HEALTH COVERAGE TAX CREDITS UNDER THE TRADE ACT OF 2002: A PRELIMINARY ANALYSIS OF PROGRAM OPERATION

Stan Dorn and Todd Kutyla
Economic and Social Research Institute

April 2004

For a summary version of this report, see Stan Dorn and Todd Kutyla, *Health Coverage Tax Credits Under the Trade Act of 2002,* The Commonwealth Fund, April 2004, available at http://www.cmwf.org/programs/insurance/dorn_tradeact_ib_721.pdf.

Support for this research was provided by The Commonwealth Fund and The Nathan Cummings Foundation. The views presented here are those of the authors and should not be attributed to The Commonwealth Fund, The Nathan Cummings Foundation, or their directors, officers, or staff, or to members of the Task Force on the Future of Health Insurance.

Additional copies of this (#725) and other Commonwealth Fund publications are available online at **www.cmwf.org.** To learn about new Fund publications when they appear, visit the Fund's website and register to receive e-mail alerts.

Contents

List of Tables and Figures

About the Authors

Stan Dorn, J.D., is a senior policy analyst at the Economic and Social Research Institute (ESRI). He has been working on health policy at the state and national level for almost 20 years, focusing on low-income consumers, Medicaid, the State Children's Health Insurance Program (SCHIP), and the uninsured. Previously, Dorn has served as director of the Health Consumer Alliance, a consortium of legal services groups in California helping low-income consumers obtain necessary health care. He has also directed the Health Division at the Children's Defense Fund, where he led the health policy team in CDF's campaign that helped pass SCHIP legislation in 1997. Dorn is a graduate of Harvard College and the Boalt Hall School of Law at the University of California, Berkeley.

Todd Kutyla, M.L.A., is a research associate at ESRI, where he works mainly on health care access, cost, and quality issues. He has conducted extensive research on the cost-effectiveness of medical innovation, worked on projects that assess the effectiveness of programs that cover underserved populations, and helped develop and administer surveys aimed at determining attitudes toward health reform proposals. Before coming to ESRI, Mr. Kutyla worked at Harvard Medical School's Department of Health Care Policy, where he managed several projects focusing on quality of care.

Acknowledgments

The authors would like to thank The Commonwealth Fund and The Nathan Cummings Foundation for their support of this research. We are also grateful to Stuart Butler of The Heritage Foundation and Jack Meyer of the Economic and Social Research Institute for their thoughtful reviews of earlier drafts of this paper as well as members of the HCTC Team, in multiple federal agencies and private firms, who contributed greatly to our analysis. The individuals who provided important information on which this report is based include: Julie R. Crom and Nina R. Kildee of Accenture; Patrick McGovern of Access Affordable Health Plan; JoAnn Volk of the American Federation of Labor-Congress of Industrial Organizations; Kim Alice, Carol Kessler, David Lipskee, and Susan Ward of Anthem Blue Cross/Blue Shield; Rhonda Moye of Blue Cross/Blue Shield of Texas; Bob Gribbon and Brian Mattiello of the Connecticut Municipal Employees Health Plan; Ross Eisenbrey of the Economic Policy Institute; Mike Brigget and Corey Burrs of the Illinois Governor's Office on Budget; Carolynn Adams, Merlene Burnham, Karin Cano, and Keith V. Taylor of the Internal Revenue Service; Jo Ann Lamphere, Rel Lavizzo-Mourey, and Daniel Shive of The Lewin Group; Tanya Plante of the Maine Office of Employee Health and Benefits; Curt Harris and Richard Hobbie of the National Association of State Workforce Agencies; Rick McHugh of the National Employment Law Project; Connie Carter, Betty Castillo, Terry Clark, Mark Morin, and Shirley Smith of the U.S. Department of Labor; Steve Finan (formerly of the U.S. Department of Health and Human Services), Roy Ramthun, and W. Thomas Reeder of the U.S. Department of the Treasury; and Emily Newport of United Steelworkers of America. Of course, the views in this report are those of the authors and should not be attributed to our funders or others who provided us with assistance.

Executive Summary

Federal income tax credits intended for the purchase of health insurance coverage have, perhaps more than any other policy element, repeatedly surfaced in proposals offered by both Democrats and Republicans to address the steady increase in the number of uninsured Americans. The new system of Health Coverage Tax Credits (HCTCs) established under the Trade Act of 2002, the United States' first experiment in roughly a decade with fully refundable and advanceable federal income tax credits for health insurance, offers a tremendous opportunity to learn how best to structure such credits.

During the current presidential campaign, President Bush and all but one of the Democratic candidates who have issued detailed health reform plans have proposed health insurance tax credits. However, except for a brief and unhappy experience with child health insurance tax credits in the early 1990s, federal income tax credits to cover the uninsured have existed in theory only. That changed on August 6, 2002, when President Bush signed into law the Trade Act of 2002. The HCTCs created by the legislation pay 65 percent of the cost of health insurance premiums for a small group of displaced workers and early retirees. Eligible for these HCTCs are approximately 200,000 to 300,000 workers (and their dependents), in two general categories:

- Workers certified by the Department of Labor as displaced by international trade, who either receive Trade Adjustment Assistance (TAA) cash payments or who would qualify for such payments but for their receipt of unemployment insurance; and
- Early retirees age 55 to 64 who receive pension payments from the Pension Benefit Guaranty Corporation (PBGC), a federal corporation that assists retirees from certain companies that no longer pay promised pensions because of bankruptcies or other reversals.

HCTCs may be used to purchase qualified policies, which fall into three major categories:

- COBRA insurance, which allows former employees to remain in health plans offered by their previous employer. HCTCs may be used to enroll in this coverage anywhere in the country, without any need for state action. Under federal law in effect for more than a decade, employers that insure their workers and have 20 or more employees must offer COBRA coverage to certain laid-off workers and their families.
- Continuation of nongroup coverage previously in effect for workers during at least the 30 days prior to their separation from employment.
- Health plans that states make available through arrangements with particular insurers. Such plans cannot receive funding from Medicaid or the State Children's Health Insurance Program. Based on a statutory interpretation adopted by the Bush administration over the objections of some key lawmakers, such plans may include nongroup insurers for any HCTC enrollee.

Fully refundable, HCTCs are available to workers of any income level, including those who owe little or no federal income tax. Rather than waiting to claim HCTCs on end-of-the-year tax returns, beneficiaries can arrange for the advance payment of HCTCs to their health insurers when monthly premiums are due.

Although this program directly benefits only a small proportion of America's nearly 44 million uninsured, it tests policy mechanisms of much wider significance. If HCTCs work well in their current form or major problems are solvable, the prospects brighten for bipartisan legislation that effectively covers millions of uninsured Americans. If instead the HCTC experience suggests that federal income tax credits, in any form, cannot work well to cover the uninsured, the search for bipartisan solutions may become significantly harder. Much is thus at stake with the new program.

This interim report describing early HCTC implementation is based on dozens of interviews with stakeholders and policymakers as well as a review of relevant documents. In addition, via the Internet and follow-up correspondence and telephone calls, the authors surveyed the state-based plans offered to HCTC

beneficiaries, as of November and December 2003, in 15 broadly representative states. During the next phase of the project, we will visit and profile three diverse states participating in Trade Act coverage. The last phase of the current project will produce a final policy report with more definitive findings and recommendations.

Of course, it is far too soon to come to any conclusions about the success or failure of HCTCs. Nevertheless, even at this early stage, we see both extraordinary accomplishments and problems that appear to require correction.

Preliminary Findings

Infrastructure development

- Federal officials have made tremendous progress establishing this new program. The interagency HCTC team and its contractors created an innovative federal–state–private partnership and a mostly electronic system for exchanging information and payments, and met the statutory deadline—August 1, 2003, less than a year after the legislation was signed—to have advance payment up and running. No similar payment system has ever existed before.
- The administrative cost of advance payment may be quite high. Such spending could be worthwhile if it creates a subsidy infrastructure that could later be expanded, at little marginal cost, to a much larger population. On the other hand, high administrative costs could be a more serious problem if they are part of ongoing program operation and expand proportionately as enrollment grows.
- The HCTC team has had to overcome more than the inevitable difficulties of pulling together an effective interagency collaboration involving multiple cabinet level departments. Each agency on the HCTC team was simultaneously addressing other major challenges related to its core mission.
- Thanks to hard work by federal and state officials as well as health plans, by the end of 2003 state-based coverage was available in 26 states and the District of Columbia, jurisdictions that together included three-fourths of all projected eligible workers in the country.
- Not only has this program been established faster and in a wider geographic area than many expected, HCTC officials have often been nimble and creative in developing effective policy. For example, grants from the Department of Labor were used to mimic the effects of tax credits and to pilot test advance-payment systems in two states. Advance-payment mechanisms have been simplified several times to save administrative costs and to prevent coverage being put at risk by consumer mistakes.

Take-up

- Relatively few eligible individuals have taken up HCTCs. By the end of December 2003, fewer than 8,400 workers had enrolled in HCTC advance payment—3.6 percent of the 235,000 workers who were identified as potentially eligible for HCTCs and to whom outreach materials were mailed. Including dependents, total advance payment enrollment reached 13,247 individuals by the end of December.
- Both among individuals identified as potentially eligible and beneficiaries actually enrolled in HCTC advance payment, approximately 60 percent are PBGC recipients. However, the distribution between PBGC and TAA enrollees varies from month to month, based on the changing fortunes of large employers. Moreover, the proportion of PBGC recipients among HCTC-eligible but unenrolled workers is currently overstated, because many TAA-eligible workers who receive unemployment insurance are not identified as potentially eligible, as is explained below.
- It is far too soon to come to definitive conclusions about take-up. Advance payment did not begin until August 2003; enrollment will surely grow as officials climb the learning curve and word of the new program spreads among potential beneficiaries; and additional households will claim HCTCs on their

year-end tax forms. However, several obstacles are already evident that, unless addressed, may limit future take-up. For example:

- For many of the unemployed and early retirees, even 35 percent of a health insurance premium is more than they can afford. For workers using advance payment of HCTCs in December 2003, their 35 percent share of the annual premium was $1,713, on average, for single coverage. In that same year, actively employed workers made annual premium payments of only $508, on average, for single coverage available from their employers. HCTCs thus presuppose that many workers will pay more for health insurance precisely when unemployment (even with unemployment insurance payments) reduces family income by an average of 40 percent.

  This 35 percent premium cost of $1,713 a year would consume 13 percent of average unemployment insurance or TAA payments and 5 percent of all income for a four-person family with income at 200 percent of the federal poverty level (FPL). According to leading studies, health insurance payments that require as little as 3 percent of income keep enrollment below 40 percent of eligible individuals.

  Some early evidence suggests that, in fact, many low-income HCTC beneficiaries may be declining the credit. In Maryland, half of Bethlehem Steel's PBGC retirees have pensions under $10,780 a year. By contrast, only 5 percent of such retirees enrolling in Maryland's state-based HCTC coverage have pensions below that level.

- Although many beneficiaries and health plans report that the advance-payment process works well, and officials are refining this process to make it more consumer friendly, there are some problems. For example, to receive advance payment, beneficiaries must first enroll in a qualified health plan and pay premiums in full for one month or more until advance payment starts. On annual tax forms, beneficiaries can claim HCTCs for such full premium costs, but they will become uninsured if they cannot afford to front these payments based on expected year-end tax refunds.

- Many eligible workers may not receive the information they need to enroll, for reasons that include the following:

  - The program's main outreach strategy is to mail a 20-page booklet to each individual whom PBGC or state workforce agencies identify as potentially eligible. Unfortunately, the material is detailed and complex, as is the HCTC program itself. In some recent years, 80 percent of TAA participants have not been high school graduates. At in-person outreach events, many workers have required one-on-one sessions lasting 20 minutes or longer to explain HCTCs. Obviously, a larger-scale program cannot depend on such individualized instruction.

  - This outreach strategy misses one of the largest groups of HCTC-eligible individuals—namely, recently displaced workers who are still receiving unemployment insurance but who meet all other requirements for TAA cash payments. State workforce agencies lack complete lists of such individuals, so many of these workers never receive information about HCTCs. Moreover, current outreach materials do not mention the key step required for these workers to be considered for HCTC eligibility—namely, applying for TAA cash payments.

- It is not yet clear what types of health coverage have the greatest appeal to HCTC beneficiaries. Some may not be enrolling because they find little value in the offered plans, which may have high deductibles or other strict limits on coverage. On the other hand, some may not be enrolling for the opposite reason—that is, because they prefer less comprehensive coverage with lower premiums. On this as on many other important topics, more time will be needed to reach definitive conclusions. However, despite the great diversity among the states in the coverage they offer (described below), no state has enrolled into advance payment more than 10 percent of its potentially eligible workers. If limitations in the types of available, state-qualified coverage were the major factor responsible for

low take-up rates to date, at least one or two states presumably would have much higher enrollment levels.

Quality and cost of coverage

- Many HCTC-eligible workers lack access to COBRA or continuation of nongroup plans purchased before job loss. Accordingly, many potentially eligible workers in the 24 states (plus Puerto Rico) without state-based coverage will be unable to use HCTCs to purchase health insurance.
- In states offering state-qualified coverage as of December 2003, 48 percent of HCTC enrollees used COBRA plans, 48 percent used state-based plans, and 4 percent retained the nongroup coverage they had before separation from employment. These state-based plans included the following:
  - In 11 states, nongroup coverage with medical underwriting that determined premiums based on the insurer's assessment of each individual's medical history.
  - In 13 states, high-risk pools, which, outside the HCTC program, primarily served individuals whose medical history made it difficult for them to obtain comprehensive, affordable coverage in the nongroup market.
  - In six states, community-rated plans, most of which charged the same amount to all enrollees in a particular area, but some of which varied premiums by age or gender.

Embodying a much less heavily regulated approach to health coverage than such earlier health subsidy programs as Medicaid and the SCHIP, the Trade Act does not impose any minimum benefit requirements or general premium rating rules. Such issues are generally left for health plans and the states to decide. The cost to workers of state-based coverage thus varies considerably, depending on the state and the characteristics of the individual purchasing coverage. For example, according to national data for November and December 2003, workers' average annual premium payments to meet their 35 percent share varied from $974 for worker-only coverage in the lowest-price quartile of state-based plans to $3,904 in the highest. Depending on the state, enrollees' 35 percent premium shares for average-priced state-qualified coverage ranged from $741 to $2,715.

For a more detailed understanding of the coverage HCTC beneficiaries receive under this new approach, we surveyed 15 broadly representative states that included five nongroup plans, seven high-risk pools, and five community-rated plans. We found the following:

- Of the 15 states we surveyed, 9 offered HCTC beneficiaries five or more coverage options. The most common variation was a choice among deductibles, which typically ranged between a low of $250 to $500 and a high of $2,500 to $5,000 for a single, covered individual.
- Several state plans offered coverage roughly comparable to typical employer-sponsored insurance. However, in 11 states the most generous plan excluded or severely limited at least two of the following benefits: maternity care, mental health care, prescription drugs, and preventive care. More specifically:
  - In seven of 15 states, all available plans either excluded maternity care or imposed a substantial additional premium charge for such coverage.
  - In seven states, the most generous coverage either excluded mental health services entirely or severely limited such care (for example, by requiring 50 percent coinsurance for most outpatient visits).
  - The most generous coverage in nine of 15 states either excluded all prescription drugs or sharply limited covered benefits (for example, with annual caps on covered drugs or very high copayments for name-brand drugs).

Similarly, in 10 of 15 states, deductibles could reach $2,500 (or more). However, at this early juncture, we do not know how many laid-off workers and early retirees view these limits as problematic and how many are willing to accept restricted benefits in exchange for lower premiums.

- Among the 15 states we surveyed, premiums varied by age in 12 states, by gender in eight, by geography in seven, and by individual health history in five. In terms of premium variation:
  - Lower-risk individuals were charged more in community-rated plans than in risk-rated plans. For example, in plans that charged women and men the same rate, young men (who obtain less health care, on average, than do young women) were required to pay an average of 36 percent more than in plans charging different rates to men and women.
  - In the median state with plans that varied premiums by gender, women were charged 53 percent more than men for the same coverage. Plans that excluded routine maternity care reduced these disparities only modestly, to a median of 48 percent higher charges for women than for men.
  - In the median state with plans that varied premiums by age, healthy, 60-year-old men were charged 238 percent more than healthy, 25-year-old men for the same plan.
  - In the median state with medically underwritten, nongroup coverage, the insurer's classification of an individual in the highest rather than the lowest risk level increased premiums by 480 percent.
- The Trade Act requires state-based plans to meet certain consumer protection requirements, including guaranteed issue of health coverage and no exclusion of preexisting conditions. However, as interpreted by the Bush administration (over the objections of some lawmakers), the Trade Act guarantees these protections only to beneficiaries with three months of continuous health coverage, with no gap in coverage lasting 63 days or longer, immediately before enrolling in state-based HCTC plans. Our survey found that many such plans provided these protections only where required by federal law, as follows:
  - Plans in seven of 15 states did not guarantee insurance to HCTC beneficiaries with recent coverage gaps.
  - In 14 of 15 states, HCTC beneficiaries with recent coverage gaps were either denied coverage altogether or had preexisting conditions excluded. In nine states, such exclusions could last for 12 months after enrollment.
- For many HCTC-eligible workers, much time passes between job loss and start of HCTC eligibility.
  - Early retirees receiving PBGC payments typically have been out of work for long periods of time.
  - By definition, recipients of TAA payments have exhausted unemployment insurance, which means they have been unemployed for six months or longer.
  - According to best-case scenarios developed by federal officials, recently displaced workers who receive unemployment insurance but otherwise qualify for TAA payments must wait at least five months between job loss and start of HCTC advance payment. In part, this is because, when a petition is filed claiming that layoffs resulted from foreign competition, 60 days must pass before laid-off workers qualify for TAA.
- Accordingly, many laid-off or retired workers who are unable to pay full health insurance premiums between job loss and start of HCTC advance payment will experience coverage gaps of 63 days or longer. As a result, they may find state-based coverage either unavailable or subject to prolonged preexisting condition exclusions. Particularly for individuals with chronic illness, such exclusions can prevent health coverage from fulfilling its objectives of improving access to health care and protecting against major financial loss. They can also reduce take-up by making coverage much less attractive to affected workers.

Recommendations

For the country's experience with HCTC to yield the most useful possible information that could guide the design of broader coverage expansions, policymakers need to consider the following steps:

- Granting the IRS flexibility to test the feasibility and impact of alternative, potentially simpler advance-payment mechanisms and higher tax credit levels, especially for low-income beneficiaries.
- Provide more extensive, publicly available analysis of current data, including publication of IRS survey results documenting the reasons for participation and nonparticipation in HCTC advance payment.
- Revising HCTC legislation and policy to provide a fairer test of health insurance tax credits by simplifying eligibility, eliminating barriers to coverage, improving outreach, and otherwise increasing take-up.

If policymakers wish to modify HCTCs to be more effective in covering the uninsured (whether among workers eligible for the current program or a broader population), they need to consider additional program modifications, such as the following:

- Beneficiaries, particularly those with low incomes, could receive HCTCs covering more than 65 percent of premiums. Income could be determined by the state agencies that administer the SCHIP or Medicaid, much as recent Medicare legislation relies on Medicaid and Social Security agencies to decide seniors' eligibility for low-income subsidies of prescription drug coverage.
- States could be given the option to provide HCTC beneficiaries with access to health plans that participate in the Federal Employees Health Benefits Program (FEHBP). To safeguard current FEHBP enrollees, HCTC beneficiaries would need to be placed in separate risk groups. This additional option would increase state flexibility, enhance consumer choice, and provide access to comprehensive benefits. In addition, an option to use FEHBP plans with established relationships to federal payers could also make it easier for the IRS to develop simpler, more consumer-friendly mechanisms for advance payment.

These two modifications are important, regardless which group of uninsured is brought into the HCTC system. Additional policy changes may also be needed, depending on the characteristics of new beneficiaries.

Acronym Glossary

Trade Act health coverage involves the intersection of three complex bodies of law and policy: health, labor, and tax. Experts in one of those areas may find themselves encountering unfamiliar terms and acronyms when this report touches on other subjects. This glossary is intended to reduce any possible confusion that might result.

ATAA—Alternative Trade Adjustment Assistance, a new Department of Labor program that began in August 2003. ATAA partially compensates certain workers age 50 and older for income losses attributable to changed employment that results from foreign competition.

COBRA—the Consolidated Omnibus Budget Reconciliation Act, a federal law that requires employers with 20 or more workers to permit former employees, under certain circumstances, to purchase employer-sponsored health insurance.

DOL—The U.S. Department of Labor.

EITC—the Earned Income Tax Credit, which is available to certain low-income workers.

ERISA—the Employee Retirement Income Security Act of 1974, a federal law that governs many companies' pensions, health coverage, and certain other employee benefits.

ESI—employer-sponsored insurance, health coverage offered and at least partially financed by employers.

FEHBP—the Federal Employees Health Benefits Program, which provides health coverage to federal workers, retirees, and certain others.

HCTC—the Health Coverage Tax Credit created by the Trade Act of 2002 to pay 65 percent of health insurance premiums for certain displaced workers, early retirees, and dependents.

IRS—the Internal Revenue Service, which administers the federal income tax system.

Mini-COBRA—state laws that require certain employers with fewer than 20 workers to offer continuation coverage comparable to COBRA.

NEG—National Emergency Grants, a Department of Labor program of assistance to states and localities experiencing significant economic hardship.

OPM—Office of Personnel Management, the federal agency that administers the Federal Employees Health Benefits Program.

PBGC—Pension Benefit Guaranty Corporation, a federal agency that makes full or partial pension payments on behalf of certain companies no longer able to make such payments to their retirees.

PPO—preferred provider organization, a common form of health insurance that allows consumers to obtain care outside managed care networks, albeit with higher cost sharing than inside such networks.

SCHIP—the State Children's Health Insurance Program, which provides health coverage to certain uninsured children who have family incomes too high to qualify for Medicaid.

SWAs—State workforce agencies, which administer programs to assist unemployed workers.

TAA—Trade Adjustment Assistance, a program administered by the Department of Labor to help certain workers displaced from their employment by foreign competition.

TRA—Trade Readjustment Allowance, which is a weekly payment provided as a part of Trade Adjustment Assistance to certain workers displaced by international competition who have exhausted their unemployment insurance.

UI—unemployment insurance, a weekly payment available for a defined period (usually six months, but sometimes longer) to certain workers who lost their jobs involuntarily and are actively looking for work.

