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Issue Brief

Limited Take-Up of Health Coverage Tax Credits: A Challenge to Future Tax Credit Design

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

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Introduction

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

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Although the HCTC program targets a relatively small population, it offers a unique opportunity to glean lessons about the design of tax credits for other uninsured populations. This issue brief analyzes a well-known problem with the HCTC program—namely, that many eligible individuals have not participated—and explores how future tax credits could be designed to overcome this problem.¹ In the past, a broad range of leaders, including both major presidential candidates in 2004, have proposed using tax credits to subsidize coverage for millions of low- and moderate-income uninsured. The effectiveness of such proposals may hinge in large part on policymakers' ability to learn from the HCTC experience and improve the design of future tax credits.

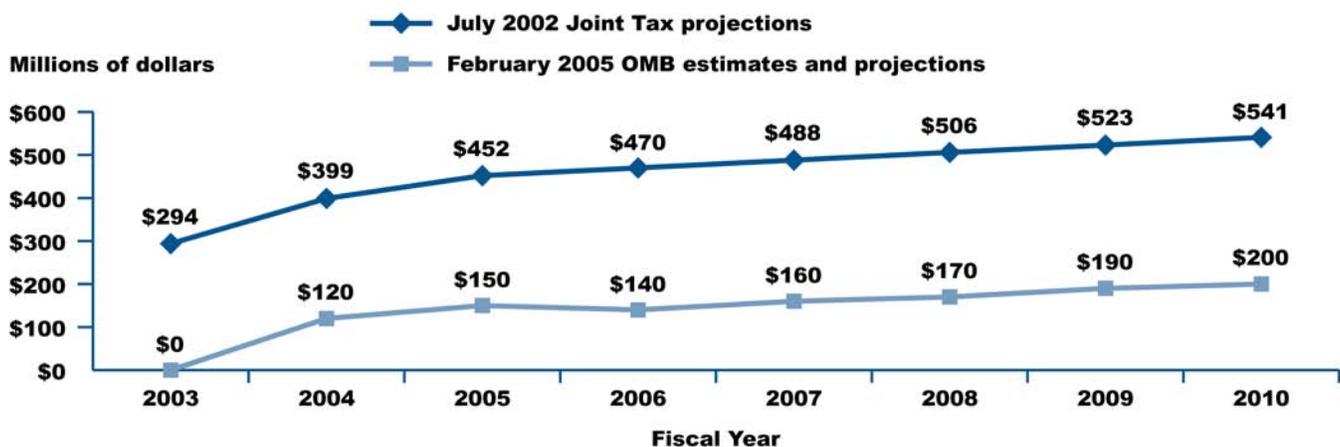
(Note: This issue brief summarizes the authors' more detailed research report, *Limited Take-Up of Health Coverage Tax Credits and the Design of Future Tax Credits for the Uninsured*, which is available at http://www.esresearch.org/documents_1-05/HCTC_TakeUp.pdf. While key sources are cited in the issue brief, the longer report includes full sources and more in-depth analysis. For readers unfamiliar with the HCTC Program, the report also includes Appendices that explain key details of program operation.)

Enrollment Lower Than Expected, More Than Sometimes Portrayed

Based on tax expenditure data, enrollment in HCTCs is about one-third of the level anticipated when the Trade Act passed. In July 2002, the Congressional Joint Committee on Taxation (Joint Tax) estimated that credits would total \$399 million in 2004, \$452 million in 2005, \$470 million in 2006, and increasing amounts in later years. In February 2005, the U.S. Office of Management and Budget (OMB) gave actual and estimated totals for the HCTC program at roughly one-third the projected levels: \$120 million in 2004, \$150 million in 2005, \$140 million in 2006, and subsequent rising amounts. (Figure 1).

Despite this gap between expectations and performance, the take-up rate for HCTCs is higher than is sometimes stated. In July 2005, out of an estimated 234,000 potentially eligible workers and retirees, only 15,640, or 6.7 percent, had completed registration and were receiving advance benefits or would receive advance benefits when they made a payment. Although a number of respected analysts have suggested a corresponding take-up rate in the neighborhood of 6 percent,² the actual take-up rate for HCTC is significantly above that level, for two reasons. First, while

Figure 1. Health Coverage Tax Credit Expenditure Costs: July 2002 Projections vs. February 2005 Estimates and Projections



Note: The February 2005 numbers combine the revenue and outlay effects identified by the Office of Management and Budget (OMB).

