trade Act health coverage to better accomplish key policy goals, viable strategies are available, albeit with design choices that can involve difficult trade-offs.

Appendix: Additional options related to HCTCs

- 1. Preventing government errors from penalizing low-income households.** After the Internal Revenue Service (IRS) has begun advance payment based on certifications of eligibility by a state workforce agency (SWA) or PBGC, sometimes the SWA or PBGC later realizes that it erred and that the individual, in fact, was ineligible. Once this is reported to IRS, the Service requires the worker to refund all advance payments that went to the insurer, which can amount to significant sums. This can entail quite a hardship for unemployed workers or early retirees and their families. Ultimately, stories about such results may discourage others from applying for HCTC. To address this problem, which is just beginning to emerge, the HCTC statute could provide that individuals are not required to repay IRS for HCTCs that were paid erroneously, due solely to a state or federal agency's mistake. Under current law, IRS may abate tax liabilities when errors result from the agency's own mathematical errors or wrongful advice.²⁵ In effect, this option would extend that authority to errors of other government agencies partnering with IRS in the operation of HCTC.
- 2. Requiring unemployment insurance (UI) agencies to identify UI recipients who may qualify for HCTCs.** To qualify for TAA cash assistance, displaced workers must first exhaust available UI benefits. To prevent such workers from going without health coverage during the six months or longer covered by UI, the Trade Act provides HCTCs to displaced workers who meet all requirements for TAA, except exhaustion of UI. Unfortunately, SWAs do not have complete lists of these workers, so many never hear about or apply for HCTCs. An employer certified as trade-impacted is not required to provide the SWA with names and contact information for laid-off workers. Some employers choose not to furnish this information, and other trade-impacted employers no longer exist. Altogether, only 21 percent of workers certified as trade-impacted wind up receiving TAA cash assistance, according to the Department of Labor (DOL).²⁶ Moreover, although a UI application identifies the applicant's last employer, UI agencies typically do not cross-check that information against the list of trade-impacted firms certified by DOL. To address this problem, UI agencies could be directed to make this comparison and to inform potentially eligible workers how they can apply for HCTCs and other TAA benefits. One trade-off is the resulting increase in state and federal costs for administration and for increased receipt of TAA assistance (including both HCTC and other services).
- 3. Exempting HCTCs from TAA's 60-day post-petition freeze.** Workers are ineligible for TAA during the 60 days after a petition has been filed with DOL seeking a finding of trade-related impact. This delays workers' receipt of HCTCs and makes it harder for workers to avoid 63-day coverage gaps that end their eligibility for consumer protections under the Trade Act. To address this problem, workers ineligible for TAA because of the 60-day post-petition freeze, but who meet TAA's other eligibility requirements, could qualify for HCTCs.
- 4. Ensuring that Health Insurance Portability and Accountability Act (HIPAA) safeguards apply to HCTC beneficiaries.** If a consumer has state-based HCTC coverage for a prolonged period, then such coverage ends and the consumer wishes to enroll in another plan, it is not clear that the consumer has rights under HIPAA to guaranteed offers of coverage or to insurance that is free of preexisting condition exclusions.²⁷ To address such problems, these HIPAA requirements could be clarified to expressly include HCTC coverage.

Notes

¹ Stan Dorn and Todd Kutyla, *Health Coverage Tax Credits Under the Trade Act of 2002*, Economic and Social Research Institute, for The Commonwealth Fund and The Nathan Cummings Foundation, April 2004, http://www.cmwf.org/programs/insurance/dorn_tradeact_ib_721.pdf; Stan Dorn and Todd Kutyla, *Health Coverage Tax Credits Under The Trade Act Of 2002: A Preliminary Analysis of Program Operation*, Economic and Social Research Institute, for The Commonwealth Fund and The Nathan Cummings Foundation, April 2004, http://www.cmwf.org/programs/insurance/dorn_tradeactfullrpt_725.pdf; and 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 and 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 and <http://www.irs.gov/individuals/article/0,,id=109960,00.html>.

² Amendment 3109 to S. 1637. For the original text of amendment, see *Congressional Record*, May 3, 2004, page S4771 (health coverage provisions begin at page S4774); for the final version of the amendment, see *Congressional Record*, May 4, 2004, page S4806 (health coverage provisions begin at page S4810).

³ For the roll call vote, see *Congressional Record*, May 4, 2004, page S4820.