Health Coverage Tax Credits Under the Trade Act of 2002: A Preliminary Analysis of Program Operation

Introduction

On August 6, 2002, when President Bush signed into law the Trade Act of 2002, the country enacted its first incremental health coverage expansion since the adoption of the State Children's Health Insurance Program (SCHIP) in 1997. The Trade Act created a new system for subsidizing health coverage for the uninsured using Health Coverage Tax Credits (HCTCs), federal income tax credits that pay 65 percent of health insurance premiums for eligible workers and their dependents. Between 200,000 and 400,000 laid-off workers displaced by international trade and early retirees receiving payments from the Pension Benefit Guaranty Corporation (PBGC) may qualify for HCTCs, along with their families.[1] HCTCs are fully refundable and therefore are available without reduction to all eligible individuals, including those who owe little or no federal income tax. Beneficiaries can, if they wish, receive HCTCs in advance, before they file annual income tax forms; such advance payments are sent each month to the beneficiaries' health insurance companies when premiums come due.

HCTCs are more important to national health policy than the small number of potential beneficiaries might suggest, because they test a new model for using tax credits to cover the uninsured. Refundable, advanceable health insurance tax credits are one of very few approaches to health coverage expansions that have a significant history of broad support in both parties. In various forms, they have been proposed by both the current and former President Bush; all but one of the Democratic candidates for President who have released health reform proposals;[2] the cosponsors of at least 16 bipartisan bills, during the past Congress alone, proposing health coverage expansions;[3] and the House and Senate Democratic Caucuses' child health coverage bills in 1997.[4]

The new program's success or failure could thus have significant consequences. The prospects for bipartisan expansion of health coverage are much brighter if HCTCs succeed in their current form or if any major problems that emerge prove fixable. On the other hand, if it turns out that refundable, advanceable health coverage tax credits cannot succeed, in any form, policymakers may find it hard to develop other types of effective health insurance subsidies capable of gaining significant, bipartisan support.

This interim report describing early HCTC implementation was based on dozens of interviews with stakeholders and policymakers as well as a review of relevant documents. In addition, via the Internet and follow-up interviews and correspondence, we surveyed the state-based plans offered to HCTC beneficiaries in 15 broadly representative states as of November and December 2003. In the next phase of the project, we will visit and profile three diverse states participating in Trade Act coverage, to provide a "ground-level" view of program implementation. The last phase of the current project will produce a final policy report with more definitive findings and recommendations.

This early snapshot of the HCTC program identifies both initial accomplishments and remaining challenges. Problems are inevitable in the early stages of any new program, of course. For example, during the first fiscal year after the adoption of SCHIP, states used only 3 percent of allotted federal SCHIP dollars. In fact, 39 states and the District of Columbia were projected to be unable to spend their first year's SCHIP allotment over the initial *three* years of program operation.[5] Despite this slow beginning, by the time SCHIP reached its fifth birthday in 2002, the program was widely viewed as a success. Among other accomplishments, the proportion of low-income children without health coverage fell by a third, from 23 percent of children with family incomes under 200 percent of the federal poverty level (FPL) in 1997 to 16 percent in 2002.[6]

In some ways, the question hanging over HCTCs is whether they will resemble SCHIP, with a slow initial rollout followed by a steep learning curve and later success, or whether they will follow in the footsteps of the ill-fated "Bentsen child health tax credits" that were added to the Earned Income Tax Credit (EITC) in

1990. As the Bentsen credits generally covered only 25 percent of premiums, few low-income families enrolled, even fewer took advantage of advance payment, and what coverage was purchased was frequently minimal. Without a significant outreach effort, the principal enrollees were the least poor EITC recipients, who typically were already insured, even without the health care credit. With few limits on the insurance companies that could receive credits, serious marketing fraud ensued, harming many low-income consumers. These health credits were repealed in 1993, after only one year of implementation, as part of broader EITC reform.[7]

The Trade Act's new credits are designed very differently than the failed credits of the early 1990s, as is made clear below. Among other changes, HCTCs may be used only with certain designated forms of health coverage; this appears so far to have prevented major marketing fraud. Nevertheless, take-up to date has been low, and there are serious questions about the value and cost of the health coverage that many states offer to HCTC beneficiaries, particularly for women, middle-aged or older workers, and people with prior health problems.

This report comes at an early stage of HCTC implementation. The workhorse of Trade Act health coverage, advance payment of HCTCs, first began on August 1, 2003. To a large extent, this paper focuses on process, on steps taken to implement the program. It is far too soon for any definitive inventory of HCTC's outcomes, much less a final verdict about whether the credit's apparent initial problems persist and, if so, whether they are fixable or fundamental.

This report's main purpose is to start learning from the HCTC experience, facilitating the future design of much broader coverage expansions aimed at some or all of the nearly 44 million Americans who lack health coverage today.[8] The following discussion thus covers four areas in turn: significant legal features of Trade Act health coverage; the general status of initial HCTC implementation; key issues that should be tracked during program implementation by observers interested in tax credits' potential as a vehicle to expand health coverage more broadly; and initial recommendations both to provide a better test of such tax credits and to serve the uninsured more effectively.

I. Key Elements of Trade Act Health Coverage

Signed into law on August 6, 2002, the Trade Act of 2002 created HCTCs to pay 65 percent of health insurance premiums for certain workers and their families. The following sections describe the eligibility requirements for HCTCs, their operation, the coverage HCTCs can be used to purchase, and federal grants available to facilitate coverage expansion under the Trade Act.

A. Eligibility

Three groups of workers, described in turn below, qualify for HCTCs:

Pension Benefit Guaranty Corporation beneficiaries. These are early retirees receiving payments from the Pension Benefit Guaranty Corporation (PBGC), a federal corporation that makes full or partial pension payments, either periodically or in one lump sum, to retirees from certain companies that have suffered bankruptcies or other financial reversals and so no longer pay promised defined-benefit pensions.[9] To receive HCTCs, PBGC retirees generally must be age 55 to 64.[10]

Trade Adjustment Assistance beneficiaries. These are workers certified by the Department of Labor (DOL), under its Trade Adjustment Assistance (TAA) program, as having lost their jobs because of foreign competition. To obtain a finding of trade-related adverse impact, three workers, a union, a company's officials, certain state workforce agencies, or those agencies' partners must file a petition with the Department of Labor. Two distinct groups of TAA beneficiaries qualify for HCTCs:

- Displaced workers receiving Trade Readjustment Allowance (TRA) cash payments, which cannot begin until a displaced worker has exhausted unemployment insurance. The maximum duration of unemployment insurance varies by state and economic conditions, but it is always available for at least six months.
- Displaced workers who are collecting unemployment insurance but meet all other TRA eligibility requirements. This eligibility category was needed to prevent denials of health coverage for six months or more after job loss, during receipt of unemployment insurance.

Alternative TAA beneficiaries. These are workers receiving Alternative Trade Adjustment Assistance (ATAA), which started on August 6, 2003. For workers over age 49 who lost their jobs because of foreign trade and then began a new line of work for lower pay, ATAA makes up part of their lost income. This new program is not yet assisting a significant number of workers. This paper accordingly focuses on the other groups of HCTC-eligible families.

Even if they fit into one of these three categories, workers are ineligible for HCTCs if they receive Medicare, Medicaid, or certain other coverage, including insurance sponsored by an employer that pays 50 percent or more of premiums. Dependents of eligible workers can also qualify for HCTCs, so long as they do not receive these other types of coverage.

Table 1 shows the number of workers in each state whom state workforce agencies or the PBGC have individually identified as potentially eligible. It understates the number of potential Trade Adjustment Assistance eligibles, because, as explained below, state workforce agencies do not know the identities of many HCTC-eligible displaced workers who are ineligible for TRA payments because they receive unemployment insurance.

Table 1. Workers Identified as Potentially Eligible for HCTCs, December 2003

State	Potentially Eligible Workers			
	Pension Benefit Guaranty Corporation	Trade Adjustment Assistance	Alternative Trade Adjustment Assistance	Total
Alabama	2,338	2,462		4,800
Alaska	73	62		135
Arizona	1,336	468	*	1,804*
Arkansas	887	654	*	1,541*
California	6,229	3,072		9,301
Colorado	1,258	913		2,171
Connecticut	2,086	680		2,766
D.C.	81			81
Delaware	264	122		386
Florida	11,059	609		11,668
Georgia	5,940	2,204	*	8,144*
Hawaii	505	40		545
Idaho	327	1,238		1,565
Illinois	7,957	4,522		12,479
Indiana	7,898	2,080		9,978
Iowa	1,183	632	*	1,815*
Kansas	868	891		1,759
Kentucky	1,135	2,861		3,996
Louisiana	696	193		889
Maine	482	1,442		1,924
Maryland	4,444	372		4,816
Massachusetts	4,265	878		5,143
Michigan	5,460	2,201		7,661
Minnesota	2,005	1,417		3,422
Mississippi	928	822		1,750
Missouri	5,519	1,612		7,131
Montana	83	259		342
Nebraska	252	119		371
Nevada	725	46		771
New Hampshire	893	333		1,226
New Jersey	4,156	2,419		6,575
New Mexico	276	173	*	449*
New York	7,752	2,972	*	10,724*
North Carolina	4,104	11,105	24	15,233
North Dakota	31	33		64
Ohio	12,337	3,769		16,106
Oklahoma	762	1,792		2,554
Oregon	475	1,329		1,804
Pennsylvania	17,964	5,710		23,674
Puerto Rico	1,009	*		1,009*
Rhode Island	239	251		490
South Carolina	1,795	2,426		4,221
South Dakota	64	18		82
Tennessee	2,670	5,470	*	8,140*
Texas	3,753	4,943	*	8,696*
Utah	526	715		1,241
Vermont	226	90		316
Virginia	2,686	4,861	46	7,593
Washington	1,068	4,969	*	6,037*
West Virginia	2,248	634		2,882
Wisconsin	1,763	4,614		6,377
Wyoming	69			69
Total	**143,149**	**91,506**	**87**	**234,742**

Notes: (1) Family members of HCTC-eligible workers are not included in these numbers. (2) Some columns do not add up to the stated totals. That is because, to protect individuals' privacy, the IRS does not disclose the number of people in a given state and category if the number is between 1 and 9, inclusive. Asterisks indicate the presence of these nondisclosed numbers. An asterisk attached to a particular number means that the number is an understatement by an undisclosed amount. A cell consisting entirely of an asterisk means that the true number of salient individuals is between 1 and 9. (3) Many TAA–eligible workers are not included in the above table because, as explained below, state workforce agencies frequently do not know the identities of such workers who receive unemployment insurance.

Source. HCTC program, January 2004.[11] Calculations by ESRI, February 2004.

B. Operation of Tax Credits

HCTCs are fully refundable, which means that they are payable in full for all eligible individuals, including those who owe little or no federal income tax. Since August 1, 2003, they have also been advanceable – in other words, beneficiaries can arrange for the Internal Revenue Service (IRS) to pay the credits each month to health insurance companies as premiums come due. Alternatively, for coverage after November 2002, a taxpayer may use the annual tax return filed after the end of the year to claim an HCTC that reimburses the year's qualified health insurance premium costs.

C. Types of Coverage

HCTCs may be used only for "qualified" coverage, which includes two basic categories:

Automatically qualified health plans. Anywhere in the country, whether or not the state government has acted, HCTCs may be used to purchase:

- Coverage that former employers offer through COBRA.[12]
- Nongroup insurance for workers who had such coverage during their final 30 days before separation from employment (which can mean either job loss or the former employer's termination of pension payments and the retiree's resulting qualification for PBGC).[13]
- Coverage through a spouse's employer, when the employer pays less than 50 percent of health insurance premiums.

State-qualified health plans. States may offer qualified insurance through certain high-risk pools,[14] so-called "mini-COBRA laws,"[15] or almost any other "arrangement" with an insurer, with one noteworthy exception. Under the Trade Act, a state-operated plan that receives matching federal funds cannot constitute state-qualified coverage. Accordingly, Medicaid and SCHIP plans have been barred from enrolling HCTC beneficiaries.[16]

State-qualified coverage is not required to meet any minimum benefit requirements (other than to constitute health insurance). Similarly, this new federal law requires neither pure community rating within each geographic area nor adjusted community rating, allowing premiums to vary by such factors as age and gender. However, for state-based coverage to qualify for HCTCs, it must meet the following four consumer protection requirements:

- The insurer must guarantee issuance of coverage;
- The insurer may not exclude preexisting conditions;
- The health plan may not cover fewer benefits than it provides to similarly situated individuals not receiving HCTCs;
- The health plan may not demand higher premiums than it charges for similarly situated individuals not receiving HCTCs.

These safeguards shield beneficiaries only if they are "qualified." That is, to be guaranteed these protections, a beneficiary must have accumulated at least three months of continuous coverage, without any gap in coverage lasting 63 days or longer.

Soon after enactment of the Trade Act, three disputes arose about state-based, qualified coverage.[17] The first concerned the extent to which such coverage can include nongroup insurance. As Congress was developing the Trade Act, some key legislators believed that, under the Act's terms, HCTCs could purchase nongroup coverage only for workers who had such coverage during the last 30 days before job loss. Other key lawmakers believed that, under the Trade Act, a state could offer qualified coverage through "arrangements" for nongroup insurance, including for workers who never used nongroup plans before.

The second dispute involved the application of consumer protections, such as guaranteed issue and the prohibition of preexisting condition exclusions. The Trade Act is clear that these safeguards apply only to HCTC beneficiaries with at least three months of continuous coverage. The legislation is equally clear that a gap of 63 days or longer ends continuous coverage. However, the bill does not state, with complete clarity, the time during which three months of continuous coverage must be in effect for such consumer protections to apply. Some legislators urged that, so long as workers had three months of continuous coverage before they lost their jobs, consumer protections should apply. Others claimed that, for consumer protections to apply, continuous coverage needed to be in effect immediately before workers sought to enroll in HCTC plans.

Finally, some lawmakers contended that the Act's prohibition against discriminatory treatment of HCTC beneficiaries precluded varying premiums based on the insurer's assessment, through individual medical underwriting, of the health risks posed by each beneficiary. Others claimed that such underwriting was permissible, so long as HCTC beneficiaries were underwritten in the same way as other consumers.

Federal officials resolved these questions as follows:

- State-based, qualified coverage through "arrangements" with insurers can include nongroup plans for any HCTC beneficiaries, including those who did not receive nongroup coverage during their final 30 days before separation from employment.
- For federally guaranteed consumer protections to apply, workers must have three months of continuous coverage, without any gap of 63 days or more, immediately before enrolling in a state-based, HCTC plan.
- If nongroup plans are no stricter with HCTC beneficiaries than with other individuals seeking coverage, the Trade Act's consumer protection requirements permit qualified plans to use medical underwriting to base premiums on HCTC beneficiaries' individual medical histories.[18]

D. Federal Grants

The Trade Act both authorizes and appropriates grants to states for starting and operating high-risk pools. It also authorizes National Emergency Grants (NEG) from the Department of Labor to fund certain state infrastructure and interim coverage costs related to HCTCs. Apparently because of issues involving the jurisdiction of various House committees, the Trade Act treats NEG grants differently than the high-risk pool grants. The statute authorizes NEG grants but, except for fiscal year 2002, does not appropriate them. Since the Trade Act was signed into law on August 6, 2002, less than one-third of the authorized NEG funding ($90 million out of $330 million) has, in fact, been appropriated. Table 2 shows the total amounts available for these grants.

Table 2. Health-Related Grants in the Trade Act: Annual Funding Levels

Fiscal Year		High-risk Pool Grants	National Emergency Grants
2002	Authorized amount	None	$60 million
	Appropriation	None	$60 million
2003	Authorized amount	$60 million	$160 million
	Appropriation	$60 million	$30 million
2004	Authorized amount	$40 million	$110 million
	Appropriation	$40 million	None
2005–2007	Authorized amount	None	$60 million
	Appropriation	None	Appropriations process not yet begun

Note. Some unspent funding from one fiscal year can be spent in later years, under the Trade Act.

Much more detailed explanations of Trade Act health coverage are available online, including the following: http://www.irs.gov/pub/irs-utl/governers_letter_hctc_guidance_ltr_ammended_080803_v2.pdf; http://www.statecoverage.net/pdf/issuebrief303trade.pdf; http://www.irs.gov/individuals/article/0,,id=109960,00.html; and http://www.aahp.org/audio/taxcredit03/HCTC_Audio_Nov03.pdf.

II. Early Implementation of Trade Act Health Coverage

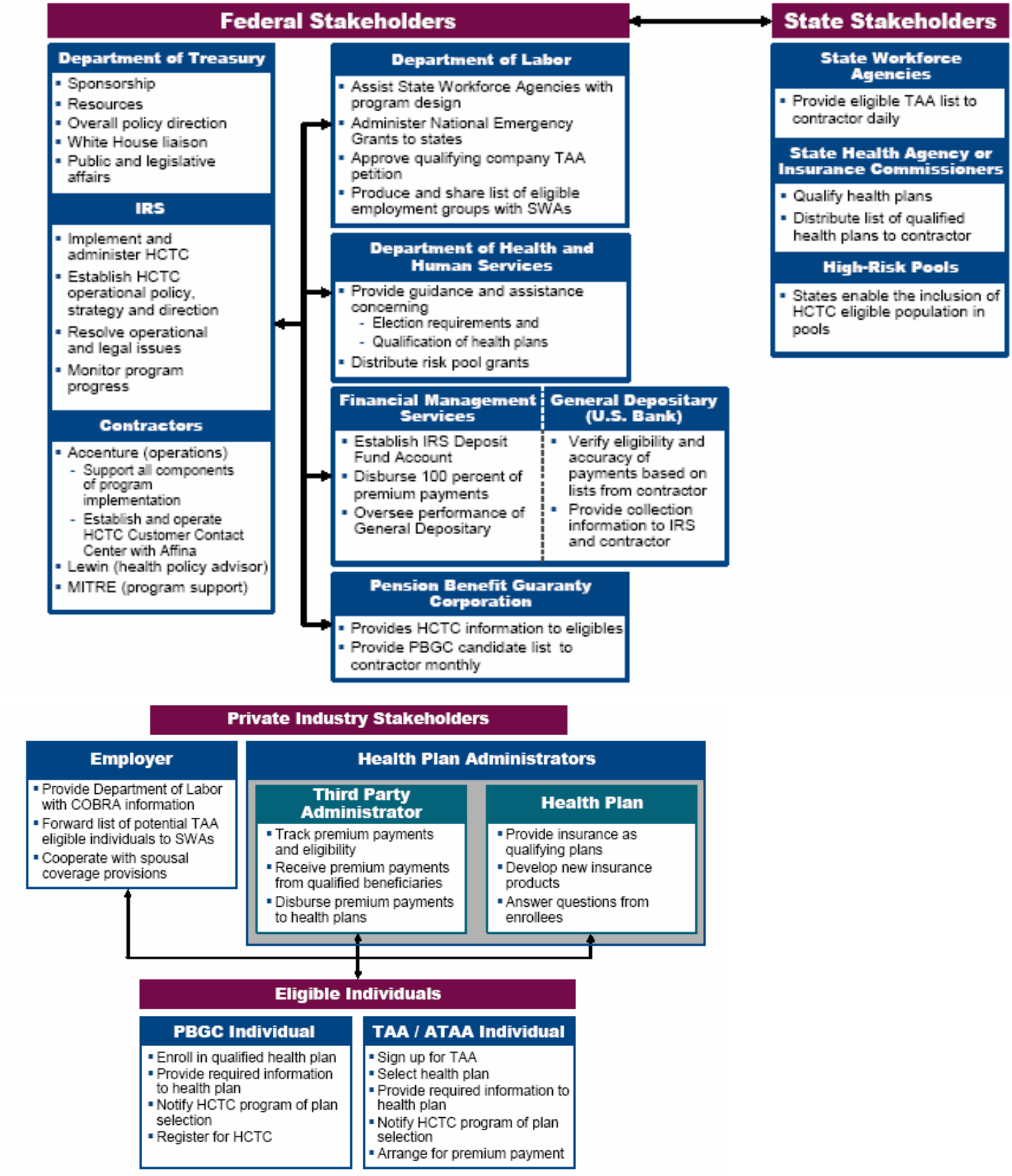
A. Administrative Structure

Soon after the Trade Act was signed into law, some observers suggested that any legislation depending on the collaboration of three cabinet-level departments—Labor, Treasury, and Health and Human Services—was doomed to failure. In fact, the required collaboration has been even broader, extending to the IRS, PBGC, state workforce agencies, state health insurance departments, private health plans, Financial Management Services of the Treasury Department, employers, banks, and others. Additional challenges facing this new system have included numerous requirements: for new legislation in many states wishing to provide qualified, state-based coverage; for clean and efficient integration of data streams from state workforce agencies, PBGC, IRS, health plan administrators, and others; and for new state arrangements with insurers, who have been asked to serve this new group of beneficiaries who collectively have no previous claims history, and who needed to be covered under market rules never before in effect. In addition, the IRS, which has informally described HCTC advance payment as a "revolutionary" policy that provides a taxpayer's credit to unrelated third parties, has been required to develop an unprecedented mechanism that makes prompt, monthly, accurate payments to health plans across the country; this system has had to take into account many health plans' strong desire to receive a single payment of the full premium from one source, rather than a 35 percent payment from the beneficiary and a separate, 65 percent payment from IRS.

The timing of HCTC implementation created further challenges. For many federal and state agencies, this new health subsidy system has required innovation and significant effort at precisely the time of other serious demands in core priority areas. For example, at the same time that HCTC implementation has required the PBGC to establish its first-ever system of facilitating retirees' health coverage, the PBGC has had to address a "sharp deterioration in the funded status of pension plans" as well as "a record deficit as the result of the recent terminations of large underfunded [private pension] plans."[19] Similarly, while HCTC implementation demands that the Department of Labor carry out new health-insurance-related activities outside its traditional expertise, the Department and its partner state agencies have been coping with several other challenges. These include assisting unemployed workers suffering from the largest number of lay-offs in more than a decade; implementing the most significant reform of TAA since the 1970s, including the creation of ATAA and the extension of TAA to numerous workers and firms affected only secondarily by foreign competition;[20] and carrying out other major reforms of worker assistance programs. Likewise, many state health officials and policymakers who have been needed to develop state-based, qualified coverage under HCTC have been understandably preoccupied with responding to extraordinary state budget crises and managing the development and implementation of perhaps the largest cost-containment measures in the history of Medicaid and SCHIP.[21]

A number of observers have rightly applauded the progress already achieved to overcome such tremendous obstacles.[22] With representation from multiple federal agencies and several private contractors, an energized team has taken charge of this new program and met the Trade Act's statutory deadlines for advance-payment implementation by August 1, 2002 and ATAA implementation by August 6, 2002. In fact, through the creative use of NEG grants to mimic the effect of advance payment, HCTC officials arranged one-month pilot tests of advance payment in two states, Pennsylvania and Maine. An innovative collaboration now links government agencies, consumers, health plans, employers, banks, and others, coordinating the flow of information and dollars this program requires. The complexity of this collaboration is dramatized by the HCTC team's depiction of key stakeholders and their principal roles, shown in flow chart form in Figure 1.