Sources: Congressional Joint Committee on Taxation, *Estimated Budget Effects of the Revenue Provisions Contained in the Conference Agreement for H.R. 3009, The Trade Adjustment Assistance Reform Act of 2002*, July 29, 2002, JCX-84-02, <http://www.house.gov/jct/x-84-02.pdf>; U.S. Office of Management and Budget, *Analytical Perspectives on the Budget, 2006*, February 2005, <http://www.whitehouse.gov/omb/budget/fy2006/pdf/spec.pdf>. Calculations by the Economic and Social Research Institute (ESRI), May 2005.

234,000 individuals were identified as potentially eligible because they received PBGC or TAA assistance, many were actually ineligible because they had other health coverage that precludes HCTC eligibility, such as Medicare or insurance heavily subsidized by a spouse's employer. Based on the Government Accountability Office's (GAO) description of Internal Revenue Service (IRS) survey results, such disqualification from HCTC may affect roughly half of individuals who do not use advance payment despite being identified as potentially eligible.³

Second, individuals who take up HCTCs include, in addition to advance payment recipients, households that receive the credits only at the end of the year, through claims on their federal income tax forms. For 2003, approximately 13,000 households that had not received advance payment obtained HCTCs via such end-of-year tax filings.⁴ According to recent IRS data, tax returns claiming year-end HCTCs for 2004 are 5.5 percent below 2003 levels.⁵ If that same reduction applies to valid claims by taxpayers who did not receive HCTC advance payment during 2004, then approximately 11,900 such households could obtain end-of-year HCTCs for 2004.⁶

September is the most recent month in 2004 for which advance payment data are publicly available.⁷ In that month, nearly 13,600 households received advance payment of HCTC. Adding the approximately 11,900 households that may have received end-of-year HCTCs for 2004 without participating in advance payment, as many as 25,500 workers may have received the credit in some form applicable to September 2004. For that month, IRS received the names of 222,000 workers who received TAA or PBGC assistance and so potentially qualified for the credit. If, as suggested by GAO, roughly half of these workers who did not use advance payment were ineligible for the credit because they were enrolled in disqualifying coverage, then approximately 118,000 households qualified for the credit. With 25,500 households

obtaining the credit in some form, the resulting take-up rate for HCTC was approximately 22 percent in September 2004.

Publicly available data thus allow, for the first time, an estimate of the HCTC take-up rate that a) excludes from the pool of potentially eligible individuals those who in fact are ineligible because they have disqualifying coverage and b) includes both advance payment participants and recipients of end-of-year tax credits. However, in assessing the significance of this estimate, two caveats are important. First, it is only a rough approximation; GAO's survey description is the only known evidence of the proportion of names sent to IRS that is ineligible for the program. The underlying survey has not been made publicly available, so it is impossible to assess its reliability.

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

By contrast, the State Children's Health Insurance Program (SCHIP) was less novel, because it built on earlier program infrastructure developed by Medicaid. It is therefore unclear whether SCHIP can fairly be used as a benchmark for HCTC enrollment. SCHIP had a 43.5 percent take-up rate in its first year (1998), 53.9 percent by its third year (2000), and 60.4 percent by its fifth year (2002).⁸

Key Causes of Low Take-Up

To date, no rigorous, controlled studies have isolated the relative importance of each factor that

impedes enrollment in the HCTC program. According to many state officials and stakeholders, however, the most important obstacle to enrollment is that many potentially eligible workers and retirees cannot afford to pay their 35 percent share of premiums.⁹

Another important reason for low take-up is that applicants are frequently required to pay one to three months of premiums, in full, before the start of advance payment. That is because, under the statute, enrollment in a qualified plan is required for HCTC eligibility, and IRS typically requires one to three months to process applications for advance payment. While beneficiaries can claim end-of-year tax credits to reimburse 65 percent of these initial payments, many workers lack the disposable income needed to make full premium payments “up front.” As of September 2005, only 12 states, which together included 39 percent of potentially eligible workers, operated “gap-filler” programs that paid 65 percent of premiums while workers waited for their advance payments from IRS.

