THE COMMONWEALTH FUND

Task Force on the Future of Health Insurance

Issue Brief

April 2004

Health Coverage Tax Credits Under the Trade Act of 2002

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The Nathan Cummings Foundation provided partial support for this project.

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 whether such credits can be effective and, if so, how they can best be structured.

In studying the progress made in implementing the Act's provisions through the end of 2003, we have noted important successes as well as potential weaknesses that may require correction. Officials have done a remarkable job establishing the federal and state infrastructure for the new program, and beneficiaries in many states are offered numerous coverage options from which to choose. On the other hand, take-up of the tax credits has been quite limited thus far; many HCTC health plans treat beneficiaries very differently based on their age, gender, and prior health history; and the new program's administrative costs may be quite high (although some such costs involve necessary infrastructure development rather than ongoing operational expenses). It bears considerable emphasis that, roughly six months after the start of advance payment, it is far too soon to come to any conclusions about the success or failure of HCTCs. Nevertheless, it is already clear that Trade Act health coverage is likely to teach policymakers important lessons about the viability and potential design features of tax credits that could cover a much larger group of uninsured Americans.

Background

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 this 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, 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 two major categories:[1]

- 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.
- 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.

Preliminary Findings

This brief (and the accompanying full report) draws on dozens of interviews with stakeholders and policymakers, a review of relevant documents, and a survey of health plans offered to HCTC beneficiaries in 15 states. Our main findings are discussed below.

Successful Infrastructure Development

Federal officials have made tremendous progress establishing this new program. By the statutory due date of August 1, 2003 (less than a year after the Trade Act was signed into law), the interagency HCTC team and its contractors had up and running a federal–state–private system for making advance payments to insurers, relying primarily on electronic exchange of information and payments. No similar payment system has ever existed before.

The HCTC team has had to overcome more than the inevitable difficulties of pulling together an effective interagency collaboration involving multiple cabinet level departments. The tasks involved were novel and complex, and each agency on the HCTC team was simultaneously addressing other major challenges related to its core mission.

This work resulted in accomplishments at the state as well as the national level. 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 (Table 1, pages 8–9).[2]

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, officials used grants from the Department of Labor to pilot-test advance-payment systems in two states before August 2003, and advance-payment mechanisms have been simplified several times to save administrative costs and to prevent consumer mistakes from placing coverage at risk.

Enrollment Challenges

Despite these accomplishments, 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 were mailed outreach materials (Table 1, pages 8–9). Including dependents, total enrollment reached 13,247 by the end of December. Additional households will claim HCTCs on their year-end federal income tax forms for 2003.

It is still early in the program's history. Advance payment did not begin until August 2003, and enrollment will surely grow as officials move up the learning curve and word of the new program spreads among potential beneficiaries. However, several obstacles are already evident that, unless addressed, may limit future take-up of HCTCs. The following sections briefly touch on each obstacle in turn.

Affordability of the beneficiary's 35 percent premium share. For many displaced workers 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 causes family income to fall by an average of 40 percent.

Some early evidence suggests that, in fact, many low-income workers who are potentially eligible for HCTCs may be declining the credits. For example, in Maryland, half of Bethlehem Steel's Pension Benefit Guaranty Corporation retirees have pensions under $10,780 a year. Only 5 percent of such retirees enrolling in Maryland's state-based HCTC coverage have pensions below that level.[3]

Timing of advance payment. To receive advance payment, beneficiaries must first enroll in a qualified health plan and pay premiums in full for one or more months until advance payment starts. On annual tax forms, beneficiaries can claim HCTCs to reimburse such costs. However, those who cannot afford to front the premium payments will remain unenrolled and uninsured. As a stopgap measure, a number of states have ameliorated this problem by using limited federal grant funds to pay 65 percent of premiums until advance payment starts.