Figure 1. HCTC Stakeholders and Roles



Source: HCTC team, 2003.[23]

B. Advance Payment

For health insurance tax credits to cover many of the uninsured, effective advance payment is essential. Two-thirds of the uninsured in general,[24] and uninsured, unemployed workers in particular,[25] have family incomes below 200 percent of the federal poverty level. Such low-income, uninsured workers have little ability to pay health insurance premiums out of pocket, in anticipation of reimbursement after filing annual tax forms.

As one of the country's first tests of tax credit advance payment for health insurance, the HCTC advance-payment mechanism has been changed several times to address emerging problems. For example:

- Originally, consumers received several notices during a month when payments were late. When this created confusion that led to disenrollment, the HCTC program eliminated all but one such notice.
- As the system was first devised, advance payment ended for the entire year if a worker's 35 percent payment was even a dollar less than the correct monthly amount. To ameliorate the resulting losses in coverage, the HCTC program adjusted this system to permit reenrollment later during the year. Finally, a new system was developed whereby, if the worker's payment is not high enough, the IRS nevertheless pays a proportionate credit, keeping advance payment in place while requiring the health plan to seek any shortfall directly from the worker.
- Originally, health plans were forbidden from participating in advance payment unless they registered as a vendor with the Treasury Department to receive electronic payments.[26] While state-qualified plans were required to register, COBRA plans were not. A number of smaller COBRA plans refused to participate in advance payment, leaving some HCTC-eligible workers without affordable access to qualified coverage. The HCTC program then devised a system of writing paper checks to COBRA administrators that refused to accept electronic payments; all COBRA plans are legally required to accept such checks as third-party payments.

Taking into account these adjustments, the latest version of advance payment includes the following steps:

1) Each state workforce agency (for TAA and ATAA beneficiaries) and the Pension Benefit Guaranty Corporation (for its beneficiaries) sends the HCTC program lists of individuals who may qualify for HCTC. Transmitted electronically, such lists are provided daily by state workforce agencies and monthly by PBGC.

2) The HCTC program mails HCTC program kits to each individual listed by the PBGC or a state workforce agency as potentially eligible. These kits contain detailed explanations of eligibility, qualified coverage, application procedures for HCTCs, and related topics.

3) The individual enrolls in qualified health coverage. The individual must pay each month's premium in full, pending completion of the HCTC registration process. Currently, at least the first month's premium typically must be paid in full before advance payment starts. If the individual turns out to be eligible for HCTCs, IRS reimburses any 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 invoices to such individuals even after advance payment has begun and the consumer is making 35 percent premium payments to the HCTC program, as explained below.)

5) The individual contacts the HCTC call center to enroll in HCTC advance payment, mailing the health plan's invoice to the HCTC program. The HCTC program uses that invoice to confirm enrollment in qualified coverage and to determine the proper dollar amount of the credit and the due date for payment to the plan.

6) The HCTC program determines whether the individual is eligible and registers the individual, if eligible, 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 to 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 proportionate 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.

   d) If no payment is received from the beneficiary by the due date, the HCTC program sends the consumer a dunning notice stating that the consumer must pay the full premium amount to the plan or lose coverage. HCTCs may reimburse such full premium payments at the end of the year, after tax forms are filed. However, these beneficiaries are terminated from advance payment until they re-register.

Several details are important to add to this account. First, anecdotal reports suggest that the requirement of paying at least one month's premium in full has deterred applications by a number of laid-off workers eligible for HCTCs.[27] This is not surprising, as advance payment was premised on the inability of many such workers to front periodic premium payments without subsidies. To address this problem, the HCTC team is working to expedite processing of initial applications for advance payment and to cut to a minimum any required payment of full, monthly premiums. Moreover, several states are using NEG grants to provide 65 percent premium subsidies before the start of advance payment.[28] It is unclear how long NEG funds can play such a role, however. In addition, some states have had difficulty integrating NEG payments and HCTCs into a single, seamless process that is easy for beneficiaries.

Second, although there have been some reports to the contrary, several health plans have said that, from their perspective, advance payment has worked smoothly.[29] Obviously, smooth and predictable payments to health plans will encourage insurers to offer qualified state-based coverage.

Third, the IRS has categorically excluded spousal employer coverage from advance payment. The IRS expects that few such employers would participate, given the administrative challenges they would have to surmount as well as the small number of HCTC beneficiaries married to employees of any given firm. As explained below, this and other policy decisions about spousal employer coverage make it of very little value to most HCTC beneficiaries.

Finally, the administrative cost of advance payment and this general approach to coverage may be quite high. Such expenditures could be worthwhile if they primarily create a subsidy infrastructure that can then be expanded, at little marginal cost, to a much larger population. On the other hand, high administrative costs may need solid justification if they are part of ongoing program operations and expand proportionately as the number of beneficiaries grows.

C. Take-up

In December 2003 nearly 8,400 workers used HCTC advance payments to obtain health coverage.[30] This represented 3.6 percent of all individually identified, potentially eligible workers. Adding dependents, the total enrollment reached 13,247 by the end of December.[31]

If anything, it would be an overstatement to claim that 3.6 percent of uninsured workers potentially eligible for HCTCs enroll in advance payment. As explained below, many unemployment insurance recipients are

unknown to state workforce agencies and so are not included in the above number of individually identified, potentially eligible workers.

At another level, anecdotal reports suggest that many advance-payment participants had insurance before they started receiving HCTCs. In some cases, these beneficiaries report that they would have continued such coverage even without subsidies. Accordingly, some HCTC participation involves subsidies to the insured, rather than coverage of the otherwise uninsured.

Of course, lessening the financial burden of health coverage for laid-off workers and retirees is a worthy goal (albeit different than coverage expansion). In other contexts, some analysts have suggested that credits should go to similar households with or without health insurance. According to these analysts, denying credits to households with prior coverage would unfairly treat similar households differently and would penalize families for their prior sacrifices in purchasing health insurance.[32] On the other hand, other analysts believe that limited federal resources to cover the uninsured must be targeted as efficiently as possible at the uninsured, noting the difficulties national leaders have faced trying to commit significant funds to expand coverage.[33] This debate illustrates the importance, as the HCTC program goes forward, of monitoring the proportion of enrollees who were previously uninsured.

Table 3 shows the number of workers enrolled in advance payment, by state. It also compares the number of actual enrollees to the pool of potentially eligible workers who were known to state workforce agencies or the PBGC and whose identities were communicated to the HCTC program.

Table 3. Workers Enrolled in HCTC Advance Payment, December 2003

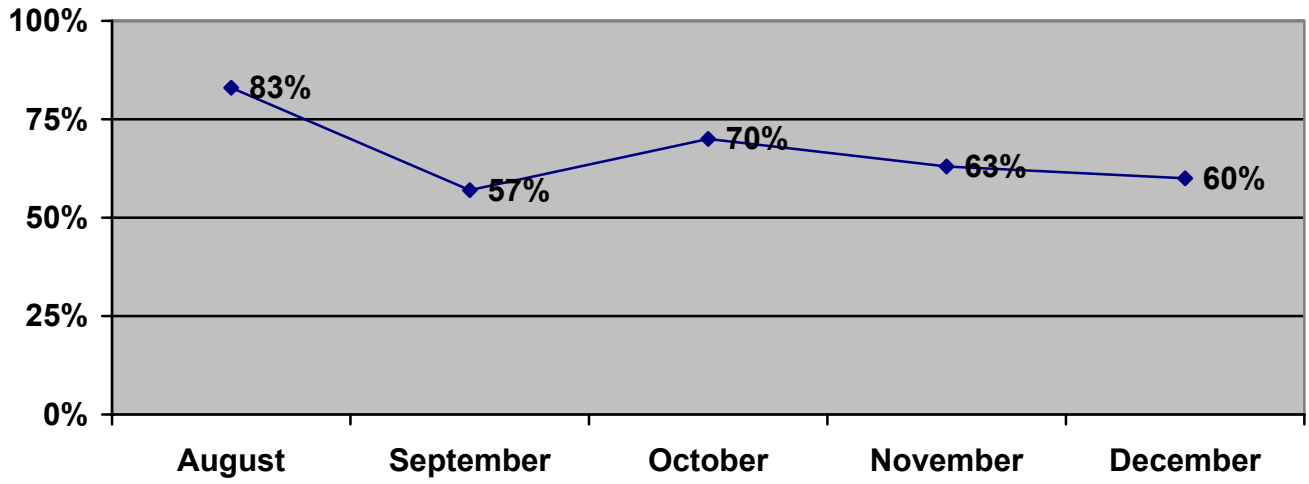
State	Number of Eligible Workers Enrolled	Percentage of Individually Identified, Potentially Eligible Workers
Alabama	82*	1.7%
Alaska	*	*
Arizona	36*	2.0%
Arkansas	18*	1.2%
California	245	2.6%
Colorado	28*	1.3%
Connecticut	37*	1.3%
D.C.	0	0.0%
Delaware	13	3.4%
Florida	283	2.4%
Georgia	56	0.7%
Hawaii	*	*
Idaho	37	2.4%
Illinois	304*	2.4%
Indiana	547	5.5%
Iowa	40*	2.2%
Kansas	19	1.1%
Kentucky	89*	2.2%
Louisiana	*	*
Maine	109*	5.7%
Maryland	485*	10.1%
Massachusetts	29*	0.6%
Michigan	454	5.9%
Minnesota	206	6.0%
Mississippi	24	1.4%
Missouri	192	2.7%
Montana	16	4.7%
Nevada	10*	1.3%
New England	11*	3.0%
New Hampshire	15*	1.2%
New Jersey	56*	0.9%
New Mexico	*	*
New York	326	3.0%
North Carolina	965*	6.3%
North Dakota	*	*
Ohio	471	2.9%
Oklahoma	16	0.6%
Oregon	50*	2.8%
Pennsylvania	1,869	7.9%
Puerto Rico	0	0.0%
Rhode Island	*	*
South Carolina	46*	1.1%
South Dakota	*	*
Tennessee	212*	2.6%
Texas	62*	0.7%
Utah	*	*
Vermont	*	*
Virginia	400*	5.3%
Washington	123*	2.0%
West Virginia	125*	4.3%
Wisconsin	94*	1.5%
Wyoming	0	0.0%
Total	**8,371**	**3.6%**

Notes. See Table 1.

Source. HCTC program, January 2004. Calculations by ESRI, February 2004.

Tending to hover around 60 percent, the proportion of HCTC advance-payment enrollees who are eligible based on PBGC responsibility (rather than TAA) has varied somewhat over the brief lifespan of this new program, as the accompanying chart (see Figure 2) illustrates.

Figure 2. Pension Benefit Guaranty Corporation Recipients as a Percentage of HCTC Advance Payment Participants, August 2003 Through December 2003



Source: HCTC Program, January 2003.[34] Note: While excluding dependents, these HCTC advance-payment participants include both enrollees and individuals in the process of registering for advance payment during a given month.

Clearly, it is too soon to come to any definitive conclusions about take-up. When year 2003 income tax forms are filed, additional workers will claim HCTCs. More fundamentally, this program is quite new, and HCTC enrollment almost certainly will grow over time. Program officials are at an early point on the learning curve, and "word of mouth" has not had much chance to spread. Nevertheless, a number of obstacles to high enrollment are already evident. In addition to the above-described challenges presented by advance payment, potential barriers include the following:

- ***Affordability of premium payments***. Although there is some evidence in the other direction,[35] most research suggests that few low-income families will take up subsidies that require them to pay anything like the 35 percent premium share born by laid-off workers using HCTCs.[36] On average, that share amounted to $1,714 per year for single coverage in December 2003.[37] Such costs would consume 13 percent of average-size TRA or unemployment insurance payments[38] or 5 percent of family income for a four-person household living at 200 percent of the federal poverty level ($36,800 in 2003). From studies of low-income subsidy programs and the purchase of nongroup coverage, a number of researchers have concluded that take-up falls below 40 percent of eligible individuals if as little as 3 percent of income is required to purchase health coverage.[39]

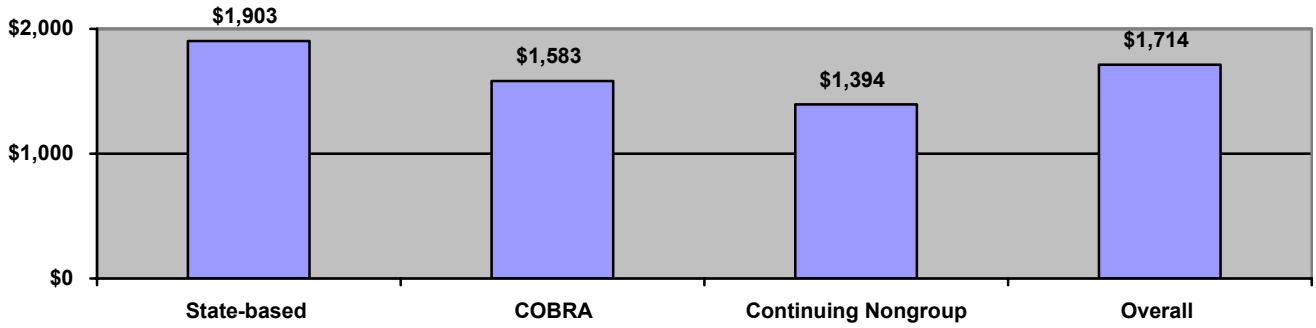
  Experts in unemployment insurance note that discretionary income is particularly hard to find in household budgets of laid-off workers; on average, family income drops by 40 percent when a worker is laid-off and receives unemployment insurance.[40] While actively employed and earning a paycheck, the average worker with employer-sponsored insurance made direct premium payments of $508 in 2003 for single coverage—significantly less than is required with HCTCs.[41] To be effective, HCTC's 65 percent subsidy thus requires many households to increase their payments for health insurance at precisely the time that their income drops.[42]

  Often, job loss makes it hard to pay basic living costs. According to a survey in May 2003, sizable proportions of unemployed workers have cut back spending on food (56 percent), lost telephone service (38 percent), or changed their housing arrangements by, for example, moving in with friends or relatives

(26 percent).[43] Many may feel they have no choice but to decline HCTCs that require substantial payments for health insurance premiums. As one recently unemployed worker explained, "People can't afford to pay the 35 percent. That would take up all my unemployment insurance money. I don't know what they expect us to do."[44]

It is worth noting that affordability could be a significant problem, whichever form of coverage HCTC beneficiaries use. Average HCTC costs remain high, regardless of the type of coverage purchased, as Figure 3 illustrates.

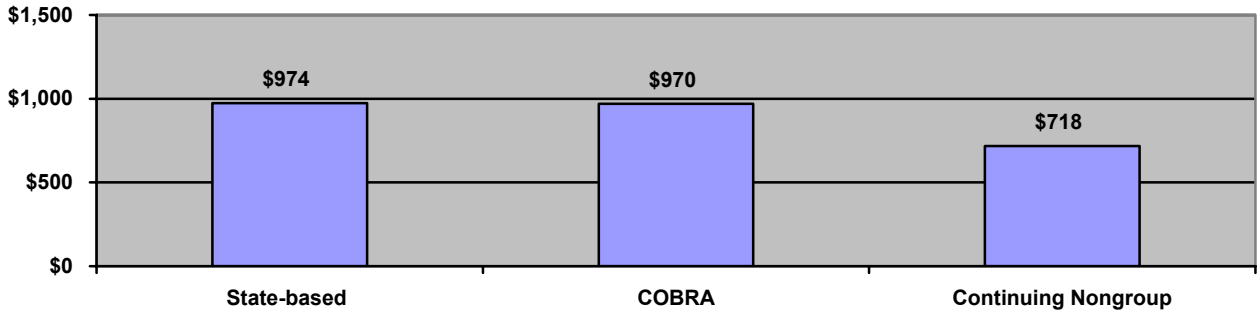
Figure 3. Average Annualized 35 Percent Premium Costs for One-Person Policy, by Type of Coverage, December 2003



Source: HCTC Program, January 2004.

Costs exceed the $508 average for employer-sponsored insurance, even for the least expensive coverage purchased by HCTCs, as shown by Figure 4.

Figure 4. Average Annualized 35 Percent Premium Costs for One-Person Policy Within the Lowest Quartile of Cost, by Type of Coverage, November and December 2003



Source: The Lewin Group, data for November and December 2003.[45] Calculations by ESRI, February 2004. Note: These premium costs average the numbers from November 2003 and December 2003 to minimize distortions resulting from the small number of observations in each quartile.

This affordability problem is made worse because HCTC beneficiaries do not always have the option to select the least expensive qualified coverage. Some beneficiaries are limited to higher-premium plans because their states do not offer limited-benefit, lower-premium plans. Moreover, some beneficiaries are unable to access low-priced coverage because of their age, gender, or (in some states) health status. According to our survey, older beneficiaries were charged the highest premiums even for the lowest-cost plans, as shown in Table 4.

Table 4. Cost and Coverage of the Least Expensive State-Based Plans in the Median-Priced, Surveyed States for Various Combinations of Age, Gender, and Health Status, November 2003

Age and Gender of Healthy Beneficiary	Annualized 35% Premium Payments Required for the Least Expensive Plan in the Median-Priced State for the Age and Gender Combination	Deductible and Selected Other Plan Features
25, male	$605	$2,500 deductible
25, female	$647	$10,000 deductible, no maternity care
42, female	$948	$2,500 deductible
60, male	$1,296	$2,500 deductible

Source: ESRI Survey. How to read this table: (1) For a healthy, 25-year-old man, this table describes the least expensive coverage in the median-priced state for such men. That state was selected by comparing the cost to a healthy 25-year-old man of the least expensive plan in each of the 15 states surveyed. The lowest-cost coverage in that median state had an annual 35 percent premium cost of $605 for such a man and included a $2,500 deductible. Such men needed to pay more for the least expensive coverage in seven states and less in seven. (2) For a healthy, 25-year-old woman, this table describes the least expensive coverage in the median-priced state for such women. That state was selected by comparing the cost to a healthy, 25-year-old woman of the least expensive plan in each state. The lowest-cost coverage in that median state had an annual 35 percent premium cost of $647 for such a woman and included a $10,000 deductible, with an exclusion of all routine maternity care services.

High costs (often with sharply limited benefits) thus appear inevitable in many states for all but the youngest workers. This may have a serious impact on HCTC take-up, because so many eligible workers are middle-aged or older. Pension Benefit Guaranty Corporation–based eligibility is limited to workers age 55 to 64; ATAA beneficiaries likewise must be age 50 or older; and according to the most recent published data, TAA beneficiaries have an average age of 42, with 59 percent over the age of 40.[46]

Some limited, early evidence suggests that, in fact, low-income HCTC beneficiaries are often turning down the credit. In Maryland, half of Bethlehem Steel's PBGC retirees have pensions below $10,780 a year. Only 5 percent of such retirees enrolling in Maryland's state-based HCTC coverage have pensions below that level. Similarly, according to informal focus groups in Maine, HCTC-eligible individuals typically have room in their household budgets for only $100 a month to pay for family coverage; but the worker's 35 percent premium share for state-based, family coverage in Maine is between $219 and $351 a month.[47]

In this context, it may be useful to track the experience of states that increase affordability for low-income HCTC beneficiaries. As will be explained below, New York offers particularly promising state-based coverage with special, discounted premiums for low-income enrollees.

- ***Consumer confusion and outreach problems***. This second obstacle to take-up applies in different ways to two groups of potentially eligible workers: those whom state and federal agencies have identified as potentially qualified for HCTCs; and those who are unknown to state and federal agencies. Each group is discussed in turn below.

  - **Individuals previously known to state and federal agencies**. HCTC outreach to several populations is fairly straightforward. Pension Benefit Guaranty Corporation retirees, TRA recipients, and ATAA recipients are all identified individuals, with addresses that are known to the PBGC and state workforce agencies. The HCTC team has pursued a sensible strategy of mailing each identified individual in these groups an HCTC program kit to prompt HCTC applications, offering a toll-free number if further information or assistance is needed.

    Although this general approach is promising for these eligibility groups, the specific outreach materials and strategies employed are not highly developed, compared to methods employed by

mature SCHIP and Medicaid programs.[48] The HCTC program kits are 20 pages long and cover complex topics in some detail.[49] Although prepared with input from communications professionals, these kits may or may not be easily understood by the target population. Kits are available in Spanish, but not other languages. This will limit their impact, if it turns out that a significant portion of HCTC-eligible workers in particular areas do not understand English or Spanish.

To illustrate the challenge of effectively educating the target population about this new and complex program, the General Accounting Office found that approximately 80 percent of TAA recipients in fiscal years 1999 and 2000 had a high school education or less.[50] (Of course, the average education level of laid-off workers varies by industry and geographic area; some layoffs involve a higher proportion of well-educated workers.) One state official described the HCTC program as "hugely complicated and difficult to explain to people…. Some people in manufacturing are functionally illiterate and you need to explain it in a face-to-face meeting."[51]

At in-person outreach events, many potentially eligible individuals have found it hard to understand this new system of health coverage subsidies. HCTC officials have frequently had to spend 20 minutes or more per consumer explaining the program. Not only does this involve very high administrative costs per enrollee, in the future many individuals are unlikely to get the benefit of such intensive person-to-person information. If the resulting confusion causes a misstep that prevents enrollment or inadvertently terminates advance payment, many eligible individuals will not receive coverage.

In part because of these program features, the information developed by federal authorities is not always easily understandable. For example, the following is a paragraph from a draft notice that the Department of Labor provided to state workforce agencies as a model for informing laid-off workers about HCTCs:

> "With respect to coverage under COBRA, there is a new provision in the Employee Retirement Income Security Act of 1974 that provides an additional COBRA election period for certain eligible TAA recipients. Under this provision, if you did not elect continuation coverage under the regular COBRA election period, you may elect continuation coverage within the 60-day period that starts on the first day of the month when you are determined to have met the definition of an eligible TAA recipient. However, such election may not be made later than six (6) months after the date you lost coverage as a result of your separation from employment that resulted in you becoming an eligible TAA recipient."[52]

Many eligible workers may have difficulty understanding this kind of language.