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

Enrollment has also been hindered by limitations in IRS’s approach to outreach. To their credit, officials have taken important steps to educate potential beneficiaries. For example, the IRS sent three mailings to encourage end-of-year HCTC claims for 2003 (though this was not repeated for 2004); officials from IRS and the U.S. Treasury Department have participated in HCTC educational events across the country; and most

important, IRS regularly mails HCTC Program Kits, which explain the program in detail, to everyone identified by PBGC or a state workforce agency as potentially qualifying for the credit.

However, several factors have limited the effectiveness of these efforts. According to a recent analysis of outreach to individuals eligible for new Medicare prescription drug subsidies, consumer education materials should be written at no more than a fifth-grade reading level.¹⁰ The HCTC Program Kit, the main educational tool for advance payment, is written at an eighth-grade reading level, making it difficult for some to understand. In addition, the kit is not mailed in languages other than English.

Even if outreach materials were improved, another key barrier would remain: namely, the IRS’s two-step enrollment process, in which the agency first provides potentially eligible individuals with HCTC information and then hopes that those receiving the information will later submit an application. This is the approach most often used by other health coverage programs, like Medicaid and the State Children’s Health Insurance Program (SCHIP). Much more effective, however, would be a one-step process where IRS (or an agency working with IRS) proactively contacted potentially eligible individuals and, during a single interaction, both educated them about available benefits and allowed them to submit a complete application. (As this strategy is novel in its application to health coverage subsidies, it would not be fair to criticize IRS or the Treasury Department for failing to employ this approach in the past, although it may be important to consider incorporating this strategy into future tax credit programs or a renewed effort to expand HCTC enrollment via IRS community partners.) To illustrate the importance of such proactive outreach, the IRS National Taxpayer Advocate Service (TAS) found that when TAS staff initiated telephone contact to assist individuals with challenging IRS audits of Earned Income Tax Credit

claims, as many as 67 percent received favorable awards. By contrast, when TAS staff provided assistance without making such telephone calls, only 38 percent obtained favorable awards.¹¹

In-person outreach events could likewise be structured to help potentially eligible individuals apply and enroll on the spot. The early months of the HCTC program saw Maryland achieve significantly higher take-up rates than any other state,¹² largely because a list of all the state's PBGC recipients was loaded onto health plan officials' laptops, allowing in-person registration and immediate enrollment at consumer information events. Since then, federal officials' application of privacy requirements has prevented further use of this strategy in Maryland and other states. Instead, in-person events can only educate potential beneficiaries, who must later apply on their own.

Another barrier to enrollment in advance payment HCTC is that the process is complex and time-consuming. Applicants must apply to between three and five public and private entities and frequently

must deliver to one or more of these entities hard-copy documents issued by the others (Table 1).

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

IRS educational materials and the HCTC consumer call center direct workers to the IRS Web site for information about state-qualified plans, including such plans' telephone numbers and Web addresses. The IRS Web site, however, includes incomplete information and broken links. Between May 24 and June 16, 2005, researchers from the Economic and Social Research Institute (ESRI) found the following:

- For 57 insurers then listed as offering state-qualified coverage, 21 listings (37%) did not include Web addresses, and one had a non-functioning Web address.

Table 1. Applications Required for Potential Beneficiaries to Enroll in HCTC Advance Payment

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

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

Note: Applications to gap-filler programs are required only if workers seek gap-filler assistance before the start of advance payment.

Source: Stan Dorn, Janet Varon, and Fouad Pervez, *Limited Take-Up of Health Coverage Tax Credits and the Design of Future Tax Credits for the Uninsured*, ESRI and Northwest Health Law Advocates. October 2005. http://www.esresearch.org/documents_1-05/HCTC_TakeUp.pdf.

- Out of 35 insurers with a direct link from the IRS site:¹³
 - Only five (or 15%) included any information about HCTC on the Web page called up by following the link.
 - For 20 insurers (57%), a viewer could not identify the HCTC-qualified health plan despite viewing all potentially pertinent links visible from that initial Web page and searching the plan’s Web site for all terms related to HCTC.