⁴ Roy Ramthun, Senior Advisor for Health Initiatives, Department of Treasury. *Health Coverage Tax Credits*. Presentation to The Commonwealth Fund, Task Force on the Future of Health Insurance. March 30, 2004.

⁵ The Lewin Group. *Advance Premium Payments: A Snap Shot of Early Experience*. Data from January 2004.

⁶ Dorn and Kutyla, op cit.

⁷ HCTC Program. *Executive Scorecard, December 2003*. January 20, 2004.

⁸ Kaiser Family Foundation and Health Research and Educational Trust. *Employer Health Coverage: 2003 Annual Survey*. September 2003. (KFF/HRET 2003 Survey) <http://www.kff.org/insurance/ehbs2003-1-set.cfm>.

⁹ Ralph E. Smith. *Family Income of Unemployment Insurance Recipients*. Congressional Budget Office, March 2004. <http://www.cbo.gov/ftpdoc.cfm?index=5144&type=1>.

¹⁰ The average UI payment (upon which TAA amounts are based) was \$261.35 per week in December 2003. U.S. Department of Labor, Employment & Training Administration. (DOLETA). *Claims Summary data for State Programs, December 2003*. January 22, 2004. <http://ows.doleta.gov/unemploy/txtdocs/sumdec03.html>.

¹¹ John Sheils and Randall Haight, *Cost and Coverage Analysis of Ten Proposals To Expand Health Insurance Coverage, Appendix A*, The Lewin Group, for the Robert Wood Johnson Foundation, Figure A-4, at page A-8, noting the Lewin Group's findings about the relationship between premium cost and purchase of nongroup coverage,

<http://www.rwjf.org/publications/publicationsPdfs/costCoverageMethodology.pdf>; Leighton Ku and Teresa A. Coughlin, "Sliding-Scale Premium Health Insurance Programs: Four States' Experiences," *Inquiry*, Vol. 36: 471-480, Winter 1999/2000. For an earlier, on-line version of the latter article, which analyzes the relationship between premium cost and enrollment in state health coverage programs serving low- and moderate-income families, see <http://www.urban.org/Template.cfm?Section=Home&NavMenuID=75&template=/TaggedContent/Vie wPublication.cfm&PublicationID=6201>. For an alternative view, see Mark Pauly and Bradley Herring. "Expanding Coverage via Tax Credits: Trade-Offs and Outcomes." *Health Affairs*. January/February 2001 (approximately half of uninsured workers with incomes up to 300% of the federal poverty level eventually would take-up tax credits paying 50% of premiums, if over the long run they came to understand the benefits of insurance or the impact of employer-funded health coverage on wages). http://130.94.25.113/1130_abstract_c.php?ID=/usr/local/apache/sites/healthaffairs.org/htdocs/Library/v20n1/s3.pdf.

¹² KFF/HRET 2003 Survey

¹³ Kanika Kapur and M. Susan Marquis. "Health Insurance for Workers Who Lose Jobs: Implications for Various Subsidy Schemes." *Health Affairs*. May/June 2003 (Calculations by ESRI, July 2003).

¹⁴ Gordon C. Milbourn III, Acting Deputy Inspector General for Audit. *Taxpayers Were Assessed Additional Tax for Advance Earned Income Credit Payments Not Received*. U.S. Department of Treasury, June 2003. Reference Number: 2003-40-126.

<http://www.ustreas.gov/tigta/2003reports/200340126fr.pdf>.

¹⁵ Center on Budget and Policy Priorities. *Free and Low-Cost Health Insurance: Children You Know are Missing Out*. 2003. State Tables, Table 10. <http://www.cbpp.org/shsh/premium-pay.pdf>. At the end of 2001, the comparable figure for a one-child policy was \$180. Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services. *State Children's Health Insurance Program (SCHIP) Database*. Premiums.

<http://aspe.hhs.gov/health/schip2/ReportSTLevel.asp?page=10.2>, as of March 31, 2004.

¹⁶ Leighton Ku and Sashi Nimalendran, *Losing Out: States Are Cutting 1.2 to 1.6 Million Low-Income People from*

Medicaid, SCHIP and Other State Health Insurance Programs, Center on Budget and Policy Priorities, December 22, 2003, <http://www.cbpp.org/12-22-03health.htm>; and Alexandra Marks, "Kids' healthcare: Band-Aids still available," *Christian Science Monitor*, April 01, 2004,

http://search.csmonitor.com/search_content/0401/p02s02-uspo.html.