- **Individuals not previously known to state and federal agencies**. Outreach is even more challenging for the final HCTC-eligible group: namely, laid-off workers receiving unemployment insurance who meet all requirements for TRA benefits except exhaustion of unemployment insurance. Although TRA benefits can last longer than unemployment insurance, this is clearly one of the largest groups of HCTC-eligible workers. By definition, TRA recipients all previously received unemployment insurance; but many other workers displaced by trade find a new job before their unemployment insurance ends,[53] so never receive TRA benefits.

  However, except for the individuals who petition the Department of Labor, the names of displaced workers formerly employed by adversely affected firms are not on any list that state workforce agencies or the Department of Labor receive routinely. Put differently, this is the one group of HCTC eligibles with many workers whose identities are unknown to state workforce agencies and the PBGC. Accordingly, many of these workers do not receive HCTC program kits and may never begin the process of eligibility determination for HCTCs.

As a result, these unemployment insurance recipients do not obtain HCTCs unless they receive and understand messages, directed at a part of the general population in which they are included, that prompt them to apply for TRA benefits. To compound matters, the program's consumer education materials do not tell this large group of potential HCTC beneficiaries how to apply for health coverage. Neither the program kit[54] nor sample education materials from the Department of Labor[55] mention that unemployment insurance recipients must apply for TRA payments in order to be considered for HCTCs.

Even if outreach materials were revised to highlight this essential step, educating unemployment insurance recipients about HCTCs would remain a challenge. The message about HCTCs is not easy to convey. Many unemployment insurance recipients may be uncertain whether they qualify for HCTCs because they may not know whether their former employer has been certified by the Department of Labor as adversely affected by trade. Moreover, it may seem paradoxical and confusing that, to obtain health coverage, workers must apply for TRA benefits, even though those benefits are not available until unemployment insurance ends, potentially many months in the future.

Not only might this be a confusing message for many workers, it must be combined with information about other time-sensitive steps required to obtain and retain HCTCs. Notably, to meet another eligibility requirement for TRA benefits (hence HCTCs), these unemployment insurance recipients must either obtain a waiver of TRA job training requirements or enter a job training program within eight weeks of Department of Labor certification of the former employer as trade-affected or 16 weeks of the individual worker's job loss, whichever comes last.

Because it is not easy for state workforce agencies new to health coverage issues to communicate clearly and accurately about HCTCs, many state workforce agencies are simply asking workers to contact the HCTC consumer help line for information about health coverage. But this understandable decision means that fewer displaced workers will apply for HCTCs. Without clear and simple advice from state workforce agencies, many displaced workers may not sort through the complexities of HCTCs and glean an understanding of what they must do to obtain and retain health coverage.

These problems are made still worse by the daunting communications environment in which state workforce agencies must operate. These state agencies (including their rapid response teams) are responsible for informing laid-off workers about a broad range of services, including TRA benefits, unemployment insurance, workers' compensation, reimbursement for certain job training and relocation costs, available employment, job search strategies, rights to pensions from former employers under the Employee Retirement Income Security Act of 1974 (ERISA), rights to continuation of health coverage from former employers under COBRA, stress management, financial management strategies, and more. The affected families are often highly distressed, for understandable reasons. They may not easily absorb messages about HCTCs that are included along with significant amounts of other information.

As indicated above, a number of states have joined with federal officials to conduct education and enrollment events, working with unions, employers, health plans, and others. Of course, these events have been small, relative to the total eligible population.[56] Except for employers that attract significant attention because of major financial setbacks, in many states the kind of community-based outreach to as yet unidentified, but potentially eligible families that proved essential to effective SCHIP implementation does not appear to have taken place with workers eligible for TAA.

- ***Potentially limited appeal of coverage options***. Unsurprisingly, much of the general take-up literature suggests that the value of a given benefit has a dramatic impact on take-up rates.[57] In this context, however, value is in the eye of the beholder, and we do not yet know the types of health coverage preferred by HCTC-eligible workers. As shown below, many states offer qualified coverage with very large deductibles or other stringent limits on covered benefits, with preexisting condition exclusions for

workers with recent coverage gaps of 63 days or more; this could make enrollment with 65 percent subsidies appear, on balance, not a wise decision for unemployed workers watching their pennies.

While employed and receiving a paycheck, very few people have enrolled in basic plans in the 43 states where they were included in small-group market reforms of the 1990s. In New Jersey, for example, no more than 0.03 percent of small employers use low-benefit plans, and such plans accounted for only 4.2 percent of nongroup market sales until the state terminated their use in that market.[58]

Of course, laid-off workers in financial difficulty may have different preferences, seeking more limited coverage with lower premium costs. In fact, anecdotal evidence suggests that one factor inhibiting take-up is that some HCTC beneficiaries desire lower-cost (hence less comprehensive) coverage than any qualified options available in their states. In some cases, these anecdotes have involved households with assets to protect from catastrophic health care costs or workers who were previously enrolled in retiree or nongroup coverage that does not qualify for HCTCs. As with many other key issues, time will be needed to determine the proportion and characteristics of laid-off workers who are willing to use HCTCs to purchase state-based coverage with significantly fewer benefits (at lower cost) than typical employer-sponsored insurance.

On a related topic, the availability of state-based options apparently influences enrollment in HCTC advance payment. Take-up rates are 4.2 percent in states that offer such coverage, but only 1.7 percent in those that do not. Surprisingly, this difference applies even to enrollment in COBRA plans, which rises from 1.1 percent of identified, potential eligibles where state-qualified coverage is not offered to 1.7 percent where such coverage is available. Notwithstanding this apparent impact of state-based coverage on enrollment, because 75 percent of identified, eligible workers now live in states where such coverage is offered, and because take-up is low everywhere, increasing the number of states with state-qualified insurance would not increase enrollment dramatically. If every state offered such coverage with the same 4.2 percent enrollment rate currently found in states with qualified insurance, take-up would rise only modestly from the current 3.6 percent level, with the number of enrolled workers increasing from nearly 8,400 to roughly 9,900.[59]

Finally, aggregate enrollment numbers available indicate that limits on available health plan options are probably not the primary factor limiting take-up at this early point in the program. States vary greatly in the types of coverage they make available to HCTC recipients, as discussed below. Nevertheless, no state, regardless of the qualified plans it offers, has enrolled more than 10 percent of identified, potentially eligible workers into HCTC advance payment.

- ***Trade Adjustment Assistance training requirements***. As noted above, workers who are eligible for HCTCs because they would qualify for TRA benefits but for their receipt of unemployment insurance must participate in TAA job training programs or obtain a waiver. However, such training programs frequently have waiting lists or close down during school vacation or late in calendar quarters when federal training funds dwindle.[60] Although in theory laid-off workers should be able to obtain a waiver of training requirements when training programs are unavailable, states have sometimes disregarded instructions from the Department of Labor to continue serving laid-off workers when training programs are closed down.[61] Moreover, one important lesson of the SCHIP experience is that each additional procedural step required for health coverage causes more eligible beneficiaries to remain uncovered, to disenroll from coverage, or both. Also, the requirement of prompt application for training programs as a precondition of HCTC eligibility is one more message piled atop an already overburdened and under-resourced outreach and consumer education system.
- ***Absence of automatic payment mechanisms.*** Neither the PBGC nor state workforce agencies give HCTC-eligible individuals the option to have their share of health insurance premiums automatically withheld from regular payments and forwarded electronically to the HCTC program. Such automatic payment mechanisms have made a tremendous difference to take-up rates in a variety of public and

private programs, ranging from Medicare to 401(k) plans.[62] In part, the absence of advance-payment mechanisms may result from payment periods that are not monthly. Both unemployment insurance payments and TRA payments are weekly, for example, and some PBGC retirees receive lump-sum, rather than periodic, pension payments. Reconciliation with HCTC's monthly premium payment requirements may not be simple. Moreover, changes in state law could be required to make unemployment insurance withholding possible. While these obstacles could perhaps be surmounted through careful program redesign, the absence of automatic payment mechanisms means that confusion, temporary incapacity, forgetfulness, neglect, or a problem with the mail can end advance payment for one or more months and possibly terminate health coverage, as explained above.

One final comment on the topic of take-up is important. If HCTCs were expanded to a different group of uninsured, the take-up rate might change, simply because the new beneficiaries would have different characteristics. For example, if HCTCs were extended to unemployment insurance recipients, many of the unique features of the TAA system that impede take-up would no longer apply, such as the requirement that, to obtain HCTCs, unemployment insurance recipients must apply for TRA payments for which the workers are ineligible, and that workers must obtain waivers when TAA training programs are closed.[63] Similarly, if HCTCs went to low-wage workers who had not experienced recent large losses in income and did not anticipate large future increases in income, such workers might assess very differently the costs and benefits of paying a 35 percent share of health insurance premiums. In addition, if a new group of beneficiaries had a younger average age, lower premiums might be charged, which could increase enrollment.

D. Automatically Qualified Coverage

This section discusses implementation of the three types of automatically qualified coverage for which, anywhere in the country, HCTCs may be used: COBRA coverage, coverage available through certain employers of spouses, and continuation of nongroup coverage for certain workers.

1. COBRA Coverage

By the end of December 2003, 56 percent of enrolled HCTC beneficiaries nationwide were in COBRA plans.[64] Some federal officials estimate that among all HCTC-eligible workers, whether or not they are enrolled in the program, roughly 40 to 60 percent have access to COBRA coverage. The range isn't higher because many of these workers' former employers have gone out of business or no longer offer health coverage and so are exempt from the requirement to offer COBRA coverage.[65]

2. Coverage from Spousal Employers

Spousal employer coverage has considerable appeal, in theory. It could be relatively affordable to workers, because HCTCs and partial employer subsidies together would reduce the displaced worker's premium costs substantially. Philosophically, some policymakers support leveraging public dollars to maximum effect by using them to supplement employer resources dedicated to health insurance, as shown by the repeated enactment of premium assistance programs for Medicaid and SCHIP.[66]

However, two federal decisions have made this option useless for most HCTC beneficiaries. The first is the policy decision, described above, not to offer advance payment for spousal employer coverage. As a result, HCTC beneficiaries whose limited resources require advance payment to take advantage of HCTCs will be unable to use the credits to enroll in spousal employer coverage. The IRS may revisit this decision in the future.

Second, the IRS has interpreted the Trade Act to require that, for spousal employer coverage to qualify for HCTCs, the employer must pay less than 50 percent of health insurance premiums *for the entire family*, including the employed spouse. Very little employer-based coverage meets that standard; on average, 76.8 percent of family premiums are paid by employers.[67]

Instead, the IRS could have interpreted the Trade Act to classify spousal employer coverage as qualified if the employer pays less than 50 percent of health insurance premiums *for dependent coverage that includes the HCTC beneficiary.* That interpretation may have brought much more coverage within reach of HCTCs. According to a national survey the Employee Benefit Research Institute conducted between July and September 2002, 41 percent of small employers (with between 2 and 50 employees) offer dependent coverage but pay less than 50 percent of premiums for such coverage.[68] While comparable national survey data about employers of all sizes have not been published, a survey of California employers in October and November 2001 found that 48.8 percent of employers in that state, of all sizes, paid less than 50 percent of premiums for dependent coverage.[69]

On the other hand, the IRS's interpretation of the 50 percent rule simplifies auditing, which is a legitimate consideration. An illegal claim for which an employer paid less than 50 percent of a family's premium can be detected relatively simply by comparing the employer's payment with the full premium amount received by the plan and amounts withheld from the worker's paycheck. Determining whether the employer paid less than 50 percent of dependent coverage, on the other hand, could require allocating an employer's contribution between worker coverage and dependent coverage, examining premium payments for other workers at a firm, reviewing employer personnel policies, and other factors. That said, the combination of defining qualified spousal employer coverage narrowly and exempting it from advance payment means that few HCTC beneficiaries are likely to use this otherwise promising source of potential coverage.

3. Continuing Nongroup Coverage for Workers Enrolled in Nongroup Plans Before Separation from Employment

Federal officials believe that few HCTC-eligible workers meet the statutory requirement of enrollment in nongroup coverage during the final 30 days before job loss or other qualifying event. Nevertheless, fully 4 percent of all HCTC advance-payment enrollees in December 2003 used this form of coverage.[70] Some have suggested that many of these enrollees could be claiming credits in error and that, in fact, their coverage does not fit the statutory requirements. On the other hand, HCTC-eligible individuals with ongoing health coverage (including through nongroup plans) that precedes HCTC eligibility may be particularly likely to take up credits, because credits defray existing household costs. By contrast, take-up is likely to be much lower among uninsured households, who would have to increase their spending for health insurance to take advantage of credits. Accordingly, even if HCTC-eligible workers who had nongroup coverage before job loss constitute a very small percentage of all *eligible* workers, they could comprise a nontrivial percentage of eligible workers who *enroll,* which is broadly consistent with current numbers.

E. State-Based Coverage

1. State Choices to Offer Coverage

By the end of 2003, 26 states (plus Washington, D.C.) offered state-based, qualified coverage to their residents with HCTCs.[*] Three out of four workers (75 percent) identified as potentially eligible for HCTCs lived in those states.[71] By itself, this widespread adoption of state-based coverage was a remarkable accomplishment, coming less than eighteen months after the Trade Act was signed into law. To make such coverage available, many states had to pass new laws, in some cases during brief legislation sessions. Creation of state-based HCTC coverage systems thus had to compete for time and attention with serious state budget crises and major health coverage cutbacks. Nevertheless, many states acted quickly to offer their residents state-based, HCTC coverage.

That said, 24 remaining states (plus Puerto Rico) do not offer state-qualified plans. Accordingly, potentially eligible workers in those states without access to COBRA or other automatically qualified coverage cannot

[*] An additional three states offered only mini-COBRA coverage, which federal officials believe is not available to more than a handful of HCTC beneficiaries.

use HCTCs to purchase insurance. This failure to provide state-based coverage may result, in part, from the difference between state insurance laws and the Trade Act's consumer protection requirements. For example, the federal Health Insurance Portability and Accountability Act (HIPAA) bars preexisting condition exclusions for certain individuals with 12 months of continuous, prior coverage. Some states reduce that period, but not to the three-month period that triggers consumer protections under the Trade Act. Accordingly, states have needed to pass legislation to convert existing forms of coverage into qualified plans under the Trade Act. This difference between Trade Act consumer protections and more familiar federal and state safeguards may have also affected some health plans' willingness to participate. Plans lack experience with groups of consumers defined in terms of HCTC eligibility and may fear that, with an unusually short required period of prior continuous coverage, adverse selection could result, with sicker workers disproportionately choosing to enroll. If health plans do not participate, states cannot offer state-qualified coverage.

Probably more important is that the states with the smallest populations of HCTC-eligible workers have generally been the least likely to undertake the work required to offer state-qualified coverage, presumably because they have the least to gain. In December 2003, the typical state with state-based coverage had more than three times as many potentially eligible workers as did states not offering such coverage (4,221 in the median state with qualified coverage vs. 1,750 in the median state without such coverage).[72]

2. Broad Overview of State-Based Plans

In the states offering qualified plans, 48 percent of HCTC advance-payment enrollees in December 2003 used COBRA coverage, 48 percent used state-based insurance, and 4 percent retained the nongroup coverage they had before separation from employment.[73] By the end of December 2003, states either offered or were preparing to make available state-based, qualified coverage as follows:

- In nine states, mini-COBRA coverage was available to HCTC beneficiaries.
- In 11 states, all HCTC beneficiaries were offered nongroup coverage with medically underwritten premiums that varied based on the insurers' assessment of each individual's health risks.
- In 13 states, high-risk pool coverage was available. Except for Maryland's pool and one new option created in Connecticut, these pools predated the Trade Act.
- In six states,[74] HCTC beneficiaries were offered other plans that were community rated. Most of these plans used pure community rating, charging all beneficiaries within a single geographic area the same premium for each class of coverage (such as worker-only or family coverage). Some plans in this category used modified community rating, with premiums that varied based on such factors as age and gender, but without any individualized assessment of health risk.

Table 5 shows the types of state-based coverage available in each state.

Table 5. Categories of State-Based, HCTC Coverage, November and December 2003

State	Mini-COBRA	High-risk Pool	Other Community-Rated Plans	Medically Underwritten, Nongroup Coverage
Alabama				X
Alaska		X		
Arkansas		X		
Colorado	X	X		
Connecticut	X	X	X[75]	
D.C.				X
Florida	X			X
Illinois		X		
Indiana				X
Iowa		X		
Kentucky	X			
Maine			X	
Maryland		X		
Michigan			X	
Minnesota		X		
Montana		X		
Nebraska	X			
New Hampshire		X		
New Jersey	X			
New York	X		X	X
North Carolina				X
North Dakota		X		
Ohio	X			X
Pennsylvania			X	
South Carolina		X		
Tennessee				X
Texas		X		X
Vermont	X		X	
Virginia				X
West Virginia				X
Total	**9**	**13**	**6**	**11**

Sources. HCTC program, January 2004;[76] IRS, November 2003.[77]

One rough indicator of these plans' appeal to HCTC beneficiaries is the percentage of advance-payment enrollees who select state-qualified coverage, rather than COBRA or other automatically qualified plans. That number varies considerably among the states. The causes of this differential enrollment are not clear, at this early stage of program operation. However, lower premiums for state-based plans seem modestly associated with higher enrollment in such plans. For example, among states where fewer than 50 percent of the state's HCTC beneficiaries enrolled in state-qualified plans, the median 35 percent annual premium payment for single coverage was $1,718. In states where more than 50 percent participate, the median payment is $1,573, or 9 percent lower.[78]

Another factor that may be relevant is the type of coverage offered by the state. As Table 6 shows, high-risk pools are associated with very low enrollment into state-based plans. By contrast, nongroup plans and community-rated coverage are both associated with higher levels of enrollment.

Table 6. Enrollment in State-Qualified Coverage, by Coverage Type: December 2003

		Type of plan offered as state-based coverage		
		High-risk pools	**Nongroup plans**	**Community-rated plans**
Proportion of Advance Payment Enrollees Choosing State-Based Plans	Median percentage	15 percent	55 percent	47 percent
	Average percentage	21 percent	49 percent	51 percent

Source: HCTC team, January 2004; Calculations by ESRI, March 2004.

To be sure, this preliminary analysis of differential enrollment must be taken with a grain of salt. It is based on data from just one month's enrollment. Much more time will be required to identify any statistically significant relationships between enrollment levels of state-qualified plans, premium prices, type of coverage offered, comprehensiveness of benefits, characteristics of HCTC enrollees in each state, and other factors. In short, these early results are suggestive rather than conclusive. Table 7 shows all of this information, by state.

Table 7. Enrollment in State-Qualified Coverage and Possible Related Factors, November and December 2003

		State-Qualified Coverage		
State	**Number of Advance-Payment Participants**	**Type**	**Average annualized 35% premium cost, one-person policy**	**Percentage of Participants Choosing State-Based Coverage**
AK	0	High-risk		n/a
AL	82	Nongroup	$741	7%
AR	18	High-risk	$1,718	*
CO	28	High-risk	$1,016	*
CT	37	High-risk		0%
DC	0	Nongroup		n/a
FL	283	Nongroup	$2,354	37%
IA	40	High-risk		0%
IL	304	High-risk	$2,715	55%
IN	547	Nongroup	$1,688	36%
MD	485	High-risk	$1,583	53%
ME	109	Community-rated	$1,859	60%
MI	454	Community-rated	$1,573	82%
MN	206	High-risk		58%
MT	16	High-risk		0%
NC	965	Nongroup	$1,611	81%
ND	0	High-risk		n/a
NH	15	High-risk	$1,033	*
NY	326	Community-rated, Nongroup	$1,321	33%
OH	471	Nongroup	$1,483	74%
PA	1869	Community-rated	$1,718	28%
SC	46	High-risk	$2,575	15%
TN	212	Nongroup	$1,323	4%
TX	62	High-risk	$2,201	15%
VA	400	Nongroup	$1,199	75%
VT	0	Community-rated		n/a
WV	125	Nongroup	$1,422	75%

Sources. HCTC team January 2004; The Lewin Group, data for November and December 2003. Calculations by ESRI, February 2004. Notes: (1) Asterisks show states with between one and four enrollees into state-qualified coverage. (2) Enrollment numbers are for December 2003. (3) The Lewin Group's data were used to estimate the average premium cost for each state. November and December premium numbers were averaged because, with small groups of enrollees, significant monthly fluctuations in average premium price can easily occur based on small changes in enrollee demographics, such as a few older or younger workers enrolling or leaving a state-based plan.

To gain a more detailed but still preliminary understanding of state-based coverage, we selected 15 states for closer examination: Alaska, Colorado, Connecticut, Illinois, Indiana, Maine, Maryland, Michigan, Montana, New York, North Carolina, Ohio, Pennsylvania, Texas, and Virginia. We chose states that would form a diverse and broadly representative sample in terms of the following characteristics: types of state-based coverage offered to HCTC beneficiaries; regions of the country; state sizes; health insurance markets; labor markets; demographic tendencies of state residents; and political environments. We gathered information about HCTC-qualified coverage in these states through the Internet and communications with state and health plan officials. We obtained premium quotes for several individual profiles (25-year-old man, 25-year-old woman, 42-year-old woman, 60-year-old man) and health risk levels. For plans that charged different premiums in different areas, and in states offering different plans in various counties, we sought quotes and plan information for residents of the state capital. The following sections of this report go through our findings in some detail, but a list of key observations and high points may be helpful at the outset.

First, the HCTC approach to health coverage involves much less regulation than most previous national efforts at coverage expansion through Medicaid or SCHIP. HCTCs have no minimum benefit requirements or premium rating rules (other than nondiscrimination requirements). To a large degree, HCTCs are simply a financing mechanism, with many critical coverage choices left to health plans and states. One important goal of this report is to educate policymakers about the empirical consequences of this innovative approach to health coverage expansion.

Second, most of the states we examined offered HCTC beneficiaries a choice of multiple plans, particularly in the states using high-risk pools and nongroup coverage. The most common variation was a choice of deductibles, typically ranging between a low of $250 to $500 and a high of $2,500 to $5,000.

Third, no state offered coverage as generous as typical employer-sponsored insurance (ESI), but some came close in providing one or more options with relatively comprehensive benefits. Some officials suggest that coverage less generous than ESI could be acceptable to many laid-off workers, who may prefer to pay as little as possible, even if that entails limited benefits.

Fourth, the cost of state-based coverage varied considerably, depending on the state and the individual purchasing coverage. Among the 15 states we examined, 12 varied premiums by age; eight also varied them by gender;[79] seven varied charges based on area of residence; and five states also used medical underwriting to determine premiums by assessing each individual's health risk level.[80] Table 8 shows, by state and coverage type, the factors that can affect premiums charged to HCTC beneficiaries in these 15 states.