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

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

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

Worker and Program Characteristics Affecting Enrollment

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

become the focus of future tax credit expansion efforts:

- The belief held by many laid-off workers, probably including some TAA beneficiaries, that they will soon be rehired and thus do not need health coverage assistance.
- The significant loss of income experienced by many of those eligible for HCTC, particularly laid-off workers receiving TAA. Some of these individuals must continue paying for fixed financial obligations they incurred while employed. This can lower the amount of discretionary income that is available to pay their share of insurance premiums, compared with other low-income people who did not previously have significantly higher incomes.¹⁴
- The age of eligible individuals, especially early retirees receiving PBGC payments. This is a factor because premium costs for state-qualified coverage (hence the amount of the beneficiary’s 35 percent premium share) can rise with age.
- The complexity of HCTC, specifically the credit’s interaction with TAA and PBGC—benefit systems run by different state and federal agencies, each with its own complicated rules, procedures, and policy goals. A future tax credit without such linkages could perhaps be structured more simply.

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

- Eligibility for HCTC is not limited to low-income households. Many displaced workers and early retirees have working spouses, for example; and many PBGC recipients supplement their pensions with earnings from new employment.
- Potential HCTC beneficiaries may attach a particularly high value to health coverage,

compared with some other groups of uninsured individuals. HCTC-eligible individuals (particularly PBGC-related HCTC beneficiaries, who are 55 to 64 years old) tend to be older than most American workers, and many have had longstanding prior coverage. By contrast, only 24 percent of the uninsured are over age 44.¹⁵ Moreover, 75 percent of individuals uninsured at any particular time have been without coverage for 12 months or longer.¹⁶

- IRS receives the name and address of all potential HCTC beneficiaries, making it possible to target outreach to a defined and limited group of individuals.

Lessons for Future Tax Credit Design

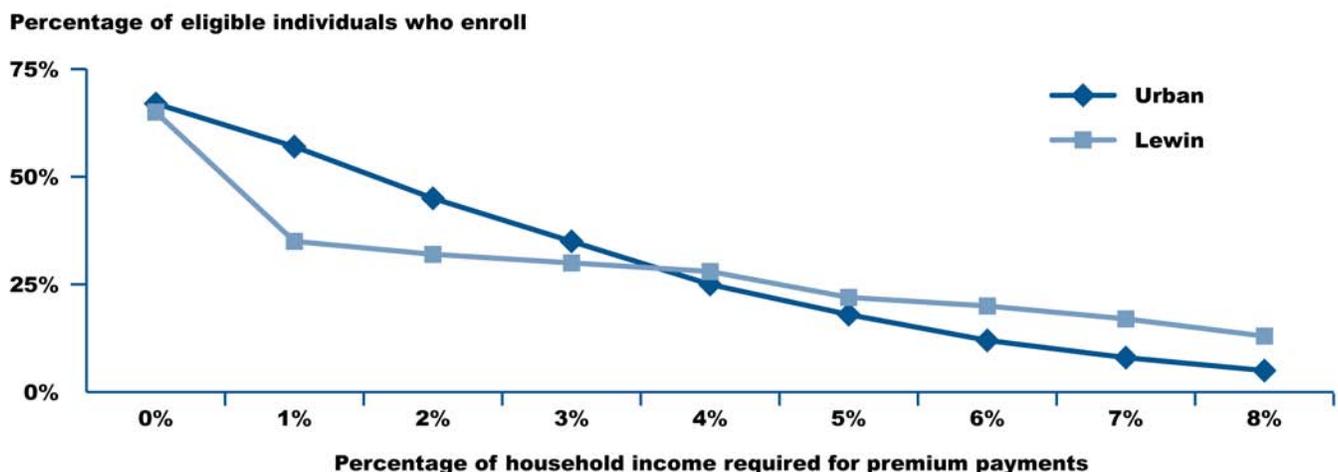
To inform the future design of health insurance tax credits, can policymakers draw useful lessons from the HCTC Program's experience? Are HCTC's take-up problems unique to this particular set of beneficiaries and institutions? Or could the causes of low enrollment in HCTC also inhibit enrollment among other groups of unin-

sured? As the following analysis of other programs and populations suggests, the kinds of barriers apparent in the operation of HCTC would probably also affect many other groups of insured with low to moderate income.