Outreach issues. The program's main outreach strategy is to mail a 20-page booklet to each individual whom the Pension Benefit Guaranty Corporation 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, which suggests that these complicated materials may be ineffective with many eligible workers. 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 also misses one of the largest groups of HCTC-eligible individuals—

namely, recently displaced workers who are still receiving unemployment insurance, but who will qualify for TAA cash payments when their unemployment benefits expire. State workforce agencies lack complete lists of such individuals, so many never receive written information about HCTCs. Moreover, current outreach materials do not explain the key step required for these workers to be considered for HCTC eligibility—namely, applying for TAA cash benefits.

Limited appeal of available coverage options. 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 plans offered by their states, which may have high deductibles or other strict benefit limits as noted below. On the other hand, some potentially eligible individuals may be deterred from enrollment because they find these state-based options *too* comprehensive, hence too expensive. More time will be needed to reach definitive conclusions about the insurance preferences of these displaced workers and early retirees. However, despite the extraordinary 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.

The Potential for High Administrative Costs

The administrative cost of advance payment is currently unstated but likely to 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 may require careful justification if they are part of ongoing program operation and will therefore expand proportionately as enrollment grows.

Characteristics of Qualified Plans

This brief has already noted that potentially eligible workers may not enroll if they believe that HCTC plans cost too much or offer too little. This section goes beyond that take-up issue and explores several other aspects of the qualified plans for which HCTCs may be used.

Workers without access to qualified plans. Some workers who are otherwise eligible for HCTC do not have access to COBRA because their former employer has fewer than 20 workers, no longer offers or did not previously provide health coverage, or for other reasons. In the 24 states (plus Puerto Rico) without state-based coverage at the end of 2003, most workers without access to COBRA will be unable to use HCTCs to purchase health insurance. Fortunately, jurisdictions without state-qualified plans now include only one of four HCTC-eligible workers.

Distribution of enrollment and plans. In states offering state-qualified coverage as of December 2003, HCTC enrollment was evenly split between COBRA plans and state-qualified coverage. At that time, 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 to get comprehensive, affordable coverage in the nongroup market; and
- In six states,[4] 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.

(For information about coverage available in each state, see Table 1, pages 8–9.)

Consequences of fewer federal requirements. Embodying a much less heavily regulated approach

to health coverage than previously enacted programs such as Medicaid, the State Children's Health Insurance Program, and Medicare, the Trade Act does not impose any minimum benefit requirements or general premium rating rules. Such issues are generally left to the health plans and the states.

For a more detailed understanding of the coverage HCTC beneficiaries receive under this new approach, we surveyed 15 broadly representative states, which included six nongroup plans, seven high-risk pools, and five community-rated plans. In most states, we found significant consumer choice. Of the 15 states we surveyed, nine provided five or more state-qualified options from which HCTC beneficiaries could choose (Table 2, page 10). 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.

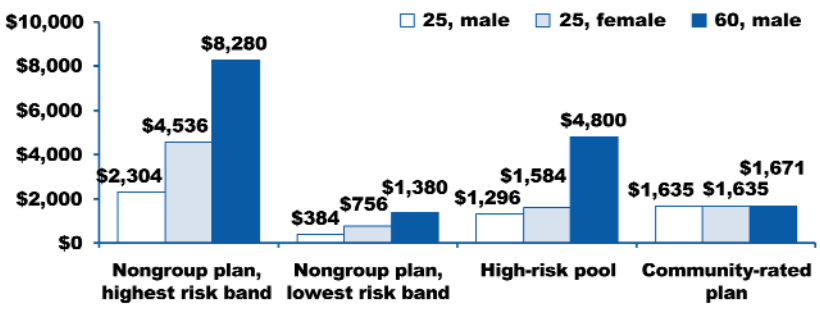
However, many of these plans had tight benefit limitations, in addition to large deductibles. In 11 of 15 states, even the most generous plan excluded or severely limited at least two of the following benefits: maternity care, mental health care, prescription drugs, or preventive care. (Of course, as noted above, some HCTC beneficiaries may prefer coverage that has relatively limited benefits but lower premiums as a result.)