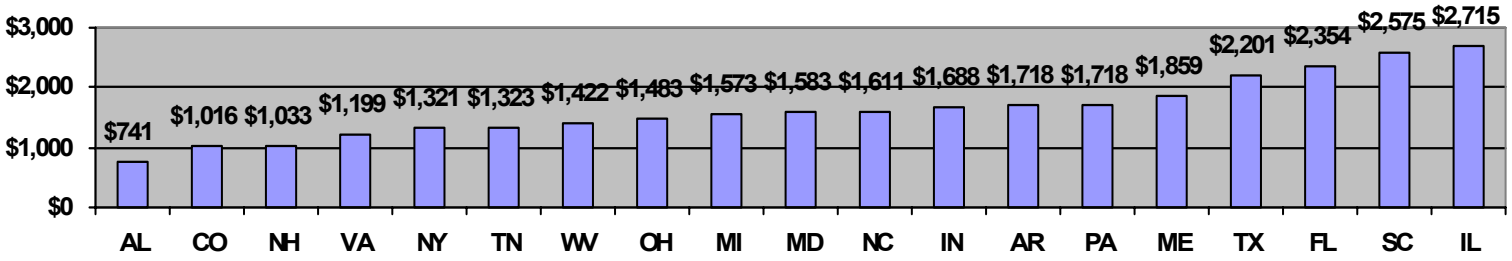
Table 8. Premium Variation, HCTC State-Based Coverage, November 2003

State (and Plan)	Basis for Premium Variation				
	Age	Gender	Geography	Individual Medical Underwriting	None
Nongroup Plans					
Indiana	X	X	X	X	
North Carolina	X	X	X	X	
Ohio (Anthem)	X	X	X	X	
Ohio (Aegis)	X		X	X	
Texas[81]	X	X	X	X	
Virginia	X	X	X	X	
High-risk Pools					
Alaska	X				
Colorado	X	X	X		
Connecticut	X	X			
Illinois*	X	X			
Maryland	X				
Montana	X				
Texas	X	X	X		
Community-Rated Plans					
Connecticut[82]	X	X			
Maine	X				
Michigan					X
New York			X		
Pennsylvania					X

* If the beneficiary has coverage gaps, the premium is significantly higher.

National data confirm that the spread of premium costs for HCTC coverage is quite broad, regardless of plan type. Among the states, average premiums vary by a factor of nearly four to one, as shown by the following chart:

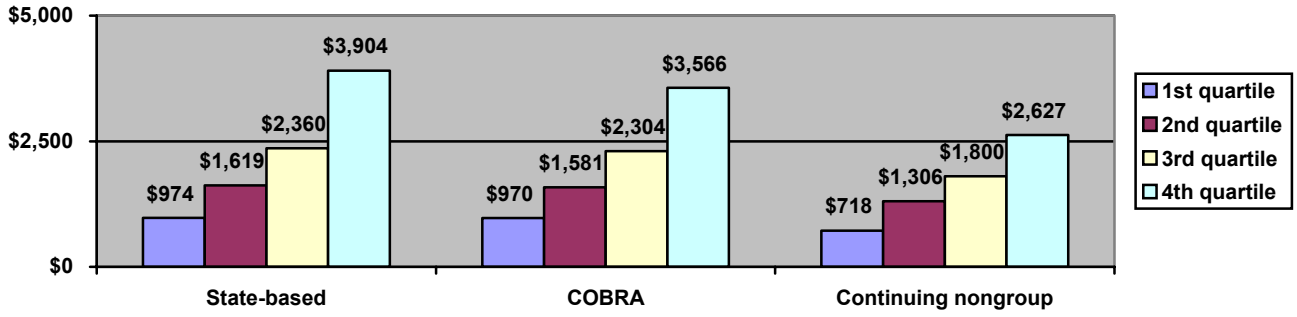
Figure 5. Average Annualized 35 Percent Premium Costs for a One-Person, State-Qualified Policy, by State: November and December 2003



Source: The Lewin Group, data from November and December 2003. Calculations by ESRI, February 2004. Note: because monthly quartiles for three types of qualified coverage contain many small populations, these numbers represent the average of applicable premium costs for November and December.

As the following chart illustrates, the highest-quartile premiums paid by HCTC beneficiaries were more than three times the size of the lowest-quartile premiums, for any given type of qualified coverage.

Figure 6. Average Annualized 35 Percent Premium Costs for One-Person Policies Nationally, by Type of Coverage and Quartile of Cost: November and December 2003



Note: See Figure 5.
Source: The Lewin Group, data from November and December 2003. Calculations by ESRI, February 2004.

In some ways, the impact of these differentials on beneficiaries can best be seen through concrete examples. For example, in North Carolina, where the state offered a medically underwritten, nongroup plan:

- A healthy, 25-year-old man could purchase a fairly comprehensive state-qualified policy with a $250 deductible by making a 35 percent premium payment of $576 a year.
- A healthy, 25-year-old woman buying that same policy would, if she wanted routine maternity care included, have to pay $1,908 a year as her 35 percent premium share. To bring that 35 percent premium payment down to $564 a year, she could select a policy with a $1,000 deductible and no coverage of maternity care.
- A healthy, 60-year-old man would need to make a 35 percent annual premium payment of $1,080 for a policy with a $5,000 deductible. If that man lacked continuous coverage before enrolling, his preexisting conditions would be excluded for 12 months.
- A 25-year-old man with significant prior health problems that placed him in the insurer's highest risk category would have to make 35 percent premium payments of $1,688 a year for a plan with a $5,000 deductible. If that man lacked continuous coverage before enrolling, the plan would exclude his preexisting conditions for 12 months.

As a contrasting example of community-rated, state-based coverage, the following are costs and coverage for the two plans available to Michigan's HCTC beneficiaries of all ages and health conditions for the 35 percent premium payments:

- $1,700 a year for a plan with a $250 deductible, $10 physician visit copayments, and 20 percent coinsurance;
- $1,400 a year for a plan with no deductible and 50 percent coinsurance.

For beneficiaries without recent, continuous coverage, both Michigan plans excluded preexisting conditions for six months.

These examples illustrate a key trade-off involving risk rating. If premium charges vary based on health risk factors, groups that use more health care are charged higher premiums. If instead beneficiaries are charged the same amount, regardless of health risk factors, the lower-risk groups can be required to pay more than under a risk-rated premium system. Ultimately, policymakers face a values-based choice between the principle that all beneficiaries should pay the same prices for the same coverage and the competing principle that those to whom the coverage is more valuable should pay more. Put differently, this involves deciding between: (a) a preference for each member of a community to share equally in the community's total costs;

and (b) a more individualized approach, where each individual bears his or her own expected costs and hidden cross-subsidies are minimized.

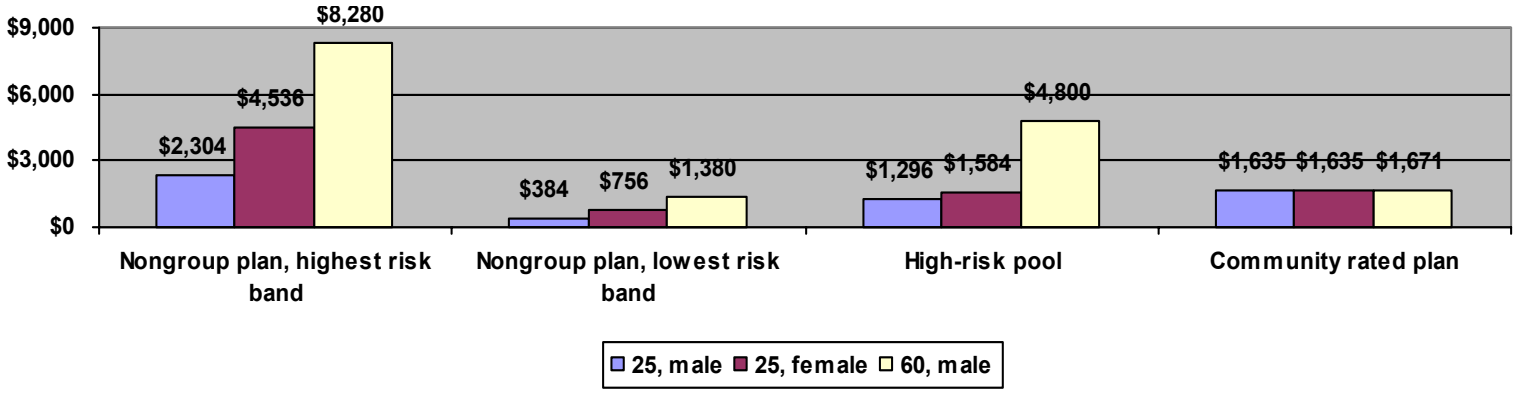
Some who usually support the latter, more individualized approach may nevertheless be troubled at the extent of the disparities that apply to state-based HCTC coverage. The combination of price differentials and preexisting condition exclusions means that some HCTC beneficiaries are, because of factors like age and gender that are outside their control, charged significantly more for much less coverage that may neither provide access to care nor, if preexisting conditions recur, protect against financial catastrophe.

These examples also illustrate a second difference in policymaker perspective, which concerns the role of interstate differences. Clearly, HCTCs buy very different types of coverage, for quite different prices, in different states. Some policymakers may view this as desirable, with states designing their health coverage systems based on varying local conditions and attitudes. Other policymakers may believe that, with a federal income tax credit for health coverage, whether that credit provides affordable access to essential health care should not depend on the credit beneficiary's state of residence.

A third issue concerns policymaker's varying preferences for more or less limited benefits. Because HCTCs require beneficiaries to pay 35 percent of premiums, some workers who would prefer more comprehensive insurance may instead feel limited, as a practical matter, to plans with large deductibles and other restrictions on covered benefits that do not typify employer-sponsored insurance. Some policymakers may support this as increasing consumers' incentives for cost-conscious decisions about health care utilization; shifting key decisions from insurers to consumers; permitting a finite sum of federal dollars to reach more workers; and returning health coverage to a true insurance model, limited to payment of large and unforeseeable expenses. Others may be concerned that high-deductible coverage might not yield the increased utilization of health care and resulting improvements in health status that are normally associated with health insurance.

Aside from these important, values-laden questions, the above examples illustrate several empirical issues. First, by comparison to community-rated plans, nongroup coverage and high-risk pools tended to offer more choices, less comprehensive coverage, and more distinctions based on age, gender, and (for medically underwritten coverage) health history. These tendencies had exceptions, however, and should not be overstated. For example, some nongroup plans in North Carolina and Virginia had deductibles of $300 or less and, for certain mental health services and prescription drugs, high cost-sharing and annual caps; but Maine's community-rated plan had a $1,000 deductible (which may soon be raised), and some community-rated plans in New York covered neither mental health services nor prescription drugs. Even as to average premium charges, the relationship between general category of coverage and cost varied greatly, depending on the state and on individual characteristics, as Figure 7 suggests.

Figure 7. Median 35% Annualized Premium Payment for One Insured in the Most Generous State-Qualified Plan, by Coverage Type, Age, Gender, and Risk: 15 Surveyed States, November and December 2003



Source: ESRI Survey.

Second, the appeal of state-based coverage, hence take-up, would increase if HCTCs covered more than a 65 percent subsidy. In that case, the amount of required payments from workers would decline to more affordable levels. Put differently, limiting all HCTC beneficiaries, regardless of income, to 65 percent subsidies reduces the appeal of all types of health coverage.

New York departs from this dynamic by lowering premium prices significantly for low-income beneficiaries.[83] There, state-based HCTC coverage includes Healthy New York plans, which HMOs wishing to operate in the state must offer to state residents whose family income is below 250 percent of the federal poverty level.[84] The premium for Healthy New York is lowered by the state's provision of reinsurance that covers certain health care costs. Accordingly, regardless of age, gender, and previous health problems, an HCTC recipient who is income-eligible for Healthy New York would have a 35 percent premium payment of $584 a year for fairly comprehensive coverage that includes prescription drugs and $512 for coverage that excludes such medication.[†]

It will be important to track New York's experience to see whether this more affordable premium cost for low- and moderate-income families has a significant effect on take-up. At this early stage, officials indicate that the majority of HCTC enrollees in New York State are ineligible for Healthy New York and so are enrolling in other forms of state-qualified insurance. This suggests that, even with scaled-back Healthy New York premiums, 35 percent premium payments may be more than most low-income households can afford.

3. Consumer Choice

Nine of the 15 states we examined offered five or more different health coverage options to HCTC beneficiaries. Nongroup plans tended to provide the most choices, followed by high-risk pools, then community-rated plans.

However, the most common variation simply involved a choice of deductibles. Aside from deductibles, most state-based coverage offered only one or two variations in covered benefits or types of insurance. Very few states provided HCTC beneficiaries with access to more than one insurance company (described in Table 9).

[†] As noted above, in states like New York, which vary premiums by geography, price quotes are for residents of the state capital. In this case, the text lists the lowest-price Healthy New York plan offered in Albany, the capital of New York State. In much more urbanized Manhattan, the lowest-price Healthy New York plan has premiums that are only 16 percent higher than in Albany.

Table 9. State-Based Coverage: Choices for HCTC Beneficiaries, November 2003

State	Number of Options	Type of Choices		
		Number of Insurers	Number and Type of Choices, Aside From Deductibles	Number and Range of Deductible Options
Medically Underwritten, Nongroup Plans				
Indiana	3	1	None	Three: $500 to $2,500
North Carolina	18	1	Two plans, with varying co-payments. For each plan, maternity coverage is optional.	Four for one plan: $250 to $2,500; five for the other: $500 to $5,000
Ohio	7	2	Two insurers structure benefits quite differently	Four deductible options for one plan: $500 to $5,000; for the other plan, three options for capping total reimbursement per spell of illness ($20,000, $10,000, or $2,500 per cause)
Texas[85]	5	1	None	Five options: $500 to $5,000
Virginia	12	1	Two plans, with varying co-payments. For each plan, maternity coverage is optional.	Three options per plan: $300 to $1,500
High-risk Pools				
Alaska	6	1	Two: indemnity plan and PPO	One for indemnity plan; five for PPO: $1,000 to $10,000
Colorado	5	1	None	Five: $300 to $5,000
Connecticut	4	1	Four: HMO, PPO, indemnity, low-income	One per plan
Illinois	8	1	One plan, with optional maternity coverage	Four: $500 to $2,500
Maryland	2	1	Two: a PPO and an HMO	One option per plan
Montana	2	1	None	Two: $1,000, $2,500
Texas	4	1	None	Four: $500 to $5,000
Community-Rated Plans				
Connecticut[86]	1	1	None	One
Maine	1	1	None	One
Michigan	2	1	Two plans, varying cost sharing	One per plan
New York	Very large number	Numerous	Three (nongroup, low income, higher-income)	One per plan
Pennsylvania[87]	4	2	None	Two per insurer: $750, $1,500

4. Covered Benefits

This section of the report compares benefits in state-based HCTC coverage to benefits offered by typical employer-sponsored insurance (ESI). This comparison is not intended to suggest anything about the desirability of typical ESI. Rather, it is motivated by three facts: first, most readers of this report are probably familiar with ESI, so it serves as a point of comparison that can be easily understood when reading about covered benefits in the new, HCTC program; second, ESI via COBRA coverage is a qualified option for HCTCs, so comparing it to state-based coverage illustrates the choices facing many HCTC beneficiaries; third, and in some ways most important, many HCTC beneficiaries' expectations of health coverage were formed while they received ESI, so ESI may be a benchmark to which such workers compare state-based plans in deciding whether they provide good value.

According to a national employer survey by the Kaiser Family Foundation and Health Research and Educational Trust,[88] ESI in 2003 had the following characteristic features:

- A deductible of $275 for in-network and $561 for nonnetwork care (average employer-sponsored PPO);
- No separate deductible for hospital care or prescription drugs (applicable to 56 and 92 percent, respectively, of workers with ESI);
- Prescription drug copayments of $9 for generic drugs, $19 for preferred name-brand drugs, and $29 for nonpreferred name-brand drugs (average employer-sponsored PPO);
- Physician office visit copayment of $15 or less (71 percent of workers with ESI);
- Coinsurance of 25 percent or less in network (91 percent of workers with PPO coverage through employers) and 39 percent or less out of network (65 percent of workers with such coverage);
- Annual coverage of at least 21 outpatient mental health visits (61 percent of workers with ESI);
- Annual coverage of at least 21 inpatient mental health days (71 percent of workers with ESI);
- Coverage of adult physicals (93 percent of workers with ESI), well-baby care (97 percent), maternity care (99 percent).

Although some came close, no state plan we examined offered HCTC recipients coverage that met this profile. Typically, state-based HCTC coverage, even the most generous version available within a state, involved higher deductibles than typical employer-sponsored insurance as well as more restricted (often significantly more restricted) coverage of nonnetwork care, maternity care, brand-name prescription drugs, and mental health care.

Of course, the most generous coverage was typically more expensive than the alternatives. Even for perfectly healthy, 25-year-old men, the worker's 35 percent premium cost for the most comprehensive option in nine of the 15 states we studied was between $1,000 and $1,700 a year.[89] By comparison, the average employee's direct share of premiums for worker-only ESI was $508 in 2003, as noted above.[90] Put differently, in the majority of states we examined, the very best health risks buying the most comprehensive coverage had to pay, compared to workers enrolling in average ESI, more than twice as much for policies offering significantly less coverage. Also as noted above, the most generous state-based coverage costs even more for women and middle-aged or older workers.

Notwithstanding these high premium costs that, for many HCTC beneficiaries, place this coverage out of reach, Table 10 shows the most generous benefits offered by each category of state-based coverage in the 15 states we examined.

Table 10. The Most Generous State-Based Coverage in Each State, November 2003

State	Deductible	Coinsurance, Non-network[91]	Particular Services: Major Differences from Average Employer-Sponsored Insurance			
			Maternity	Mental Health	Prescription Drugs	Other
Nongroup Plans						
Indiana	$500	50%	None		No name brand drugs	
North Carolina	$250	30%	None w/o extra premium	50% coinsurance; $2,000 annual cap	$1,000 annual cap on name brand drugs; $40 copayment off formulary	$150 emergency room copayment
Ohio	$500	50%	None		No name brand drugs	
Texas[92]	$500	40%	None	Only "organic brain disease"	$2,500 cap	
Virginia	$300	30%	None w/o extra premium	50% coinsurance, for six or more outpatient visits	40% coinsurance; $5,000 cap	
High-risk Pools						
Alaska	$1,000	40%	None	50% coinsurance; $4,000 outpatient cap		No preventive care, except selected tests
Colorado	$300	50%		$2,500 annual outpatient cap; 50% coinsurance after $1,500	40% coinsurance for name brand on formulary; 60% coinsurance off formulary	
Connecticut, low income	$200	N/A			None	No preventive care, except selected tests
Illinois	$500	40%	None w/o extra premium		$100 maximum per prescription	$300 deductible for nonnetwork hospital
Maryland	None	N/A				$250 copayment per inpatient admission
Montana	$1,000	20%		Outpatient: $2,500 deductible and 30% coinsurance; inpatient: $4,000 cap over 24 months		
Texas	$500	40%		Only serious mental illness covered		No preventive care above age 6 (except flu vaccine and chronic illness)

State	Deductible	Coinsurance, Non-network[91]	Particular Services: Major Differences from Average Employer-Sponsored Insurance			
			Maternity	Mental Health	Prescription Drugs	Other
Community-Rated Plans						
Connecticut[93]	None	N/A				$500 copayment for inpatient care
Maine	$1,000	30%				
Michigan	$250	40%			50% coinsurance	$500 cap on preventive care
New York	None	N/A		None	None, w/o extra premium. If chosen, $100 deductible, $3,000 cap, pay extra cost of name brand drug over generic.	
Pennsylvania[94]	$750	20%			Retail: 50% coinsurance, $250 deductible; $3,000 cap for all	Generally, no coverage for preventive care

5. Gender Differences

As indicated above, plans in seven out of the 15 states we examined either flatly excluded routine maternity care or provided it only to those who paid a substantial additional charge.[95] In eight of these 15 states, premiums charged to young women were significantly higher than those charged to men of the same age and health status. The largest disparities occurred when women were given the option and elected maternity coverage; such disparities are not surprising, given foreseeable disproportionate enrollment (that is, adverse selection) by women who anticipated pregnancy. What is surprising is that differentials persisted even among plans that flatly excluded routine maternity care coverage. In fact, the exclusion of such care reduced the median differential only modestly, from a median of 68 percent for plans that included routine maternity care to a median of 48 percent higher charges for women than for men in plans that excluded such care. Viewed by coverage category, all these gender differentials tended to be starkest for nongroup plans, smaller in high-risk pools, and lowest for community-rated plans.

To assess the size of gender-based premium differentials (Table 11), we compared premiums that the most generous plan in each state charged to healthy, 25-year-old men and women. Among the plans that varied premium charges by gender, the plan with the median differential charged such women 53 percent more than men (annual 35 percent premium payments of $2,333 for healthy, 25-year-old women vs. $1,526 for similar men).

In plans that charged men and women the same amount, women paid less than in risk-rated plans and men paid more. Taking into account differences in the generosity of covered benefits, men paid an average of 36 percent more in plans that charged women and men the same premium than in plans with costs that varied by gender.[96]

Table 11. Gender Differences in Most Generous, State-Based Coverage, November 2003

State	Status of Maternity Care			Healthy, 25-Year-Old Man, Most Generous Plan, 35% Annualized Premium Cost	Healthy, 25-Year-Old Woman, Most Generous Plan, 35% Annualized Premium Cost, in Dollars and Compared to Similar Men	
	Included	Excluded	Optional		With Maternity Care	Without Maternity Care
Nongroup Plans						
Indiana		X		$324		$480 (48% higher)
North Carolina			X	$576	$1,908 (231% higher)	
Ohio		X		$264		$396 (50% higher)
Texas[97]		X		$689		$886 (29% higher)
Virginia			X	$384	$756 (76% higher)	
High-risk Pools						
Alaska		X		$1,584		$1,584 (equal)
Colorado[98]	X			$1,526	$2,333 (53% higher)	
Connecticut	X			$1,130	$2,201 (95% higher)	
Illinois			X	$804	$1,284 (60% higher)	
Maryland	X			$1,092	$1,092 (equal)	
Montana	X			$1,296	$1,296 (equal)	
Texas	X			$1,416	$1,992 (41% higher)	
Community-Rated Plans						
Maine[99]	X			$1,632	$1,632 (equal)	
Michigan	X			$1,704	$1,704 (equal)	
New York[100]	X			$588	$588 (equal)	
Pennsylvania[101]	X			$1,638	$1,638 (equal)	

6. Age Differences

Age differences in coverage, as of November 2003, are tracked in Table 12. In 12 of the 15 states we examined, healthy, 60-year-old men were charged more for the most generous, state-qualified coverage than were healthy, 25-year-old men. Among these 12 states, the plan with the median differential saw older men paying 238 percent more (annual 35 percent premium cost of $1,944 vs. $576) for the same coverage.