Premium Requirements

Perhaps the most important obstacle to HCTC enrollment has been that enrollees are required to pay 35 percent of their premiums. The effect of similar cost-sharing requirements on future tax credit proposals would vary, depending on the group being targeted. By definition, the higher-income uninsured tend to have more ability to pay, compared with those who earn less. But two-thirds (65%) of the uninsured have incomes below 200 percent of the federal poverty level (FPL).¹⁷ If future tax credits seek to cover the low-income uninsured, premium costs like those imposed by HCTC are likely to deter participation by most potential beneficiaries. Analyses of take-up rates for health coverage programs serving low-income households have found that when premium payments consume even 5 percent of household income, take-up rates fall below 25 percent (Figure 2). Based

Figure 2. Relationship Between Take-Up Rates and Percentage of Income Required for Premium Payments



Sources: John Sheils and Randall Haught, *Cost and Coverage Analysis of Ten Proposals to Expand Health Insurance Coverage* (Appendix A), The Lewin Group, Oct. 1, 2003 (prepared for *Covering America*, The Robert Wood Johnson Foundation), <http://www.esresearch.org/publications/SheilsLewinall/A-Methodology.pdf>; Leighton Ku and Teresa A. Coughlin, *The Use of Sliding Scale Premiums in Subsidized Insurance Programs*, The Urban Institute, March 1, 1997, <http://www.urban.org/Template.cfm?Section=ByAuthor&NavMenuID=63&template=/TaggedContent/ViewPublication.cfm&PublicationID=6201>, later revised and published in *Inquiry* 36 (Winter 1999/2000): 471–80.

on this research, the average monthly HCTC premium share for a one-person policy, \$144 a month in mid-2004, would be expected to yield a take-up rate of less than 30 percent among households with incomes as high as 250 to 300 percent of FPL.

Consider the experience of Washington State, which operates the Basic Health Program, the nation's oldest state-based premium-subsidy program for low-income, uninsured workers. Since the early 1990s, the program has covered the working uninsured with incomes up to 200 percent of the FPL. During that time, small changes in premium levels have been followed by large changes in enrollment. For example, when average household premium payments fell from 21 to 16 percent of premiums, enrollment rose by 146 percent. When average household payments were raised from 16 to 19 percent of premiums, demand for coverage fell by 45 percent. Several peer-reviewed, published studies have found a strong causal relationship between Basic Health Program premium requirements and enrollment levels.

In recent years, program administrators in many states have likewise found that even modest premium requirements can noticeably affect enrollment in low-income health coverage programs. For example:

- In September 2003, a subsidized health insurance program for Massachusetts residents receiving unemployment insurance began to charge premiums of \$20 and \$30 a week for individuals and families, respectively. By February 2004, enrollment declined by nearly 50 percent.
- In 2003, Oregon's Medicaid program made significant policy changes for non-elderly adults with income below 100 percent of the FPL, including raising monthly premiums. For example, premiums increased from \$6 to \$9 for single adults with incomes between 11 percent and 50 percent of the

FPL. During the six months following the changes, 44 percent of previous enrollees lost coverage; many who left the program cited higher premium charges as the main cause.

- In Texas, an annual \$15 fee for children's coverage was changed in October 2003 to a monthly \$15 premium for families with incomes between 100 percent and 150 percent of the FPL. Officials also increased copayments and cut benefits. During the nine-month period after the changes, 35 percent of families in this income group left the program, often because of inability to afford monthly premiums.
- In January 2002, Rhode Island's Medicaid program began charging families with incomes above 150 percent of FPL premiums on a sliding scale of \$43 to \$58 per month. During the first three months this policy was in effect, nearly one of five affected families (18%) disenrolled.
- In October 2002, Washington State dropped 28,000 immigrants from its Medicaid program, which did not charge premiums. Instead, the state offered them coverage through the state's Basic Health Program, which charged premiums on a sliding scale starting at \$10 a month. Roughly half of these immigrants never enrolled, however, and many who enrolled soon left. By April 2003, only 12,000 of the original 28,000 (43%) retained publicly funded coverage.