Both national data and our survey found considerable variation in the cost to beneficiaries of state-based coverage (Figure 1). Nationally, beneficiaries' average annual premium payments to meet their 35 percent share varied, in November and December 2003, from $974 for single coverage in the lowest-price quartile of state-based plans to $3,904 in the highest. According to our survey, premiums varied by age in 12 of 15 states, by gender in eight, by geography in seven, and by individual health history in five. Not surprisingly, 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 amounts, men (who consume less health care, on average, than do women) were required to

Example of State-Based HCTC Coverage in December 2003: North Carolina

- A healthy, 25-year-old man could purchase a fairly comprehensive 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, to include routine maternity care, have to pay $1,908 a year as her 35 percent premium share. To bring that payment down to $564 a year, she could select a policy with a $1,000 deductible and no maternity care.
- A healthy, 60-year-old man would need to make 35 percent annual premium payments of $1,080 in order to buy 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 in order to buy 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.

Figure 1. Median 35% Annual Premium Payment for One Insured in the Most Generous State-Qualified Plan, by Coverage Type, Age, Gender, and Risk*



* Fifteen surveyed states, November 2003–December 2003.
Source: Economic and Social Research Institute.

pay an average of 36 percent more than they would pay in plans with premiums that vary by gender. On the other hand, most state-qualified plans with risk-rated premiums charged women, middle-aged or older workers, and (in some states) consumers with prior health problems significantly more than young, healthy men enrolling in identical coverage.

Regardless of premium levels, 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, the Trade Act guarantees these protections only to beneficiaries with three months of continuous health coverage, without any gap in coverage lasting 63 days or longer. Under the Bush administration's statutory interpretation (which some key legislators disputed), such continuous coverage must be in effect immediately before enrolling in state-based HCTC plans.

Our survey found that most state-based plans limit these consumer protection measures to beneficiaries who meet this requirement for prior continuous coverage. In seven of the 15 states we surveyed, plans did not guarantee insurance to HCTC beneficiaries with recent coverage gaps. In 14 of 15 states, HCTC beneficiaries with recent coverage gaps either were denied coverage altogether or could have their preexisting conditions excluded. In nine states, such exclusions could last for 12 months after coverage began.

Officials estimate that, under the "best case scenario," it takes five months for a TAA beneficiary to receive the first HCTC advance payment following the loss of a job. In part, this is because, when a petition is filed with the Department of Labor claiming that a layoff resulted from foreign competition, 60 days must pass before laid-off workers may qualify for TAA. Workers who cannot afford to pay full premium costs based on the hope of year-end tax refunds may thus experience coverage gaps lasting 63 days or more, which will subject them to denials of state-based coverage in many states and preexisting condition exclusions in almost all states we surveyed.

Policy Alternatives

Following are suggested strategies that could allow HCTCs to reach two different but complementary goals: to help guide the design of future reforms and to improve HCTCs' coverage of the uninsured.

Revising HCTCs to Provide Better Information About Coverage Expansion Strategies

For the country's experience with HCTCs to yield the most useful possible information, policymakers need to consider the following steps:

- Modifying HCTC legislation to grant IRS the flexibility to test and evaluate alternative policies in two areas: (a) simpler and more consumer-friendly advance payment mechanisms; and (b) higher credit levels, particularly for low-income populations; and
- Modifying 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.

Revising HCTCs to Cover the Uninsured More Effectively

For HCTCs to do a better job of covering the uninsured, policymakers need to consider additional modifications to HCTC legislation:

- Beneficiaries—particularly those with low incomes—could receive HCTCs covering more than 65 percent of premiums.
- States could be given the option to provide HCTC beneficiaries with access to health plans that participate in the Federal Employees Health Benefits Program. This could expand state options and beneficiary choices, increase access to comprehensive coverage, and facilitate the development of simpler, more consumer-friendly mechanisms for advance payment.

Conclusion

The country has just begun an experiment in using refundable, advanceable federal income tax credits to cover the uninsured. The Bush administration has already surmounted a number of difficult and important hurdles. For the program to achieve its goals, however, problems remain that may need to be addressed.