In the nongroup market, older men paid higher premiums even for markedly ***less*** generous coverage. On average, the annual, 35 percent premium payment from 60-year-olds was $1,600 for nongroup plans with an average deductible of $3,800. By contrast, 25-year-olds paid an average of $447 for such plans with an average $660 deductible. Put differently, compared to younger men, older men paid more than three times as much for nongroup plans that have deductibles nearly six times as large.

Table 12. Age Differences in State-Based Coverage, November 2003

State	Most Generous Coverage		Coverage With Mid- To Low-Range Premium			
			Healthy, 25-Year-Old Man		Healthy, 60-Year-Old Man	
	Healthy, 25-Year-Old Man: 35% Annualized Premium Cost	Healthy, 60-Year-Old Man: 35% Annualized Premium Cost (and Compared to Similar 25 Year Old)	35% Annualized Premium Cost	Deductible	35% Annualized Premium Cost	Deductible
Nongroup Plans						
Indiana	$324	$1,344 (310% higher)	$324	$500	$852	$2,500
North Carolina	$576	$1,944 (236% higher)	$492	$1,000	$1,080	$5,000
Ohio	$264	$1,272 (375% higher)	$264	$500	$588	$5,000
Texas[102]	$689	$2,062 (199% higher)	$512	$1,000	$832	$5,000
Virginia	$384	$1,380 (264% higher)	$384	$300	$798	$1,500
High-risk Pools						
Alaska	$1,584	$4,980 (215% higher)	$648	$10,000	$2,076	$10,000
Colorado[103]	$1,526	$5,990 (293% higher)	$422	$5,000	$1,661	$5,000
Connecticut[104]	$1,130	$4,910 (499% higher)	$694	$200	$3,014	$200
Illinois	$804	$4,800 (102% higher)	$600	$2,500	$3,720	$2,500
Maryland	$1,092	$2,196 (153% higher)	$684	$2,500	$1,296	$2,500
Montana	$1,296	$3,276 (195% higher)	$696	$2,500	$2,016	$2,500
Texas	$1,416	$4,188 (196% higher)	$588	$5,000	$1,752	$5,000
Community-Rated Plans						
Maine[105]	$1,632	$2,388 (46% higher)	$1,632	$1,000	$2,388	$1,000
Michigan	$1,704	$1,704 (same)	$1,296	50% coinsurance	$1,296	50% coinsurance
New York[106]	$588	$588 (same)	$516	None	$516	None
Pennsylvania[107]	$1,638	$1,638 (same)	$1,367	$1,500	$1,367	$1,500

Notes. The four columns on the right show the coverage that each individual could purchase for the total premium closest to $1,451. With such a premium, the worker's 35 percent payment, after receiving an HCTC, equaled the average worker's share of employment-based, single coverage in 2003, which was $508. The coverage listed for healthy 60-year-old men turns out to be, in each case, the lowest-cost plan. The same is true for coverage of 25 year olds, except for the nongroup plans.

7. Medical Underwriting

The above premium quotes applied to healthy individuals. In states offering medically underwritten, nongroup coverage, such numbers represented only the preliminary base quote. After providing the base premium level, the insurer reviewed the health history of each beneficiary and varied the premium

accordingly. Table 13 shows the extent of such premium variation, based on the insurer's classification of the beneficiary's level of risk:

Table 13. Impact of Individual Risk Rating on Premiums: Medically Underwritten, Nongroup HCTC State-Based Plans, November 2003

State	Ratio of Premium for Highest-Risk Enrollee to Premium for Lowest-Risk Enrollee, with Age, Gender, Area of Residence, and Smoking Status Held Constant
Indiana	2.5 to 1
North Carolina	7 to 1
Ohio (Anthem)	2.5 to 1
Ohio (Aegis)	1.7 to 1
Texas[108]	5.8 to 1
Virginia	6 to 1

For example, in the state with the median difference between highest- and lowest-risk premiums (Texas), a 42-year-old woman in perfect health was required to make 35 percent annual premium payments of $1,381 to buy coverage with a $500 deductible. A 42-year-old woman in substandard health buying that same coverage had 35 percent annual premium payments of $8,043. Even for a plan with a $5,000 deductible, the higher-risk woman had to make 35 percent premium payments of $3,242.

In addition to the obvious impact on individuals with chronic illness or other health problems in their past, such underwriting has the effect of further raising premiums for older beneficiaries, because they are more likely to have past or present health problems.

8. Consumer Protections: Guaranteed Issue and Preexisting Condition Exclusions

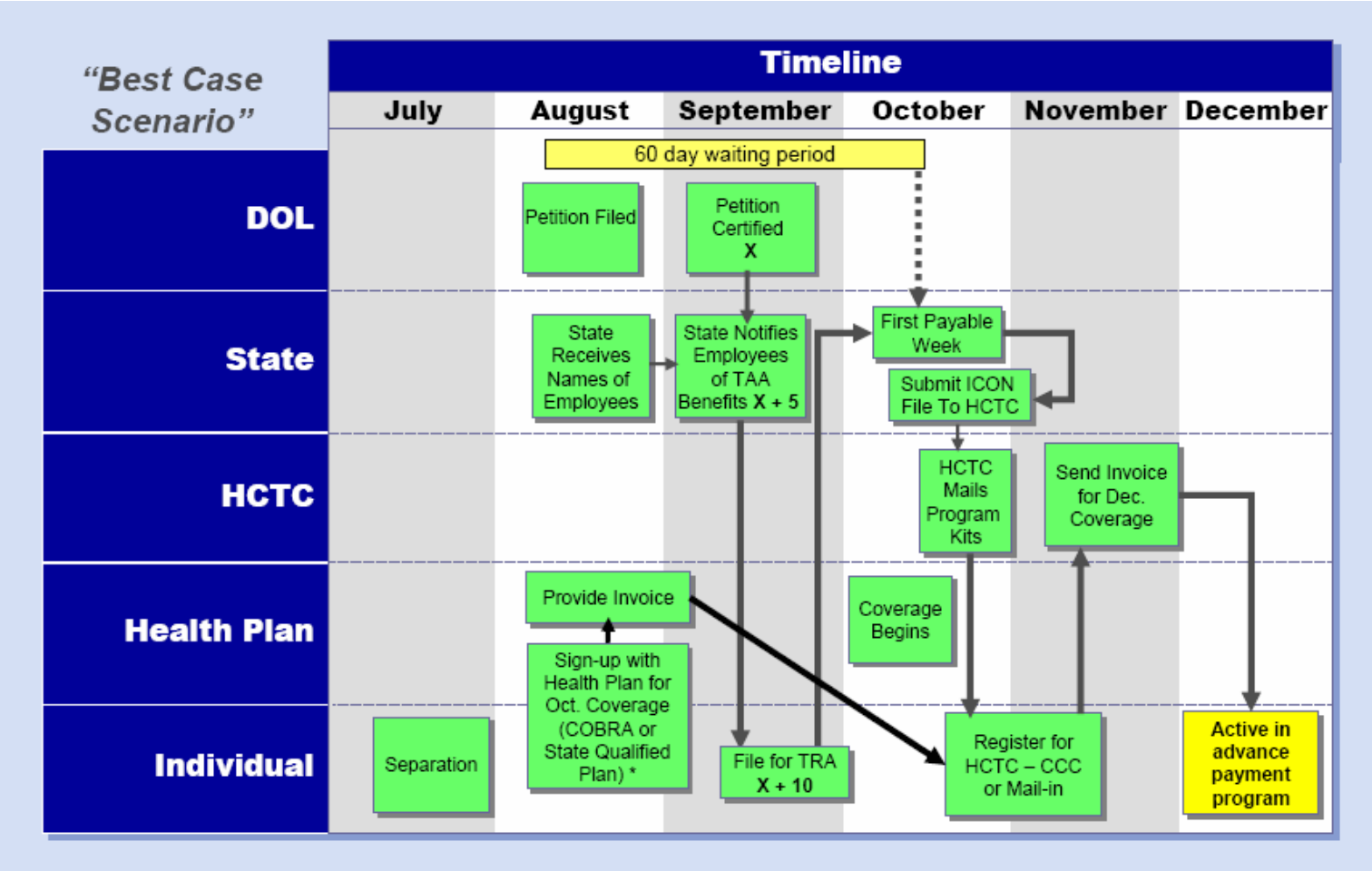
HCTC-eligible individuals who did not have three months continuous coverage immediately preceding enrollment in state-based plans lose the benefit of Trade Act consumer protections and so can be denied coverage or subjected to preexisting condition exclusions.[109] The following sections assess the impact of these provisions by exploring three questions in turn: Do many HCTC-eligible workers experience recent coverage gaps? Do many health plans deny guaranteed issue and exclude preexisting conditions for individuals with coverage gaps? And how well does health coverage achieve its objectives without these consumer protections?

a. Many HCTC-eligible workers experience coverage gaps. Many PBGC early retirees have gone for months or years since their final job. For some, long periods have passed since retiree coverage was available. Long coverage gaps may also apply to many TRA recipients, all of whom have been unemployed for the six months or more required to exhaust unemployment insurance. Finally, such gaps may affect many workers who are HCTC-eligible because they would qualify for TRA benefits but for their receipt of unemployment insurance. This eligibility category was intended to provide health coverage subsidies soon after job loss. However, the workers belonging to this group frequently may not obtain coverage quickly enough to qualify for consumer protections, given the following process required to enroll in HCTC advance payment.

For displaced workers who have just lost their jobs, enrollment in HCTC advance payment begins when someone files a petition for the Department of Labor to find that the workers' former employer was adversely affected by foreign trade. Under the Trade Act, the Department of Labor is supposed to decide such petitions within 40 days. According to recent official estimates, the Department of Labor now decides these petitions, on average, in 26 days.[110] During the first 60 days after a petition is filed, no workers from the affected company can qualify for TRA benefits.[111]

If the Department of Labor denies the petition, the petitioners can appeal. If the Department of Labor grants the petition, affected workers do not receive HCTCs until they learn about their rights to benefits and then apply for an individual determination of TAA eligibility. As noted above, the state workforce agency is responsible for educating workers from the affected company about the full range of benefits available under TAA and other programs, even though the state agency frequently may not know the identity of all affected workers. Once the worker learns about available benefits and submits a TRA application, the state workforce agency must determine whether the applicant meets all TRA eligibility requirements (including prompt and continuous enrollment in training, absent a waiver), except exhaustion of unemployment insurance. If the state workforce agency finds such eligibility, the applicant's name is placed on the daily list the state workforce agency transmits to the HCTC program. Only at that point does the applicant begin the generally applicable process of enrolling in advance payment. It is thus not surprising that the best-case scenario depicted by federal authorities (flow charted in Figure 8) shows a five-month gap between job loss and the start of advance payment.

Figure 8. Trade Adjustment Assistance–Related HCTC Enrollment: A Best-Case Timeline



Source: HCTC Team October 2003.[112]

Even though a five-month delay between layoff and the start of advance payment is troubling, this figure is correctly labeled as a best-case scenario. For example, it assumes that the state will obtain the names of all former employees of trade-impacted firms whereas, in fact, frequently only the names of petitioning employees are available. Similarly, additional time is consumed if the Department of Labor delays its decision about the petition beyond the 26-day average; such delays can be understandable, given the

sometimes complex economic factors that the Department of Labor must evaluate to decide whether a particular layoff resulted from trade liberalization. Moreover, if the Department of Labor at first denies the petition, then reverses its decision after petitioners file an appeal, more time is required. In addition, this timetable assumes that laid-off workers do not require additional time to learn about the steps needed to obtain HCTCs, and that the requirement of enrolling in training or obtaining waivers does not create additional delays.

Many laid-off workers lack the resources to pay health insurance premiums, unassisted, for however many months pass between separation from employment and the commencement of advance payment. If any of these factors, alone or together, cause gaps in coverage of more than 63 days, the affected workers will lose federally guaranteed consumer protections. The following section explores whether plans, in most states, take advantage of this federal permission to deny guaranteed issue or to exclude preexisting conditions for workers or family members with recent coverage gaps.

b. Many state-qualified plans deny guaranteed issue and exclude preexisting conditions for individuals with coverage gaps. According to our survey, states and plans were evenly split in their willingness to extend the guaranteed issue safeguard beyond the requirements of federal law. Altogether, plans in eight out of 15 states guaranteed insurance to beneficiaries with recent coverage gaps, even though federal law permitted them to deny coverage to such workers.[113] By contrast, almost all plans excluded preexisting conditions when permitted by federal law. In all but one state we surveyed,[114] HCTC beneficiaries with recent coverage gaps could be subjected to preexisting condition exclusions.[115] In nine of 15 states, such exclusions lasted up to 12 months after enrollment, as Table 14 illustrates.

Table 14. Consumer Protections for Nonqualified HCTC Beneficiaries, November 2003

State	Is Issue Guaranteed for Nonqualified Beneficiaries (i.e., Beneficiaries with Recent Coverage Gaps)?	Are Preexisting Conditions Excluded for Nonqualified Beneficiaries (i.e., Beneficiaries with Recent Coverage Gaps)?	If So, for How Many Months?
Nongroup Plans			
Indiana	No	Yes	12
North Carolina	Yes	Yes	12
Ohio (Anthem)	No	Yes	12
Ohio (Aegis)	Yes	Yes	12[116]
Texas[117]	No	Not applicable: coverage never provided for individuals with recent gaps	
Virginia	No (offered different plan)	Yes	12
High-risk Pools			
Alaska	Yes	Yes	6
Colorado	If gap exceeds 90 days, no coverage[118]	Yes, if gap exceeds 90 days	6
Connecticut	Yes for two plans; no for low-income plan	Yes	12
Illinois	No[119]	Yes	6
Maryland	No	Yes	3–6[120]
Montana	Yes	Yes	12
Texas	No	Yes	Up to 12[121]
Community-Rated Pools			
Connecticut[122]	Yes	No	
Maine	Yes	No	
Michigan	Yes	Yes	6
New York	Yes	Yes	12[123]
Pennsylvania	Yes	Yes	12

c. When these protections are absent, health coverage may be unable to achieve its goals. Obviously, if coverage does not issue, it does not accomplish its goals. Preexisting condition exclusions can also prevent health insurance from reaching its objectives. During the exclusion period, coverage does not improve access to care related to previous health problems, potentially resulting in grim health outcomes for patients with chronic illness. Many affected beneficiaries would not even be protected against financial catastrophe if, during the exclusion, they experienced a costly illness related to previous health problems.

Even more fundamentally, applying preexisting condition exclusions to individuals with recent coverage gaps discourages enrollment by such individuals, because coverage will be less valuable to them. But precisely such individuals must enroll for HCTCs to have a substantial impact on the uninsured.

III. Issues to Track

While it is too early to come to definitive conclusions about the success or failure of this new program, some important concerns have already emerged. The following outline identifies some of the key issues that should be followed by policymakers wishing to use this new program to glean lessons for designing much larger coverage expansions.

1) Take-up
   a) What proportion of eligible individuals use HCTCs to purchase health coverage?
   b) What proportion of eligible individuals in the following categories enroll in HCTC?
      i) Low-income workers vs. higher-income workers, measured (pending filing and analysis of 2003 federal income tax returns) by such proxy indicators as pension income information available to PGBC and state workforce agency data about laid-off workers' prior earnings and current unemployment insurance or TRA payments.
      ii) PBGC eligibles vs. TRA recipients vs. TAA eligibles receiving unemployment insurance.
      iii) Residents of states that offer state-based coverage with varying levels of affordability and comprehensive benefits.
      iv) Different age and gender groups.
      v) Advance-payment beneficiaries vs. recipients of year-end, lump-sum payments after filing tax returns.
2) Goals achieved by HCTCs—covering the uninsured vs. subsidizing the already insured.
   a) What proportion of HCTC enrollees would be uninsured without the credits? What proportion use the credits to reduce the financial burden imposed by health coverage that beneficiaries would have obtained, with or without HCTCs?
   b) What evidence could suggest possible answers to that question?
      i) The proportion of HCTC beneficiaries who lacked health coverage before enrolling could set a lower bound on the proportion that would have been uninsured without credits. Most health plans should have this information, because it determines whether consumer protections apply.
      ii) Surveys of HCTC-eligible workers, including both enrollees and those who do not enroll, are probably needed. As some HCTC recipients may overstate the impact of HCTCs on their willingness to remain insured, such surveys are likely to set an upper bound on the proportion of HCTC recipients who would remain uninsured, with or without credits.
3) Goals achieved by health coverage—access to health care vs. protection against financial catastrophe.
   a) What proportion of HCTC enrollees enroll in plans with relatively low deductibles and relatively generous benefits? What proportion of HCTC-eligible workers have access to such plans (and at what cost)?
   b) What proportion enroll in plans with high deductibles? What proportion of HCTC-eligible workers have access to such plans (and at what cost)?
   c) To what extent does this enrollment reflect the preferences of HCTC beneficiaries? To what extent does it reflect limited choices offered to them? What proportion of HCTC-eligible workers are deterred from enrolling because they lack access to the kind of coverage they prefer or because it costs more than they are willing to pay? These questions could begin to be answered through surveys and focus groups.

d) Based on surveys, focus groups, anecdotes, and reports from health plans, providers, and other observers, what is the impact of preexisting condition exclusions on:

   i) Access to health care.

   ii) Protection against financial setbacks.

   iii) Enrollment.

e) Based primarily on consumer surveys, what is the impact of coverage (including type of plan) on:

   i) Health care utilization.

   ii) Health status.

   iii) Patient satisfaction.

4) Advance payment

a) Effectiveness with beneficiaries

   i) Do particular aspects of advance payment present obstacles to HCTC beneficiaries? Examples include:

      (1) Requiring full payment of premiums for one or more months before advance payment starts

      (2) Beneficiary confusion

      (3) Requiring year-end filing of tax returns

      (4) Requiring prompt, monthly payment of the worker's share of premium costs

   ii) How do HCTC-eligible workers feel about advance payment?

   iii) Note that these questions could perhaps be answered through stakeholder interviews and public opinion research.

b) Effectiveness with health plans

   i) Do they receive payment in full and on time?

   ii) Do they report satisfaction with advance payment? Stakeholder interviews could help answer this question.

c) Efficiency—what are the administrative costs of advance payment? To what extent are they start-up or infrastructure development costs that will diminish, per capita, as enrollment grows?

IV. Implications for Policy

The following ideas for policymakers represent strategies to accomplish two distinct goals: first, making Trade Act coverage the best possible test of refundable, advanceable health insurance tax credits; and second, increasing the effectiveness of Trade Act credits in covering the uninsured. The latter goal is relevant both to adjusting HCTCs so they better serve existing beneficiaries and to expanding credits to cover other, larger groups of uninsured. Each of these major goals is explored in turn below.

A. Improving the Trade Act's Capacity to Educate the Country About Using Tax Credits to Cover the Uninsured

The following suggestions are meant to improve HCTCs' capacity to serve, in effect, as a pilot project testing the potential effectiveness of health insurance tax credits with a broader population.

Grant federal agencies the authority to test alternative approaches to advance payment. For example, the Trade Act could be amended to authorize the IRS to make advance payments to entities and individuals other than the beneficiary's health plan, and to make approximate rather than exact advance payments (subject to later adjustment) if the IRS determines that: (a) appropriate safeguards are in place to prevent fraud and minimize erroneous payments; and (b) either: (1) testing an alternative payment methodology may yield useful information to guide the design of broader coverage expansions; or (2) applying the relevant payment methodology nationally would better accomplish the HCTC program's objectives. The following are some examples of policies that the IRS could test with such increased flexibility:

- Providing advance payment of HCTCs directly to eligible beneficiaries, after they show that they have paid premiums to a qualified plan.
- Permitting beneficiaries to set up automatic withholding of 35 percent shares from unemployment insurance, TRA, or PGBC checks. If such checks are not for monthly periods, withheld amounts could closely approximate such worker payment shares. IRS could then provide approximate 65 percent monthly advance payments, which would be adjusted in later months to compensate for any interim inaccuracies.
- If their qualified health plan agrees, giving beneficiaries the option not to start health coverage until advance payment is available (that is, the plan has sent information to the HCTC program showing the amount and due date for monthly premiums, the HCTC program has found the beneficiaries eligible, and advance-payment registration is complete). Note: this policy and that described in the next bullet could probably be done under existing law.[124]
- If the qualified plan agrees, permitting a beneficiary to pay the 35 percent premium share directly to the plan, which would recover the remaining 65 percent from the IRS.
- Permitting states to provide 65 percent premium subsidies to an apparently eligible individual who has applied for but not yet been enrolled in advance payment, with the IRS reimbursing the state for such costs if and when the individual enrolls in advance payment. In this example, the individual could be denied such initial state subsidies unless the beneficiary agrees to assign to the state the individual's right to HCTCs for the month in question. If the individual is ultimately found ineligible for HCTCs, he or she could refund the state's subsidy (perhaps via increased withholding from benefit checks, pension checks, or future paychecks), or, if the individual was without fault, NEG funds could cover the shortfall.

Grant federal agencies the authority to test the impact on take-up of larger HCTCs, especially for low-income beneficiaries. Income could be determined along lines similar to those in the low-income subsidy provisions of the recently enacted Medicare prescription drug bill, as explained below. Obviously, all such tests should be accompanied by evaluations and followed by publicly available reports, so policymakers,

stakeholders, and the public can incorporate the lessons of HCTC implementation into their analysis of various future coverage expansions.

Analyze and report on data available through existing systems. Using data already in hand, the HCTC program needs to report, on a periodic basis, key information showing the aggregate characteristics of five groups of individuals: those who are mailed program kits, those who apply for advance payment, those who are found eligible, those who enroll in coverage, and those who disenroll. Not only would such reports promote transparency and accountability, they could help administrators spot emerging trends and guide ongoing program adjustments. For example, the Department of Labor could ask state workforce agencies to indicate the percentage of names sent to the HCTC program that are TRA recipients and the percentage receiving unemployment insurance. If the latter percentage is quite small, that would confirm a probable need for targeted outreach to these workers.