The impact of apparently modest premium requirements on enrollment in low-income health coverage programs is not hard to understand. Many low-income households have such little discretionary income that money for premiums would come from cutting back other necessities. A recent study of low-wage workers in 10 U.S. communities found that a typical family needs

from \$27,660 per year (in New Orleans, before Hurricane Katrina) to \$59,544 per year (in Boston) just to meet basic needs. To pick one example from this research, a single-parent family in Philadelphia with a school-aged child and a preschooler needs income equivalent to 230 percent of FPL, supplemented by the Earned Income Tax Credit, to pay for housing, child care, food, transportation, taxes, and the like (excluding any money for entertainment, carry-out or fast food, savings, credit card debt, or emergency expenses).¹⁸

In August 2005, the Congressional Budget Office (CBO) released a new analysis of individual coverage, with findings that are consistent with the analysis presented here. CBO concluded that “modest premium subsidies...would have a small potential impact on reducing the ranks of the uninsured.” According to CBO, paying even 50 percent of health insurance premiums would cause individual coverage among the otherwise uninsured to rise by only 3.5 percentage points, from 16.3 percent to 19.8 percent. The CBO report noted that this conclusion was consistent with most other academic research on take-up rates for individual coverage as well as with observed enrollment in HCTC.¹⁹

Requiring Full Premium Payments During the Processing of Applications

Tax credit programs are likely to reach few low-income people if they must pay full premiums while their subsidy applications are being processed. Many low-income households lack the discretionary income to “front” premium payments while awaiting refunds. For the HCTC program, gap-filler programs run by state workforce agencies and funded by grants from the Department of Labor have been a creative, short-term solution for potential beneficiaries who live in states operating such programs. Yet having a separate government agency, with its own administrative procedures and funding, provide each worker with the first few months of subsidies before IRS starts making

advance payments raises questions about efficiency, coordination, and seamlessness of coverage.

A different approach worth serious consideration would be to model health insurance tax credit statutes on Medicare, Medicaid, and SCHIP, none of which make enrollment in qualified coverage an element of eligibility. Under this approach, applicants would not be required to pay premiums while they wait for their applications to be processed.

Exclusion of Preexisting Conditions

Another deterrent to HCTC enrollment—namely, state-qualified plans’ exclusion of preexisting conditions for beneficiaries with recent coverage gaps—could dissuade many uninsured with known health problems from taking up coverage in similarly structured, future tax credit programs. A comprehensive review of take-up studies across a broad range of public and private programs concluded that a key determinant of enrollment rates is the value of the benefit offered to eligible individuals.²⁰ Policymakers need to find strategies that, while protecting health insurers from disproportionate enrollment by very sick individuals, nevertheless offer health insurance that potential beneficiaries regard as valuable because it covers their known health problems.²¹

Outreach and Enrollment

To some degree, the practices needed to reach potential beneficiaries would vary with the population being targeted for coverage. The need for multilingual materials depends on the proportion of individuals with limited English proficiency. The importance of easily readable materials also depends somewhat on the population targeted, although this would likely be important to most coverage expansions. Nearly two-thirds of the uninsured (63%) either did not complete high school or stopped their formal education after receiving a high school degree.²²

By contrast, almost any target population is likely to enroll in much larger numbers if the

administering agency and its community partners employ proactive approaches that use a single interaction to educate potential beneficiaries and sign them up. The broad applicability of this approach is illustrated by a study of British physicians who were encouraged to enroll in certain training programs. When researchers called the physicians, informed them about the training, and allowed them to register during the call, 82 percent enrolled, compared with 22 percent of similar physicians who were mailed written materials that described the training and urged the physicians to enroll.²³

As applied to health insurance tax credits, a similar approach could be efficient only if available data allowed such “one-step outreach and enrollment” to be targeted narrowly on good candidates for subsidy eligibility. Even if such outreach included careful targeting, however, policymakers considering this approach would first need to weigh likely enrollment gains against the increased cost of this outreach strategy.²⁴

Complex Application Procedures

Cumbersome and complex application procedures have proven to be a significant barrier to enrollment in programs other than the HCTC. For example, take-up of retirement security accounts with identical levels of tax savings can vary from 10 percent to 86 percent, depending on the amount of work required to enroll.²⁵ Similarly, take-up of various Medicare benefits ranges from 96 percent to 33 percent, depending in significant part on ease of enrollment.²⁶ The HCTC experience is one more reminder that designers of future tax credits will need to incorporate simple application procedures, at a minimum allowing people to apply for assistance by filing one form with one public or private agency.²⁷