Of course, problems are precisely what can be expected in any new program that departs significantly from previous policy. Even the State Children's Health Insurance Program, which is now widely acclaimed as a success, had to overcome major start-up challenges. For the HCTC program as well it will take some time to assess the significance of any initial stumbles.

During the past decade, tax credits have been the method most frequently proposed, by both major political parties, to help millions of uninsured Americans obtain health coverage. The basic question facing policymakers is whether HCTCs' shortcomings, whatever they turn out to be, are fixable through policy redesign or are inherent in the operation of tax credits, no matter how they are structured. Much more experience is needed before this question can be answered, but it is already clear that the HCTC program may teach significant lessons about how best to structure health insurance tax credits if they are included in future efforts to cover millions of uninsured Americans.

Notes

[1] A third type of coverage used by a small proportion of advance payment enrollees is, like COBRA, available without state action. In any state, workers who had nongroup coverage during at least their final 30 days before separation from employment may apply HCTCs to such coverage. Such nongroup plans were used by 4 percent of advance payment enrollees in December 2003.

[2] In three additional states, the only form of state-qualified insurance is so-called "mini-COBRA coverage." Functioning much like COBRA continuation coverage, mini-COBRA coverage must, under laws in many states, be offered to laid-off workers by certain firms with fewer than 20 employees. Federal officials believe that only a very small number of HCTC beneficiaries qualify for mini-COBRA coverage.

[3] Sonya Schwartz and Adele Bruce, *The Trade Act Health Insurance Subsidy: An Update from the States,* Families USA, December 2003.

[4] Only five of these plans are operational; one was not approved as comprising qualified coverage.

Table 1. Trade Act Implementation by State, December 2003

State	Potentially Eligible Workers[i]			Advance Payment Enrollees		State-Based Plans			
	Under Pension Benefit Guaranty Corp.	Under Trade Adjustment Assistance[ii]	Total[iii]	Number[iii]	Proportion of Potential Eligibles	Mini-COBRA[iv]	High-Risk Pool	Other Community-Rated Plans	Nongroup Coverage
Alabama	2,338	2,462	4,800	82★	1.7%				X
Alaska	73	62	135	★	★		X		
Arizona	1,336	468★	1,804★	36★	2.0%				
Arkansas	887	654★	1,541★	18★	1.2%		X		
California	6,229	3,072	9,301	245	2.6%				
Colorado	1,258	913	2,171	28★	1.3%	X	X		
Connecticut	2,086	680	2,766	37★	1.3%	X	X	X[v]	
Delaware	264	122	386	13	3.4%				
Washington, D.C.	81	0	81	0	0.0%				X
Florida	11,059	609	11,668	283	2.4%	X			X
Georgia	5,940	2,204★	8,144★	56	0.7%				
Hawaii	505	40	545	★	★				
Idaho	327	1,238	1,565	37	2.4%				
Illinois	7,957	4,522	12,479	304★	2.4%		X		
Indiana	7,898	2,080	9,978	547	5.5%				X
Iowa	1,183	632★	1,815★	40★	2.2%		X		
Kansas	868	891	1,759	19	1.1%				
Kentucky	1,135	2,861	3,996	89★	2.2%	X			
Louisiana	696	193	889	★	★				
Maine	482	1,442	1,924	109★	5.7%			X	
Maryland	4,444	372	4,816	485★	10.1%		X		
Massachusetts	4,265	878	5,143	29★	0.6%				
Michigan	5,460	2,201	7,661	454	5.9%			X	
Minnesota	2,005	1,417	3,422	206	6.0%		X		
Mississippi	928	822	1,750	24	1.4%				
Missouri	5,519	1,612	7,131	192	2.7%				
Montana	83	259	342	16	4.7%		X		
Nebraska	252	119	371	11★	3.0%	X			
Nevada	725	46	771	10★	1.3%				
New Hampshire	893	333	1,226	15★	1.2%		X		
New Jersey	4,156	2,419	6,575	56★	0.9%	X			
New Mexico	276	173★	449★	★	★				
New York	7,752	2,972★	10,724★	326	3.0%	X		X	X
North Carolina	4,104	11,129	15,233	965★	6.3%				X
North Dakota	31	33	64	★	★		X		
Ohio	12,337	3,769	16,106	471	2.9%	X			X

Table 1. Trade Act Implementation by State, December 2003 (cont.)