One critical variable in analyzing the impact of HCTCs is household income; the lowest-income, unemployed households have by far the greatest likelihood of being uninsured, as noted below.[125] However, only limited information about beneficiary income is available, at this point. The PBGC has information about each beneficiary's pension amount, and state workforce agencies know about each TAA beneficiary's prior earnings and current unemployment insurance or TRA payments, but none of those agencies know about unearned income, spousal income, or assets. Despite such limitations, the information already in hand could allow some preliminary but nevertheless important initial analysis of the relationship between income and enrollment, taking into account pensions, prior worker earnings, and unemployment insurance or TRA payments. Exemplifying the importance of even limited information at this stage is the above finding from Maryland, that recipients of pensions under $11,000 a year comprised half of all Bethlehem Steel retirees but fewer than 5 percent of such retirees enrolling into the state's HCTC plan. If results are similar in other states and for other beneficiary categories, they will strongly suggest that HCTCs do not eliminate financial barriers for low-income families.

Of course, much more definitive information about family income and other household characteristics will become available after federal income tax forms are filed for 2003. It will be important to analyze such information to compare advance-payment enrollees, individuals who seek year-end HCTCs, and individuals who were mailed HCTC program kits but did not claim HCTCs. While costly, such an income analysis may be undertaken in part by the IRS in any event, simply to profile individuals who appear to be claiming the HCTC fraudulently or erroneously. The marginal cost of expanding that analysis as described here seems more than justified by the usefulness of the resulting information, which could help design national policy for millions of uninsured Americans.[126]

The IRS has apparently surveyed HCTC participants and potentially eligible nonparticipants to understand the causes of low take-up rates. Survey results should be disclosed publicly, to inform the broader national debate about strategies to expand health coverage.

In addition to providing basic information about the characteristics of participants and nonparticipants, such surveys (and related focus groups) could help answer a number of basic questions that are central to analyzing the impact of HCTCs, including the following: How many HCTC beneficiaries report that they would have been uninsured, without credits? How do HCTC-eligible individuals view advance payment? How satisfied are HCTC beneficiaries with their health plans? What health care services do participants and nonparticipants receive? Which desired services (if any) do they delay or go without, and for what reasons? How (if at all) has their health status been affected by their receipt or nonreceipt of HCTCs?

Revise HCTC legislation to provide a fairer test of health insurance tax credits by simplifying eligibility, eliminating barriers to coverage, and otherwise improving take-up. For example:

- Like exhaustion of unemployment insurance, both the 60-day waiting period after filing petitions with the Department of Labor and TAA job training requirements are preconditions for receipt of TRA payments that could be made inapplicable to HCTC eligibility.

- Workers could be given the ability to apply to state workforce agencies for HCTCs, without seeking TRA payments.
- A presumptive eligibility system, modeled on Medicaid presumptive eligibility for pregnant women, women with breast or cervical cancer, and children,[127] could cover the IRS's share of premiums pending the start of advance payment for workers who appear to qualify for HCTCs. Under this approach, advance payment could begin immediately when a worker on an eligibility list submitted to the IRS by PBGC or a state workforce agency applies to enroll in a qualified plan and tenders a 35 percent premium payment.
- State agencies administering unemployment insurance programs could be required to cross-check their recipient data, which include the identity of former employers, against the list of firms that have been certified as trade-impacted. For former employees of such firms, state workforce agencies would then evaluate their potential eligibility for HCTCs and add the names of apparently eligible workers into the daily data feeds provided to the HCTC program.[128] Pending implementation of such a policy, officials could develop materials to help state workforce agencies and other stakeholders inform workers that unemployment insurance recipients wishing health coverage assistance should quickly apply for TRA payments and TAA training programs or training waivers.
- The operation of consumer safeguards could be adjusted so that consumer protections apply for workers who had *three months of continuous coverage at the time of job loss* or other separation from employment. To guard against adverse selection, workers could be denied HCTCs unless they apply (and if found eligible, enroll in qualified coverage) within a defined period (such as 90 days) after receiving their HCTC program kits or other formal notice of potential eligibility. An additional possible safeguard against adverse selection would permit the exclusion of conditions that first appear during any 63-day or longer coverage gap between separation from employment and HCTC eligibility.
- If consumer protections were adjusted in this way, policymakers could consider aligning the Trade Act's preexisting condition safeguards with current state law, so that, for example, the same period of continuous coverage would trigger legal prohibitions against exclusions. This could make it easier for states to persuade insurers to offer coverage. On the other hand, such a change could subject more consumers to preexisting condition exclusions, with serious consequences for some beneficiaries.
- The number of HCTC beneficiaries without access to qualified coverage could be reduced by making mini-COBRA and retiree plans automatically qualified; by revising the above-described IRS policies to make spousal employer coverage more widely available; and potentially by creating "fallback" options that, without any state action, could be made available to beneficiaries in states without state-based options.
- State capacity to conduct outreach and otherwise expedite enrollment could be enhanced by appropriating (rather than merely authorizing) NEG grants or other administrative support; by providing field-tested, multilingual, readily understandable educational materials that are much simpler than the current HCTC Program Kit (although such simplification would require leaving out some important information); by commissioning unions and other community groups to conduct outreach, following the example of successful community education programs under SCHIP; by conducting and sharing market research about how best to educate potential HCTC beneficiaries about the program; by informing displaced workers who receive unemployment insurance that, to obtain HCTCs, they must first apply for TRA payments and either TAA training or waivers of TAA training requirements; and by facilitating regular exchanges of information about effective outreach strategies among state and health plan officials across the country.

B. Additional Modifications to Trade Act Health Coverage that Could Improve HCTCs' Effectiveness in Covering the Uninsured

In addition to the above suggestions, the two ideas listed below could increase HCTCs' effectiveness in covering the uninsured. They could be implemented either to provide better coverage of existing beneficiaries or to help HCTCs serve a larger group of uninsured Americans. As an example of a proposal that would expand HCTCs to new populations, Senate Finance Committee Chairman Grassley (R-IA) and Ranking Member Baucus (D-MT) introduced S. 1693 in October 2003, which would provide HCTCs to unemployment insurance recipients, including those who lost their jobs for reasons unrelated to foreign trade.

Provide larger HCTCs, particularly for low-income beneficiaries. Both for the uninsured as a whole[129] and for specific target groups proposed for expansion (such as laid-off workers[130] and employees of small firms[131]), the majority of uninsured have family incomes below 200 percent of the federal poverty level. As suggested above, few of these low-income households have room in their budgets to pay 35 percent of health insurance premiums. Accordingly, HCTCs are much more likely to assist the bulk of the uninsured if they increase in size substantially for lower-income households.[132] Congress recently acknowledged the inability of many low-income households to afford substantial payments for health coverage by including, in Medicare prescription drug legislation, subsidies that reduce or even eliminate (for individuals with incomes at or below 135 percent of the federal poverty level) required premium payments.

Of course, given the changes in income experienced by laid-off workers, whatever administrative mechanism is used to adjust HCTC size based on household income would need to have the capacity to assess very recent household income—not a function typically performed during the year by the IRS. Fortunately, in Medicare, which has much less experience than the IRS in evaluating income, the recent prescription drug bill provides a helpful model. Under that legislation, individuals establish their eligibility for low-income subsidies by applying to state Medicaid agencies or Social Security offices, which have experience analyzing recent income, and which the legislation directs to use streamlined application procedures. A related but slightly different set of agencies would probably work even better for laid-off workers: namely, state agencies that administer SCHIP programs, which have already streamlined their application procedures substantially, in most states.[133] Regardless of which agencies are used, however, beneficiaries would need to be limited to standard credits unless they affirmatively applied to such agencies and obtained a determination of low household income. To avoid an unfunded mandate, the relevant state agencies would need federal reimbursement for the resulting administrative costs.

Policymakers could also consider increasing credit size for moderate-income beneficiaries, depending on the characteristics of any new groups served by HCTCs.

Use the Federal Employees Health Benefit Program (FEHBP) to provide health plans for which advance payment may be used. At a minimum, each state could have the option to contract with the Office of Personnel Management (OPM) to offer HCTC beneficiaries access to the FEHBP health plans that are available to federal employees living in the state. HCTC beneficiaries would need to be in a separate pool, to avoid putting current FEHBP beneficiaries at risk. Existing OPM mechanisms could educate HCTC enrollees about available health plan options. Premiums charged to HCTC beneficiaries could be the same as those charged to federal employees. Risk segmentation and adverse selection could be addressed by risk-adjusted premium payments from the federal government that are invisible to the beneficiary (and by government-funded reinsurance). In other contexts, similar risk-adjustment mechanisms to prevent adverse selection have been urged by respected analysts at such diverse institutions as the Heritage Foundation[134] and the Urban Institute,[135] which suggests possible bipartisan support.

This change to qualified coverage could be accomplished most easily through a statutory change that would authorize or direct OPM to offer this coverage to HCTC beneficiaries in states that elect this option, addressing administrative costs by turning over to OPM the state's proportionate share of authorized NEG funding. Such an approach would simultaneously address many of the emerging problems with HCTCs.

Beneficiaries would gain access to comprehensive benefits that promote access to essential health care. Horizontal inequities based on state of residence, gender, and age would be substantially reduced if many states chose this option. Finally, as the HCTC program would need to interface with a smaller number of defined plans, all of which have current relationships to federal agencies, simpler and more consumer-friendly systems could be devised for advance payment. This would be particularly true if a condition of health plan participation in FEHBP were enrolling HCTC beneficiaries in states that choose this option. Under such circumstances, it might be easier to persuade plans to depart from their standard procedures for accepting premium payments, particularly if the expansion population (hence the volume of new business) is substantially greater than under the current HCTC program.[136]

Ironically, the FEHBP is one of the few policy vehicles for coverage expansion, aside from tax credits, with a history of support that crosses traditional philosophical divides. Some conservative analysts like FEHBP because it uses market pressures, rather than regulations, to shape health plan behavior. Consumers can choose from among many different types of health coverage, and FEHBP gives enrollees financial incentives to select less expensive plans. Insurers retain significant freedom to innovate, which is illustrated by FEHBP plans offering consumer-directed health coverage in 2003 and the possibility that FEHBP plans could soon offer Health Savings Accounts.[137] Some liberal analysts like FEHBP because it offers comprehensive, affordable, and community-rated coverage, with guaranteed issue and without preexisting condition exclusions.[138] Marrying HCTCs to FEHBP could thus work in terms of both bipartisan politics and effective health policy.

From some perspectives, the simplest and most effective approach would simply make FEHBP the alternative to automatically qualified coverage. However, some conservative policymakers may be troubled at the notion of any national system for health coverage, even one that is market-based with much local variation, like FEHBP. To avoid this concern while still incorporating the benefits of FEHBP, at least three approaches are possible. First, FEHBP coverage could be a "default" option in states not otherwise providing state-qualified coverage. Under that approach, potential HCTC beneficiaries without access to COBRA coverage or other automatically qualified plans would nevertheless have a place they could use their tax credit, despite state inaction. Second, FEHBP coverage could be made available nationwide for HCTC beneficiaries, supplementing other forms of state-based coverage (if any). Third, as a relatively modest but nevertheless potentially important policy change, FEHBP coverage could be an option available to any state that chooses to contract with OPM.

These approaches, which supplement current state HCTC options rather than replace them with FEHBP, would preserve states' ability to structure coverage based on local circumstances and values. In fact, they would enhance state flexibility beyond what is available under the Trade Act. With HCTCs, state officials must either forego the benefits of HCTCs for their residents or dedicate scarce administrative resources and legislative time to developing health coverage systems for HCTC beneficiaries. With a FEHBP option, states would have the additional choice of conserving for other purposes their administrative and policymaking resources while still giving their residents access to coverage through HCTCs.

For policymakers who prefer vigorous private competition, a FEHBP option would improve Trade Act health coverage for another reason. Under FEHBP, multiple insurers compete for business in every part of the country, often offering fairly diverse types of coverage and benefits. Giving states the option to offer FEHBP plans could thus increase consumer choice significantly beyond the current HCTC system, in which the typical state has one insurer offering several different plans, which often differ only in the size of their deductibles.[‡]

[‡] Other options could be made available to states as well. For example, states could be authorized, not simply to use Medicaid and SCHIP "look-alike" plans, but to enroll HCTC beneficiaries in their Medicaid and SCHIP programs. Conversely, current nongroup markets, under state insurance laws rather than Trade Act safeguards, could be opened up to HCTCs. While each of these approaches has advantages and disadvantages, each has provoked fierce opposition from different groups of lawmakers and so is unlikely to form the basis of a bipartisan agreement. The text focuses instead on FEHBP-based approaches because of both FEHBP's strengths as a health policy system and its potential for broad, bipartisan acceptance.

Conclusion

The country has just begun an important experiment in using refundable, advanceable federal income tax credits to cover the uninsured. While the Bush administration and its partners have worked hard and creatively to make HCTCs effective, and key hurdles have already been surmounted, problems are beginning to emerge that may need to be addressed for the program to achieve its goals.

Of course, problems are precisely what can be expected in any new program that departs significantly from previous policy. Even a program like SCHIP, for example, which is now widely acclaimed as a success, had to overcome major start-up challenges. Clearly, time will be required to assess the significance of any initial stumbles under this new program.

For policymakers seeking effective, bipartisan strategies to cover the uninsured, many issues will be important to track as the HCTC program unfolds. The trends to follow include who takes up HCTCs; the operation of advance payment; administrative costs; the extent to which HCTCs cover the uninsured (rather than provide financial relief to the already insured); whether HCTC-purchased coverage is sufficiently comprehensive to promote access to routine but necessary health care or whether it primarily safeguards household assets against large and unforeseen losses; and the cost to consumers of coverage purchased by HCTCs, including differences that emerge based on gender, age, and health status.

Underlying these and other specific issues, the basic question facing policymakers is whether HCTCs' shortcomings, whatever they turn out to be, are fixable or inherent in the operation of tax credits. Much more experience will be needed before this question can be answered. It is already clear, however, that the HCTC program is likely to teach significant lessons about the consequences of many different approaches to health insurance tax credits, the basic mechanism most frequently proposed on a bipartisan basis during the past decade to address the growing national problem of millions of Americans without health insurance.

Notes

1. HCTC Program. *Executive Scorecard, December 2003* (December Scorecard). January 20, 2004. See later discussion of the number of eligible workers. At earlier points, federal officials used different estimates. HCTC Program, Internal Revenue Service. *Health Coverage Tax Credits: Innovations in Public-Private Partnerships.* (Innovations) November 13, 2003. Estimates for September 30, 2003. http://www.aahp.org/audio/taxcredit03/HCTC_Audio_Nov03.pdf.

2. Sara R. Collins, Karen Davis, and Jeanne M. Lambrew. *Health Care Reform Returns to the National Agenda: The 2004 Presidential Candidates' Proposals.* The Commonwealth Fund. Revised November 17, 2003. http://www.cmwf.org/programs/insurance/collins_reformagenda_671.pdf.

3. From the 107th Congress, the following bills with bipartisan cosponsors included proposals to create health insurance tax credits: S. 284, S. 590, S. 674, S. 683, S. 1502, S. 2042, S. 2679, H.R. 526, H.R. 1181, H.R. 1331, H.R. 2082, H.R. 2250, H.R. 2563, H.R. 4604, H.R. 4909, and H.R. 5174.

4. See, e.g., S. 13, during 105th Congress.

5. Genevieve M. Kenney, Frank C. Ullman, and Alan Weil. *Three Years into SCHIP: What States Are and Are Not Spending.* Urban Institute September 1, 2000. http://www.urban.org/UploadedPDF/anf_a44.pdf. In February 2000, one analysis concluded, "Despite the creation of [SCHIP] to provide more resources to states, the number of children enrolled in Medicaid or [S]CHIP has actually declined in the 12 states with the largest number of uninsured children." National Campaign for Jobs and Income Support. *Analysis of State Budgets Reveals That a Few States Are Diverting TANF Funds Away from Anti-Poverty Programs*. February 2000. Other observers noted in early 2001, "Implementation of SCHIP has been a learning experience for both state and federal policymakers. Among the more difficult problems that states have faced are how to inform families that have always been outside the traditional welfare system that their children are eligible for coverage under this new public program, and how to simplify the enrollment process to make it easy for families to participate." Linda T. Bilheimer and David C. Colby. "Expanding Coverage: Reflections On Recent Efforts." *Health Affairs.* January/February 2001. http://content.healthaffairs.org/cgi/reprint/20/1/83.pdf.

6. Centers for Disease Control and Prevention, National Center for Health Statistics. "Early Release of Selected Estimates Based on Data from the 2002 National Health Interview Survey," June 2003. http://www.cdc.gov/nchs/about/major/nhis/released200306.htm. After several years, states had achieved significant progress improving outreach and simplifying enrollment. Donna Cohen Ross and Laura Cox. *Preserving Recent Progress on Health Coverage for Children and Families: New Tensions Emerge.* Center on Budget for Policy Priorities, prepared for the Kaiser Commission on Medicaid and the Uninsured. July 2003. http://www.cbpp.org/7-30-03health.pdf. Just during the brief interval from 1998–1999 to 2000–2001, the percentage of eligible, low-income children enrolled in Medicaid and SCHIP rose from 60.5 to 65.7 percent. Peter J. Cunningham. "SCHIP Making Progress: Increased Take-Up Contributes to Coverage Gains." *Health Affairs.* Vol. 22, No. 4. July/August 2003. http://www.healthaffairs.org/1130_abstract_c.php?ID=http://www.healthaffairs.org/Library/v22n4/s28.pdf. From 1997 through 2001, at the very time adults were experiencing increased delays and denials of health care services, the proportion of children delayed or denied care dropped by 19 percent, from 6.3 to 5.1 percent of all American children. Bradley C. Strunk and Peter J. Cunningham. *Treading Water: Americans' Access to Needed Medical Care, 1997–2001.* Center for Studying Health System Change. March 2002. http://www.hschange.com/CONTENT/421/. Other research found that, compared to uninsured children, those with SCHIP are significantly more likely to receive preventive care and significantly less likely to obtain care in hospital emergency rooms. Sheri Eisert and Patricia Gabow. "Effect of Child Health Insurance Plan Enrollment on the Utilization of Health Care Services by Children Using a Public Safety Net System." *Pediatrics*. Vol. 110, No. 5. November 2002.

7. Bilheimer and Colby, op cit., citing U.S. General Accounting Office, *Health Insurance Tax Credit Participation Rate Was Low,* 1994; and House Ways and Means Subcommittee on Oversight, *Report on Marketing Abuse and Administrative Problems Involving the Health Insurance Component of the Earned Income Tax Credit*, 1993.

8. Robert J. Mills and Shailesh Bhandari. *Health Insurance Coverage in the United States: 2002*. U.S. Census Bureau Current Population Report P60-223. September 2003. http://www.census.gov/hhes/www/hlthin02.html.

9. One technical clarification is important in this context. Pension plans are administered by trustees, which are legally separate from the former employer. The trustee's actions, not firm bankruptcies, trigger PBGC entitlement (although it is almost always true that such trustee actions are in response to bankruptcies or other financial reversals experienced by the former employer).

10. Strictly speaking, PBGC retirees may be any age above 54. However, since almost all Americans over age 64 are enrolled in Medicare, and Medicare enrollees are excluded from HCTC eligibility, the text uses the shorthand expression of referring to PBGC retirees age 55–64.

11. December Scorecard, op cit.

12. "COBRA" refers to federal legislation requiring that, when certain qualifying events like job loss occur for workers insured by employers with 20 or more workers, the firm must continue covering such workers, if the workers pay the full premium, plus a 2 percent "add-on" for administrative costs. Ordinarily, laid-off workers have a 60-day window, after receiving notice from their employers, in which to elect COBRA coverage. However, under the Trade Act, a new COBRA enrollment opportunity arises for 60 days after a worker qualifies for HCTCs. However, this second opportunity does not exist if more than six months have passed since job loss; and COBRA coverage elected during this second window excludes health care provided between job loss and commencement of HCTC eligibility.

13. For PBGC beneficiaries, the qualifying event occurs 30 days before termination of the former employer's pension plan.

14. Before the Trade Act, states used high-risk pools to serve two groups: individuals whose health conditions make it difficult or expensive to buy nongroup coverage, and, in many states, individuals exhausting COBRA coverage and transitioning to nongroup insurance.

15. These state laws require firms with fewer than 20 workers to provide continuation coverage similar to COBRA.

16. However, Medicaid and SCHIP "look-alike" plans can comprise qualified coverage and accept HCTCs. Under this approach, the insurers that operate Medicaid or SCHIP plans can offer HCTC beneficiaries the same benefits, cost sharing, and provider networks as in the insurers' Medicaid or SCHIP plans, but place HCTC beneficiaries in a risk pool distinct from Medicaid and SCHIP. Ruben King-Shaw, AcademyHealth conference call, April 7, 2003 http://www.statecoverage.net/tradeact.mp3. No state currently offers such look-alike coverage.

17. These disputes are memorialized in Letter from Senator Max Baucus, Chairman of Senate Finance Committee, to Treasury Secretary Paul O'Neil, Labor Secretary Elaine L. Chao, and Health and Human Services Secretary Tommy Thomson, October 17, 2002; and Letter from Bill Thomas, Chairman of House Ways and Means Committee, to Labor Secretary Elaine L. Chao, October 21, 2002.

18. Letter from Secretaries Paul H. O'Neill, Elaine L. Chao, and Tommy G. Thompson to Senator Max Baucus, undated.

19. Testimony of Stephen A. Kandarian, Executive Director, Pension Benefit Guaranty Corporation, before the Senate Special Committee on Aging. October 14, 2003. http://www.pbgc.gov/news/speeches/testimony_101403.htm.

20. For example, if a dress manufacturer shuts down its plant because of foreign competition, and the nearby zipper factory lays off workers as a result, the laid-off zipper workers can receive TRA payments as secondarily affected workers. In the past, that was true only for job losses resulting from the North American Free Trade Agreement (NAFTA), but not from other trade pacts.

21. For examples of such cutbacks, see Vernon Smith, Rekha Ramesh, Kathy Gifford, Eileen Ellis, and Victoria Wachino. *States Respond to Fiscal Pressure: State Medicaid Spending Growth and Cost Containment in Fiscal Years 2003 and 2004.* Kaiser Commission on Medicaid and the Uninsured. September 2003. http://www.kff.org/medicaid/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=22126.

22. For example, Grace-Marie Turner. *Health Policy Matters Newsletter.* Galen Institute. November 14, 2003. http://www.galen.org/medicare.asp?docID=563; Janet Trautwein. *Trade Act Tax Credits: A Path to Broader Health Care Coverage?* Alliance for Health Reform Briefing. August 1, 2003. http://www.kaisernetwork.org/health_cast/uploaded_files/080103_alliance_tradeact_trans.pdf.