Conclusion

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

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

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

NOTES

- ¹ The strategies discussed in this issue brief could also be useful if policymakers consider amending the HCTC statute to help the program reach more of its intended beneficiaries.
- ² See, for example, Lael Brainard, Robert E. Litan, and Nicholas Warren, “A Fairer Deal for America’s Workers in a New Era of Offshoring,” The Brookings Institution and the Kauffman Foundation, May 19, 2005. Draft chapter in forthcoming book, Lael Brainard and Susan M. Collins (eds.), *Offshoring White-Collar Work—The Issues and Implications*, The Brookings Trade Forum, 2005, http://www.brookings.edu/es/commentary/journals/tradeforum/2005btf_brainard.pdf.
- ³ U.S. Government Accountability Office (GAO), *Health Coverage Tax Credit: Simplified and More Timely Enrollment Process Could Increase Participation*, September 2004, GAO-04-1029, <http://www.gao.gov/cgi-bin/getrpt?GAO-04-1029>.
- ⁴ HCTC Program, *Monthly Executive Scorecard September 2004—v 1.0* (September Scorecard), October 13, 2004. Note: the totals for year-end claims of 2003 HCTCs were based on returns processed by May 2004. Additional credits for 2003 may have been claimed since then, but cumulative totals are not publicly available.
- ⁵ IRS, *Tax Year 2004 Taxpayer Usage Study*, Report No. 15, p. 1. Data are for returns received from January 1 through August 26, 2005 (Tax Year 2004) and January 1 through August 27, 2004 (Tax Year 2003). Released in September 2005. <http://www.irs.gov/pub/irs-soi/04tp15tb.xls>. Calculations by ESRI, October 2005.
- ⁶ While it is the best estimate that can be produced based on publicly available information, this number probably overestimates valid claims for end-of-year HCTCs on behalf of taxpayers not receiving advance payment in 2004. Almost certainly, a higher percentage of HCTC claimants received advance payment in 2004 than in 2003, since advance payment was available for all of 2004 but only the last five months of 2003.
- ⁷ HCTC, *September Scorecard*, 2004.
- ⁸ Thomas M. Selden, Julie L. Hudson, and Jessica S. Banthin, “Tracking Changes in Eligibility and Coverage Among Children, 1996–2002,” *Health Affairs* 23 (Sept./Oct. 2004): 39–50. <http://content.healthaffairs.org/cgi/content/full/23/5/39>.
- ⁹ Stan Dorn, Tanya Alteras, and Jack A. Meyer, *Early Implementation of the Health Coverage Tax Credit in Maryland, Michigan, and North Carolina: A Case Study Summary*, ESRI, prepared for The Commonwealth Fund and the Nathan Cummings Foundation, April 2005, http://www.cmwf.org/publications/publications_show.htm?doc_id=271904.
- ¹⁰ Access to Benefits Coalition, *Pathways to Success: Meeting the Challenge of Enrolling Medicare Beneficiaries with Limited Incomes*, National Council on the Aging, June 24, 2005, <http://www.accesstobenefits.org/library/pdf/ABC%20ReportFNL62305.pdf>.
- ¹¹ National Taxpayer Advocate, *2004 Report to Congress: Volume 2, Earned Income Tax Credit (EITC) Audit Reconsideration Study*, December 31, 2004, IRS Publication 2104B (Rev.12–2004) Catalog Number 23655L, <http://www.irs.gov/pub/irs-utl/nta2004arcvol2interactive.pdf>.
- ¹² In December 2003, Maryland plans used HCTC advance payment to cover 10.1 percent of all individuals identified by PBGC or state workforce agencies as potentially eligible. At the time, the national average was 3.6 percent. The second-highest such percentage was 7.9 percent, in Pennsylvania. Stan Dorn and Todd Kutyla, *Health Coverage Tax Credits Under the Trade Act of 2002: A Preliminary Analysis of Program Operation*, ESRI, prepared for The Commonwealth Fund and the Nathan Cummings Foundation, April 2004, http://www.cmwf.org/publications/publications_show.htm?doc_id=226530.
- ¹³ For all but one of these plans, the IRS Web site included the statement, “Information is not necessarily related to HCTC.” While this language was commendably honest, it did little to help the many potential beneficiaries who could not receive HCTCs until they identified and enrolled in qualified state-based plans.
- ¹⁴ On the other hand, during at least the early portion of unemployment, laid-off workers may have savings that exceed those of low-income workers who did not previously have higher earnings.
- ¹⁵ Catherine Hoffman, Alicia Carbaugh, Allison Cook, *Health Insurance Coverage in America: 2003 Data*