¹⁷ HCTC Program. *Executive Scorecard, December 2003*. January 20, 2004

¹⁸ See 42 USC Sections 1396r-1, 1396r-2, and 1396r-3. While presumptive eligibility for pregnant women is a longstanding Medicaid option, more recent federal statutory changes gave states the flexibility to apply presumptive eligibility to women with breast or cervical cancer and to children, through either Medicaid or SCHIP. In 2002, 32 states provided presumptive eligibility to pregnant women; 22 states did so for women with breast or cervical cancer; and 11 states made children presumptively eligible. National Governors Association, Center for Best Practices, *MCH Update 2002: State Health Coverage for Low-Income Pregnant Women, Children, and Parents*, June 9, 2003, <http://www.nga.org/cda/files/MCHUPDATE02.pdf>; Kaiser Family Foundation, *KFF State Health Facts on Line: Medicaid Breast and Cervical Cancer Treatment Coverage Expansions, 2002*,

[http://www.statehealthfacts.kff.org/cgi-](http://www.statehealthfacts.kff.org/cgi-bin/healthfacts.cgi?action=profile&area=District+of+Columbia&category=Medicaid+%26+SCHIP&link_category=Women's+Health&link_subcategory=Medicaid+Policy&link_topic=Breast%2FCervical+Cancer+Expansions)

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¹⁹ Dorn and Kutyla, op cit. The median state was identified separately for each type of risk-rating. Accordingly, the 53 percent differential for women is taken from the median state among the 8 surveyed states that varied premiums based on gender; the 238 percent differential for older men is taken from the median state among the 12 that risk-rated based on age; and the 480 percent differential based on risk category is taken from the median state among the 5 that used medical underwriting to determine premiums.

²⁰ Dorn and Kutyla, op cit.

²¹ Institute of Medicine. *Care without Coverage: Too Little, Too Late*. 2002.

²² Dorn and Kutyla, op cit.

²³ Published studies have found this result with the Federal Employees Health Benefits Program. See, e.g., Curtis S. Florence and Kenneth E. Thorpe, "How Does The Employer Contribution For The Federal Employees Health Benefits Program Influence Plan Selection?" *Health Affairs*, Vol. 22, No. 2, March/April 2003, <http://content.healthaffairs.org/cgi/reprint/22/2/211.pdf>; Bradley M. Gray and Thomas M. Selden, "Adverse Selection and the Capped Premium Subsidy in the Federal Employees Health Benefits Program," *Journal of Risk and Insurance*, June 2002, Vol. 69, no. 2, pp. 209-224.,<http://www.blackwell-syergy.com/servlet/useragent?func=synergy&synergyAction=showFullText&doi=10.1111/1539-6975.00015>.

²⁴ The latter approach – "back-room" risk adjustments that do not affect the consumer's premium costs – has been championed by a broad range of analysts, from The Heritage Foundation to the Urban Institute. Robert E. Moffit, *Recent Premium Increases and the Future of the FEHB*, Testimony before the House Subcommittee on Civil Service and Agency Organizations, October 16, 2001, <http://www.heritage.org/Research/HealthCare/Test101601.cfm>; John F. Holahan, Len M. Nichols, and Linda J. Blumberg, "Expanding Health Insurance Coverage: A New Federal/State Approach," in Jack A. Meyer and Elliot W. Wicks (eds.), *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/holahan.pdf>.

²⁵ 26 USC Section 6404. In some cases, the IRS' decision whether to grant abatement requires a decision about whether taxpayers contributed to the errors in question. For example, interest is abated if it results from unreasonable delay by IRS, provided that "no significant aspect of such error or delay can be attributed to the taxpayer involved." 26 U.S.C. 6404(e)(1). Similarly, penalties resulting from erroneous advice from IRS can be abated only if the relevant portion "of the penalty or addition to tax did not result from a failure by the taxpayer to provide adequate or accurate information." 26 U.S.C. 6404(f)(2)(B).

²⁶ In FY 2002, the most recent year for which all relevant data known to the author are available, 170,000 workers were certified as displaced because of trade but only 35,400 were expected to receive TAA cash assistance. DOLETA. March 2001. *2002 Annual Performance Plan for Committee on Appropriations*. <http://www.doleta.gov/perform/2002pln.pdf>.

²⁷ 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, for the National Academy for State Health Policy. April 2004. http://www.nashp.org/Files/NASHP_HCTC_paper_final_4-5-04.pdf.