23. These graphics are taken from the document, HCTC Team. *The August 1, 2003 Implementation: A Readiness Communication to the Health Plan Administrator Community.* (IRS Administrator Guide) http://www.irs.gov/pub/irs-utl/hctc_health_plan_administrator_guide.pdf.

24. Catherine Hoffman and Marie Wang. *Health Insurance Coverage in America: 2002 Data Update*. Kaiser Commission on Medicaid and the Uninsured. December 2003. http://www.kff.org/uninsured/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=29340.

25. 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).

26. For more information about this Central Contractor Registration process, see www.ccr.gov.

27. *Trade Act Tax Credits: A Path to Broader Health Coverage?* Alliance for Health Reform Briefing. August 1, 2003. http://www.kaisernetwork.org/health_cast/uploaded_files/080103_alliance_tradeact_trans.pdf.

28. *Health Coverage Tax Credits: Innovations in Public-Private Partnerships.* American Association of Health Plans/Health Insurance Association of America. Audio Conference. November 13, 2003. http://www.aahp.org/audio/taxcredit/.

29. American Association of Health Plans, op cit. (statements by participants from Blue Cross/Blue Shield plans serving Florida and Alabama).

30. December Scorecard, op cit. For an earlier set of numbers, see HCTC Team. *Health Coverage Tax Credits: Innovations in Public-Private Partnerships*. November 13, 2003. http://www.aahp.org/audio/taxcredit03/HCTC_Audio_Nov03.pdf. For newspaper accounts of HCTC take-up, see Robert Pear. "Sluggish Start for Offer of Tax Credit for Insurance." *New York Times.* January 25, 2004. See also Kristen Downey. "Health Care Subsidy Helps Some Jobless." *Washington Post.* December 31, 2003.

31. The Lewin Group. *A December Snap Shot of Early Experience*. December 2003 (December Snap Shot).

32. For example, Mark V. Pauly. "An Adaptive Credit Plan for Covering the Uninsured." *Covering America: Real Remedies for the Uninsured, Vol. 1.* Economic and Social Research Institute. 2002. http://www.esresearch.org/RWJ11PDF/pauly.pdf.

33. For example, Judith Feder, Larry Levitt, Ellen O'Brien, and Diane Rowland. "Assessing the Combination of Public Programs and Tax Credits." *Covering America: Real Remedies for the Uninsured, Vol. 1.* Economic and Social Research Institute. 2002. http://www.esresearch.org/RWJ11PDF/feder.pdf.

34. December Scorecard, op cit.

35. 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://content.healthaffairs.org/cgi/reprint/20/1/9.pdf.

36. For example, see two reviews of the relevant literature: Julie Hudman and Molly O'Malley. *Health Insurance Premiums and Cost-Sharing: Findings from the Research on Low-Income Populations*. The Kaiser Commission on Medicaid and the Uninsured. March 2003. http://www.kff.org/medicaid/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=14310. Leighton Ku. *Charging the Poor More for Health Care: Cost-Sharing in Medicaid*. Center on Budget and Policy Priorities. May 2003. http://www.cbpp.org/5-7-03health.pdf.

37. December Scorecard, op cit. Calculations by ESRI, February 2004. As noted in later text, workers who must pay full premiums for one or months because of delays or other problems with advance payment will expend, out of pocket, increased amounts.

38. The average unemployment insurance payment (upon which TRA 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.

39. John Sheils and Randall Haught. *Cost and Coverage Analysis of Ten Proposals to Expand Health Insurance Coverage, Appendix A.* The Lewin Group, for the Robert Wood Johnson Foundation. October 2003. 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, pp. 471–480, Winter 1999/2000. For an earlier, online 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/ViewPublication.cfm&PublicationID=6201

40. Ralph E. Smith. *Family Income of Unemployment Insurance Recipients*. Congressional Budget Office, March 2004. ftp://ftp.cbo.gov/51xx/doc5144/03-03-UnemploymentInsurance.pdf. See also U.S. Department of Labor, Employment & Training Administration. *Unemployment Insurance Chart Book.* Data for Calendar Year 2002. http://www.ows.doleta.gov/unemploy/content/chartbook/descript.asp.

41. Kaiser Family Foundation and Health Research and Educational Trust. *Employer Health Coverage: 2003 Annual Survey*. September 2003. (KFF/HRET 2003 Employer Survey) http://www.kff.org/insurance/ehbs2003-1-set.cfm. This number does not include lost wages resulting from the employer's payment for the remainder of health insurance premiums. While standard economic theory suggests that (assuming equal treatment by the tax laws) such lost wages should generally equal the cost of health insurance, the empirical evidence of such a wage effect is quite mixed. See Michael A. Morrisey, guest editor. *International Journal of Health Care Finance and Economics.* "Special Issue: Why Do Employers Do What They Do? Studies of Employer-Sponsored Health Insurance." Volume 1, Number 3/4. September/December 2001. More fundamentally, adding in some measure of foregone wages would create an apples-to-oranges comparison. The discussion in the text notes that HCTCs presuppose that workers will pay more for health insurance at precisely the time when their family income, even with unemployment insurance, drops by 40 percent. If wage effects of ESI were taken into account in describing the changed health insurance costs, the stated earnings drop would be much greater than 40 percent; earnings before separation from employment would need to be stated as much higher because the employer's health insurance costs would need to be included as income to the worker. More broadly,

because little evidence suggests that workers believe in such wage effects, the more relevant comparison, for purposes of understanding the impact on workers' beliefs and attitudes, may be to direct worker payments for health insurance.

42. With family coverage, a similar pattern applies. While employed, workers' annual share of premiums for family coverage averaged $2,412 in 2003, according to the Kaiser/HRET survey. In December 2003, HCTC policies covering more than one person required an average, annualized 35 percent premium payment of at least $3,419. December Snap Shot, op cit. Calculations by ESRI, February 2004 (calculating weighted average premiums for all qualified coverage types based on number of persons covered by policies purchased for more than one person per policy, slightly underestimating the average cost by assuming only three people on each policy covering more then two people). (Note: average premiums for policies covering three or more persons exceeded average premiums for policies covering two people, since the former are more likely to be comprised of older adults, and premiums in most states are age-rated.)

43. Peter D. Hart Research Associates. *Unemployed in America: The Job Market, the Realities of Unemployment, and the Impact of Unemployment Benefits*. Prepared for the National Employment Law Project. May 2003. Many were also faced with significant health care costs, which creates an incentive to take up available coverage. http://www.nelp.org/document.cfm?documentID=346.

44. Downey, op cit.

45. December Snap Shot, op cit. The Lewin Group. Advance Premium Payments: A Snap Shot of Early Experience. Data from November, 2003 ("November Snap Shot"). Calculations by ESRI, February 2004.

46. Statement of Loren Yager, Director, International Affairs and Trade. *Trade Adjustment Assistance: Improvements Necessary, but Programs Cannot Solve Communities' Long-Term Problems.* General Accounting Office. July 20, 2001. GAO-01-988T. http://www.gao.gov.

47. Sonya Schwartz and Adele Bruce. *The Trade Act Health Insurance Subsidy: An Update from the States.* Families USA. November 2003. http://www.familiesusa.org/site/DocServer/TAARA_Implement_Nov_2003.pdf?docID=2441

48. *Reducing the Number of Uninsured Children: Outreach and Enrollment Efforts*. Testimony of Donna Cohen Ross, Center on Budget and Policy Priorities before the Senate Finance Committee. March 15, 2001. http://www.cbpp.org/3-15-01dcrtest.htm. See also Children's Defense Fund. *Outreach Innovation: New and More Effective Ways to Sign Them Up*. Spring 2001 "Sign them up" Newsletter. http://www.childrensdefense.org/childhealth/chip/signthemup/newsletters/signthemup_spring_2001.pdf.

49. The kits are available on-line at http://www.irs.gov/pub/irs-utl/hctc_program_kit.pdf.

50. Statement of Loren Yager, op cit.

51. Downey, op cit.

52. U.S. Department of Labor, Employment & Training Administration. *Letter Notifying Certain TAA-Certified Individuals of Potential Eligibility for the Health Insurance Tax Credit.* (Sample Letter) December 03, 2002. http://wdr.doleta.gov/directives/attach/TEGL16-02_Attach.html.

53. Even under the challenging labor market in the year 2003, 57 percent of regular unemployment insurance recipients found new jobs before their unemployment insurance was exhausted. Maurice Ensellem. *Worker Perspective on Unemployment Insurance in 2004*. National Employment Law Project. October 23, 2003. http://www.workforceatm.org/sections/pdf/2003/uidirconf03p10.pdf.

54. HCTC Program Kit, available at http://www.irs.gov/pub/irs-utl/hctc_program_kit.pdf as of January 27, 2004.

55. For example, Sample Letter, op cit.

56. See generally Schwartz and Bruce, op cit.

57. Dahlia K. Remler and Sherry A. Glied. "What Other Programs Can Teach Us: Increasing Participation in Health Insurance Programs." *American Journal of Public Health*, Vol. 93, No. 1. January 2003. http://www.ajph.org/cgi/content/abstract/93/1/67.

58. *Report of the Task Force on Affordability and Accessibility of Health Care in New Jersey*. New Jersey Department of Health and Senior Services, January 2001.

59. December Scorecard, op cit. Calculations by ESRI, February 2004.

60. TRA payments must be provided for up to 30 days during scheduled or other normal breaks in the training, which lessens (but does not eliminate) this problem. DOLETA. *Trade Act of 2002 Workshop*. (Undated) http://www.doleta.gov/tradeact/wpd/2002act_training.pdf.

61. Statement of Loren Yager, op cit. For a discussion of TAA training issues, including those mentioned in the text, see General Accounting Office. *Trade Adjustment Assistance: Trends, Outcomes, and Management Issues in Dislocated Worker Programs.* GAO-01-59. October 2000. http://www.gao.gov/new.items/d0159.pdf.

62. Remler and Glied, op cit.

63. Another example, discussed in the consumer protection section of this paper, is the denial of TRA payments within 60 days of filing a petition with the Department of Labor seeking a finding of trade-related adverse impact, which makes it very difficult to avoid gaps in coverage of 63 days or longer.

64. December Snap Shot, op cit. Calculations by ESRI, February 2004. If dependents are excluded from this analysis, 54 percent of HCTC-eligible workers and retirees were enrolled in COBRA. December Scorecard, op cit.

65. American Association of Health Plans, op cit.

66. Ed Neuschler and Rick Curtis. *Premium Assistance: What Works? What Doesn't?* Institute for Health Policy Solutions. April 2003. http://ihps.org/Prem%20Asst-What%20Works%20IHPS%20April2003.pdf.

67. 2001 Employer-Sponsored Health Insurance Data. *Private-Sector Data by Firm Size, Industry Group, Ownership, Age of Firm, and Other Characteristics*. September 2003. Agency for Healthcare Research and Quality. Table I.D.3. http://www.meps.ahrq.gov/MEPSDATA/ic/2001/Tables_I/TID3.pdf.

68. Paul Fronstin and Ruth Helman. *Small Employers and Health Benefits: Findings from the 2002 Small Employer Health Benefits Survey*. Employee Benefit Research Institute. January 2003. http://www.ebri.org/pdfs/0103ib.pdf.

69. The California Nurses Association, California Medical Association, American Small Business Alliance, and the Foundation for Taxpayer and Consumer Rights. *Business Health Survey Results*. December 2001. It is not clear whether this includes the 18.9 percent of employers who report that they do not offer dependent coverage. Either way, a significant proportion of California employers of all sizes that offer dependent coverage pay less than 50 percent of premiums. http://www.businesshealthsurvey.org/survey/results_dec2001.pdf.

70. December Snap Shot, op cit. Calculations by ESRI, February 2004. If dependents are excluded, 8 percent of HCTC-eligible workers and retirees were enrolled in continuing nongroup coverage. December Scorecard, op cit.

71. December Scorecard, op cit.

72. December Scorecard, op cit. Calculations by ESRI, February 2004.

73. December Scorecard, op cit. These numbers show the distribution of primary beneficiaries among different types of qualified coverage in these states, without considering their dependents. Comparable information is not published that includes dependents.

74. As noted below, one of these states (Connecticut) did not have its community-rated plan approved as offering qualified coverage during the time period covered by this report, even though this plan was listed on the IRS website as an HCTC-qualified plan.

75. Although listed on the IRS website, this plan had not been approved as qualified coverage by the end of 2003.

76. December Scorecard, op cit.

77. Internal Revenue Service. *HCTC: List of State-Qualified Health Plans.* As posted on IRS website November 25, 2003. http://www.irs.gov/individuals/article/0,,id=110016,00.html.

78. December Scorecard, op cit. December Snap Shot, op cit. November Snap Shot, op cit. Calculations by ESRI, February 2004. Note: enrollment numbers from the December Scorecard were for December 2003, and premium data from the two Snap Shots averaged November 2003 and December 2003 data. States without any enrollees into state-based coverage were excluded, since no average premium could be ascertained based on enrollment.

79. One of these states (Ohio) offered one plan with and one plan without gender-based premiums.

80. One of these states (Texas) offered nongroup coverage with medical underwriting as well as high-risk pool plans without it.

81. This plan was slated to begin accepting HCTC beneficiaries in February 2004.

82. This state's policies on guaranteed issue and preexisting conditions were tentative, as of November 2003. At that time, the state was still negotiating with insurers, and the federal government had not certified this coverage as qualified.

83. Although no surveyed state went as far as Healthy New York in lowering premiums for low- to moderate-income individuals, two other states also cut such individuals' premium costs. Colorado's high-risk pool discounted premiums by 20 percent for individuals with incomes below $36,000 a year. Along similar lines, Connecticut's high-risk pool added a new category of coverage in 2003 that lowered premiums for HCTC enrollees with incomes below 200 percent of the Federal poverty level. The latter coverage was quite comprehensive for low-income beneficiaries, who faced only a $200 individual deductible and had no other out-of-pocket cost sharing. The plan excluded prescription drugs, however. Premiums for this option varied by age and gender, so that a 25-year-old man's 35 percent premium share was $694 a year; such costs for a 25-year-old woman were $1,351; for 60-year-old men, they were $3,014 a year.

84. Healthy New York plans must also be offered to certain employees of small companies. This eligibility category is not relevant to unemployed HCTC beneficiaries, however, and so is not discussed in the text.

85. This plan was slated to begin accepting HCTC beneficiaries in February 2004.

86. Federal authorities had not approved this coverage as qualified, although it was listed on the IRS website in November 2003.

87. This describes coverage offered in the part of the state that includes the capital. Other portions of the state had different plans available.

88. KFF/HRET 2003 Employer Survey, op cit.

89. One of these states (Texas) had a high-risk pool for which such men would pay $1,416 and a nongroup plan for which they would pay $689.

90. As noted above, this number does not include lost wages resulting from the employer's payment for the remainder of health insurance premiums.

91. In this column, the designation, "N/A," signifies a plan that did not cover services out of network (except in emergencies).

92. This plan was slated to begin accepting HCTC beneficiaries in February 2004.

93. Federal authorities had not yet approved this coverage as qualified, although it was listed on the IRS website in November 2003.

94. This describes coverage offered in the part of the state that includes the capital. Other portions of the state were served by different plans.

95. One of these states (Texas) offered one high-risk plan covering maternity care and a nongroup plan excluding it.

96. This estimate is based on average premiums charged in the two sets of plans (those with gender rating and those without it). We measured the gender-neutral cost of the benefit package by adding the women's average premium to the men's. We then adjusted the average men's premium in non-risk-rated plans downward, to compensate for such plans' richer average benefit packages, deriving the 36 percent extra amount charged to men in the average non-risk-rated plan.

97. This plan was slated to begin accepting HCTC beneficiaries in February 2004.

98. The listed premiums include low-income discounts, available for beneficiaries with incomes under 200 percent of the Federal poverty level.

99. Maine may raise its deductible shortly. If that happens, premiums will decline.

100. These premiums were for HCTC beneficiaries who had low incomes and so enrolled in Healthy New York, under which the state lowered premiums by providing reinsurance that covered certain health care costs.

101. This describes coverage offered in the part of the state that includes the capital. Other portions of the state had different plans available.

102. This plan was slated to begin accepting HCTC beneficiaries in February 2004.

103. The listed premiums include low-income discounts, available for beneficiaries with incomes under 200 percent of the Federal poverty level.

104. The plan with a $200 deductible was limited to beneficiaries with incomes below 200 percent of the Federal poverty level.

105. As indicated above, Maine may soon raise its deductible. If that happens, premiums will decline.

106. Such premiums were for HCTC beneficiaries with incomes low enough to qualify for Healthy New York, under which the state lowered premiums by providing reinsurance that covered certain health care costs.

107. This describes coverage offered in the part of the state that includes the capital. Other portions of the state had different plans available.

108. This plan was slated to begin accepting HCTC beneficiaries in February 2004.

109. The other two consumer protections in the Trade Act are nondiscrimination against HCTC beneficiaries in premiums and covered benefits. We did not examine the extent to which plans discriminated in these ways against nonqualified beneficiaries.

110. Statement of The Honorable Elaine L. Chao, Secretary, U.S. Department of Labor, *Testimony Before the House Committee on Ways and Means*. March 04, 2004. http://waysandmeans.house.gov/hearings.asp?formmode=view&id=1219.

111. 19 USC 2291(a) (Trade Action section 231(a)). See also U.S. Department of Labor, Employment & Training Administration. *Attachment B to UIPL No. 33-03, Eligibility Examples.* http://workforcesecurity.doleta.gov/dmstree/uipl/uipl2k3/uipl_3303a2.htm.

112. HCTC team. *NASWA National Unemployment Insurance Directors' Conference: Health Coverage Tax Credits*. October 22, 2003. http://www.workforceatm.org/sections/pdf/2003/uidirconf03p7.pdf.

113. In Ohio, one plan guaranteed coverage and the other did not. Virginia denied standard coverage to individuals with coverage gaps, but may have offered alternative coverage. Colorado denied coverage to individuals with coverage gaps of 90 days or more. Colorado and Illinois denied coverage to HCTC beneficiaries with coverage gaps who did not meet the standard enrollment criteria for those states' high-risk pools (for example, prior denials of coverage by nongroup insurers, absence of any waiting list, etc.). According to some observers, Maryland and (for some beneficiaries) Illinois guaranteed issue for individuals enrolling in HCTC by October 1, 2003. Sonya Schwartz and Marc Steinberg. *A Shelter in the Storm: How a Subsidy Could Help Unemployed Workers Get Health Insurance.* October 2003. http://www.familiesusa.org/site/DocServer/TAARA_expansion.pdf?docID=2161.

114. This tabulation counts Connecticut as a state in which preexisting conditions could be excluded, as the high-risk pool open to HCTC beneficiaries permitted such exclusions. The community-rated plan listed on the IRS website did not exclude such conditions, but federal authorities had not approved the plan as qualified.

115.In some states that did not issue coverage to beneficiaries with coverage gaps, there was no policy to which preexisting condition exclusions could apply.

116. The exclusion was reduced to six months for medical conditions untreated during the six months before starting coverage with Aegis.

117. This plan was slated to begin accepting HCTC beneficiaries in February 2004.

118. Individuals with coverage gaps were enrolled only if they met the state's criteria for its high-risk pool (i.e., the beneficiary must have had one of several listed conditions or must have been rejected by private insurers).

119. Individuals with coverage gaps were enrolled only if they met the state's criteria for its high-risk pool (i.e., the beneficiary must have had one of several listed conditions or must have been rejected by private insurers). Even if they met the criteria, the state had a waiting list, so enrollment would have been delayed.

120. The length of exclusion depended on the length of the prior coverage gap.

121. The actual period of exclusion depended on the length of prior coverage gaps.

122. Connecticut's policies on guaranteed issue and preexisting conditions were tentative, as of November 2003, when the state was negotiating with insurers.

123. The exclusion applied only to individuals who lacked continuous coverage during three of the twelve months preceding the application for Healthy New York.

124. The individual's indication of a desire to trigger this process could be viewed as an attempt to enroll in an HCTC plan, which would stop the 63 day "coverage gap" clock from ticking.

125. Kapur and Marquis, op cit. Calculations by ESRI, July 2003.

126. Of course, any such analysis should be aggregated, excluding all identifying information, to protect individuals' privacy.

127. 42 U.S.C. 1396r-1, 1396r-1a, 1396r-1b.

128. Alternatively, legislation could give the following choice to an employer certified as adversely affected by foreign competition: either the employer provides the state workforce agency with a list of laid-off workers, so the agency can educate the workers about HCTCs and other available assistance; or the employer directly sends such workers outreach materials provided by the state.

129. Hoffman and Wang, op cit.

130. Kapur and Marquis, op cit.

131. Danielle H. Ferry, Bowen Garrett, Sherry Glied, Emily K. Greenman, and Len M. Nichols. "Health Insurance Expansions for Working Families: A Comparison of Targeting Strategies." *Health Affairs.* July/August 2002. http://content.healthaffairs.org/cgi/reprint/21/4/246.pdf.

132. Such increases could be structured in many different ways. For example, part of the credit could be fixed in amount, and part could be a percentage of the total premium. Another creative suggestion offered by Stuart Butler of the Heritage Foundation would increase the tax credit amount and add it to adjusted gross income, which would, in effect, partially phase out tax credits as income rises into higher tax brackets. See generally Stan Dorn and Jack A. Meyer. *Nine Billion Dollars a Year to Cover the Uninsured: Possible Common Ground for Significant, Incremental Progress.* ESRI. October 2002. http://www.esresearch.org/newsletter/october/cpolicy4.pdf.

133. Cohen Ross and Cox, op cit.

134. Robert E. Moffit. *Recent Premium Increases and the Future of the FEHBP*. Testimony before the House Subcommittee on Civil Service and Agency Organizations. October 16, 2001. http://www.heritage.org/Research/HealthCare/Test101601.cfm.

135. 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.

136. Other steps might also be needed to make participation in this new program attractive to FEHBP plans, whether or not policymakers condition FEHBP contracts on participation in state-selected HCTC systems. For example, during the first several years of program operation, federal funds could pay for reinsurance, and plans could have profit margins slightly higher than those permitted under FEHBP. See Dorn and Meyer, op cit.

137. Stephen Barr. "House Panel Hears Concerns About Offering Health Savings Accounts." *Washington Post.* March 25, 2004, Page B02. http://www.washingtonpost.com/wp-dyn/articles/A22467-2004Mar24.html.

138. Dorn and Meyer, op cit.