State	Potentially Eligible Workers[i]			Advance Payment Enrollees		State-Based Plans			
	Under Pension Benefit Guaranty Corp.	Under Trade Adjustment Assistance[ii]	Total[iii]	Number[iii]	Proportion of Potential Eligibles	Mini-COBRA[iv]	High-Risk Pool	Other Community-Rated Plans	Nongroup Coverage
Oklahoma	762	1,792	2,554	16	0.6%				
Oregon	475	1,329	1,804	50*	2.8%				
Pennsylvania	17,964	5,710	23,674	1,869	7.9%			X	
Puerto Rico	1,009	*	1,009*	0	0.0%				
Rhode Island	239	251	490	*	*				
South Carolina	1,795	2,426	4,221	46*	1.1%		X		
South Dakota	64	18	82	*	*				
Tennessee	2,670	5,470*	8,140*	212*	2.6%				X
Texas	3,753	4,943*	8,696*	62*	0.7%		X		X[vi]
Utah	526	715	1,241	*	*				
Vermont	226	90	316	*	*	X		X	
Virginia	2,686	4,907	7,593	400*	5.3%				X
Washington	1,068	4,969*	6,037*	123*	2.0%				
West Virginia	2,248	634	2,882	125*	4.3%				X
Wisconsin	1,763	4,614	6,377	94*	1.5%				
Wyoming	69	*	69*	0	0.0%				
Total	**143,149**	**91,593**	**234,742**	**8,371**	**3.6%**	**9**	**13**	**6**	**11**

Note: In the columns listing eligible workers and workers enrolled in HCTC advance payment, some of the 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.

[i] These columns list the numbers of workers, in various categories, who were known to state workforce agencies or the Pension Benefit Guaranty Corporation and for whom such agencies sent identifying information to the HCTC program. That program in turn mailed such workers outreach materials. As explained in the text, many unemployment insurance recipients who could qualify for HCTCs based on Trade Adjustment Assistance (TAA) are not included in these numbers because their identities are frequently unknown to state workforce agencies. If such recipients were added, the estimated number of potential TAA-eligible workers would probably increase substantially.

[ii] This column also includes workers who potentially qualify under the Alternative Trade Adjustment Assistance program.

[iii] Family members of HCTC-eligible workers are not included in these numbers.

[iv] Many states' laws require so-called "mini-COBRA" coverage to be offered to laid-off employees who formerly were insured by firms with fewer than 20 employees. Before HCTCs may be used to purchase such coverage, a state with a mini-COBRA law must affirmatively elect to treat such coverage as qualified under the Trade Act.

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

[vi] Although it was listed on the IRS website in November and December 2003, this plan was not slated to begin accepting HCTC beneficiaries until February 2004.

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

Table 2. Selected Features of State-Based Plans Surveyed in November and December 2003