- Update, Kaiser Commission on Medicaid and the Uninsured (KCMU), Urban Institute, November 2004, <http://www.kff.org/uninsured/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=49550>.
- ¹⁶ Jennifer Haley and Stephen Zuckerman, *Is Lack of Coverage a Short- or Long-Term Condition?* The Urban Institute, prepared for the Kaiser Commission on Medicaid and the Uninsured, June 2003, <http://www.kff.org/uninsured/upload/Is-Lack-of-Coverage-A-Short-or-Long-Term-Condition.pdf>.
- ¹⁷ Hoffman et al., *Coverage in America*, 2004. In 2005, the FPL is \$9,570 a year for a one-person household, \$12,830 for a two-person household, \$16,090 for a three-person household, \$19,350 for a four-person household, etc.
- ¹⁸ Donna R. Lenhoff, *Coming Up Short: A Comparison of Wages and Work Supports in 10 American Communities*, prepared for Wider Opportunities for Women, Summer/Fall 2004, <http://wowonline.org/docs/dynamic-CTTA-43.pdf>.
- ¹⁹ David Auerbach and Sabina Ohri, *The Price Sensitivity of Demand for Nongroup Health Insurance*, Congressional Budget Office, August 2005, <http://www.cbo.gov/ftpdocs/66xx/doc6620/08-24-HealthInsurance.pdf>.
- ²⁰ Dahlia K. Remler and Sherry A. Glied, "What Other Programs Can Teach Us: Increasing Participation in Health Insurance Programs," *American Journal of Public Health* 93 (January 2003): 67–74, http://www.cmwf.org/publications/publications_show.htm?doc_id=221496.
- ²¹ For example, the HCTC statute could be revised to exclude from the determination of whether individuals lost continuous coverage (and so are subject to preexisting condition exclusions) two periods of time: a) between loss of employment or employer-funded pension and notice of potential HCTC eligibility; and b) between application for and start of HCTC advance payment.
- ²² Hoffman et al., *Coverage in America*, 2004.
- ²³ C. A. Lock, E. F. S. Kaner, N. Heather et al., "A Randomized Trial of Three Marketing Strategies to Disseminate a Screening and Brief Alcohol Intervention Programme to General Practitioners," *British Journal of General Practice* 49 (1 September 1999): 695–698, <http://www.ingentaconnect.com/content/rcgp/bjgp/1999/00000049/00000446/art00004>.
- ²⁴ For example, telephoning Medicare beneficiaries to enroll them in low-income prescription drug subsidy programs is estimated to cost approximately \$66 per successful enrollee. Access to Benefits Coalition, *Pathways to Success*, 2005. If comparable outreach to potential HCTC beneficiaries involved similar expenses, the resulting cost per successful HCTC enrollee would be nearly 2 percent of the average annual HCTC subsidy for a one-person policy. Before deciding to implement such an approach to HCTC outreach, policymakers would need to weigh this administrative cost against the likely increase in enrollment.
- ²⁵ Lynn Etheredge, *Health Insurance Coverage at Transitions: What Works, What Doesn't Work*, Health Insurance Reform Project of George Washington University, prepared for Maryland State Planning Grant, Health Care Coverage Workgroup, April 11, 2003, <http://www.dhmh.state.md.us/hrsa/pdf/LynnEtheredge.pdf>; Brigitte Madrian and Dennis Shea, *The Power of Suggestion: Inertia in 401(k) Participation and Savings Behavior*, National Bureau of Economic Research, Working Paper No. 7682, May 2000, p. 51, <http://www.nber.org/papers/7682>.
- ²⁶ National Cancer Institute, *SEER-Medicare: Medicare Enrollment & Claims Data*, <http://healthservices.cancer.gov/seermedicare/medicare/>; Alex D. Federman, Bruce C. Vladeck, and Albert L. Siu, "Avoidance of Health Care Services Because of Cost: Impact of the Medicare Savings Program," *Health Affairs* 24 (Jan./Feb. 2005): 263–70, <http://content.healthaffairs.org/cgi/content/full/24/1/263>.
- ²⁷ For example, with HCTCs, applicants could have the option to waive otherwise applicable privacy rights, thereby permitting the agency to which they apply (a state workforce agency, qualified health plan, or IRS) to work with other entities as needed to establish and maintain HCTC coverage. Without such waivers, workers may need to apply separately to each such entity, separately relaying personal information to each agency.

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