State	Number of Coverage Options[iii]	Extent That Premiums Are Higher Than for a Healthy Man, Age 25[i]: Healthy Woman, Age 25[iv]	Healthy Man, Age 60	Man with Health Risks, Age 25[v]	Services Excluded or Very Limited in the Most Generous State-Qualified Plans[ii]: Maternity	Mental Health	Prescription Drugs	Preventive Care	Range of Deductibles	For Workers with Recent Coverage Gaps: Is Issue Guaranteed?	Are Preexisting Conditions Excluded?
Nongroup Plans											
Indiana	3	48%	310%	150%	X		X		$500–$2,500	No	Yes
North Carolina	18	231%	236%	600%	X	X	X		$250–$5,000	Yes	Yes
Ohio[vi]	7	50%	375%	150%	X		X		$500–$5,000	No	Yes
Texas[vii]	5	29%	199%	480%	X	X			$500–$5,000	No	N/A[viii]
Virginia[ix]	12	76%	264%	500%	X	X	X		$300–$1,500	No[x]	Yes
High-Risk Pools											
Alaska	6	Equal	215%	Equal	X	X		X	$1,000–$10,000	Yes	Yes
Colorado[xi]	5	53%	293%	Equal		X	X		$300–$5,000	No	Yes
Connecticut	4	95%	499%	Equal			X	X	$200	Yes[xii]	Yes
Illinois	8	60%	102%	Equal	X				$500–$2,500	No[xiii]	Yes
Maryland	2	Equal	153%	Equal					$0-$2,500	No	Yes
Montana	2	Equal	195%	Equal					$1,000–$2,500	Yes	Yes
Texas	4	41%	196%	Equal		X		X	$500–$5,000	No	Yes
Community-Rated Plans											
Connecticut[xiv]	1	N/A	N/A	N/A					$0	Yes	No
Maine	1	Equal	46%	Equal					$1,000	Yes	No
Michigan	2	Equal	Equal	Equal			X	X	$250—50% coinsurance	Yes	Yes
New York	Large number	Equal	Equal	Equal		X	X		$0	Yes	Yes
Pennsylvania[xv]	4	Equal	Equal	Equal			X	X	$750–$1,500	Yes	Yes

[i] These percentages show differences in premiums for the most generous plan in each state. Where premiums differed by geography, the listed premium differentials are for residents of the state capital.

[ii] Plans are classified as offering very limited services if they either required payment of premium surcharges to obtain the listed benefits, charged 40 percent or higher coinsurance, capped annual covered services at $1,000 or less, denied mental health services unless illness was severe or involved "organic brain disease," or excluded preventive care except for selected tests (like mammograms) or services for young children.

[iii] Such options involve any differences in coverage, including deductibles.

[iv] Where routine maternity care coverage was available at the beneficiary's option (in North Carolina and Virginia), this pricing information includes the additional premium charges for such care.

[v] These differentials are for the highest risk levels applied (based on individual medical underwriting) by each nongroup insurer.

[vi] Ohio offered state-qualified coverage through two nongroup insurers. Except for the column listing the number of coverage options in the state, which includes both insurers, the other information in this row refers to the more conventional and potentially generous of the two insurers. The other nongroup insurer limited costs by capping total reimbursement per spell of injury or illness.

[vii] Although it was listed on the IRS website in November and December 2003, this plan was not slated to begin accepting HCTC beneficiaries until February 2004.

[viii] Texas did not provide coverage to individuals with coverage gaps, so the issue of preexisting condition exclusions did not arise.

[ix] This row describes the nongroup coverage listed on the IRS website and offered in Virginia in November and December 2003. It does not include coverage offered by an additional nongroup insurer, which was first qualified by state letter on December 23, 2003, and was not listed on the IRS website in November or December 2003.

[x] Individuals with coverage gaps may have been offered a different plan.

[xi] For beneficiaries with recent coverage gaps of 90 days or more, Colorado's plan did not guarantee issue and excluded preexisting conditions.

[xii] Connecticut's two preexisting high-risk-pool plans guaranteed issue. A new such plan for low-income state residents did not.

[xiii] 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.

[xiv] For this community-rated plan, Connecticut's policies on guaranteed issue and preexisting conditions were tentative, as of November and December 2003. At the time, the state was still negotiating with insurers, premiums had not been set, and the federal government had not certified this coverage as qualified.

[xv] This row describes coverage that was offered in the part of the state that includes the capital. Other portions of the state had different HCTC plans available.

Source: ESRI survey, November and December 2003.

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Acknowledgments

The authors would like to thank The Commonwealth Fund and The Nathan Cummings Foundation for their support of this project. We are also grateful to Stuart Butler of The Heritage Foundation for his thoughtful review of an earlier draft of this paper, as well as members of the HCTC Team in multiple federal agencies and private firms, who generously provided information that contributed greatly to our analysis. None of the individuals who assisted us is responsible for the views expressed in this issue brief, which are exclusively those of the authors.


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