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Issue Brief

Administrative Costs for Advance Payment of Health Coverage Tax Credits: An Initial Analysis

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ABSTRACT: Health Coverage Tax Credits (HCTCs), created under the Trade Act of 2002, pay 65 percent of health insurance premiums for certain workers displaced by international trade and early retirees. These credits can be paid directly to insurers when monthly premiums are due, in advance of annual tax return filing. While HCTC administrative costs have fallen significantly since program start-up, they still comprise approximately 34 percent of total spending. Changes to the HCTC program could lower administrative costs, but the size of the resulting savings is unknown. These findings have important implications for any future tax credit plan intended to cover the uninsured.

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Introduction

New federal initiatives to cover the uninsured are under serious discussion by national policymakers and interest groups. Such initiatives include many proposals to use fully refundable federal income tax credits to subsidize uninsured individuals' purchase of coverage.[1] In considering the merits of this approach, policymakers can learn from the country's only current use of tax credits to cover the uninsured—namely Health Coverage Tax Credits (HCTCs), which were created under the Trade Act of 2002. HCTCs pay 65 percent of health insurance premiums for certain workers displaced by international trade and early retirees.[2] The credits can either be claimed after the end of the year, when annual income tax forms are filed, or advanced monthly to health insurers to help pay premiums.

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This issue brief examines an aspect of the HCTC program that has received little attention in prior research: the extent to which public dollars are spent on administrative costs, rather than on health care services. It will not address the administrative cost of paying HCTCs after the end of the year, when they are claimed on federal income tax forms. Such expenses are quite modest, since they result from the standard Internal Revenue Service (IRS) mechanisms for processing those forms. Rather, the current analysis concerns the administrative costs incurred through payment of HCTCs to insurers when monthly premiums are due, in advance of filing year-end tax forms.

Such advance payment might be a critically important feature of any tax credit plan intended to cover the uninsured. Two-thirds of the uninsured (66.3 percent) live in low-income families, with earnings at or below 200 percent of the federal poverty level (FPL).[3] In 2006, the FPL was $9,800 a year for an individual and $13,200 for a household of two. Few households with such low incomes have enough discretionary funds to pay health insurance premiums throughout the year in the expectation of receiving a refund after filing their annual tax forms. Advance payment represents an innovative attempt to address this "cash flow" problem and provide subsidies when they are needed, as premiums are due. This issue brief measures the administrative costs associated with this policy innovation, distinguishing between the initial establishment of the HCTC program and the ongoing operational costs of this advance payment mechanism.

Key Findings

During the start-up phase of HCTC advance payment, administrative costs significantly exceeded subsidy amounts. From February 2003 through August 2004, the federal government spent $82.9 million on administration (primarily for private contractors) but only $44.9 million in subsidies. Such infrastructure development costs were not unreasonable, given the unprecedented nature of HCTC advance payment, the statutory mandate for advance payment implementation within a year of legislative enactment, and the intended, future use of this infrastructure to serve millions of uninsured Americans.

On the other hand, operational administrative costs remained high after program start-up, although they have fallen greatly over time. IRS administrative costs dropped from $47 million in FY 2004 to approximately $20 million per year in FY 2006 and FY 2007. During FY 2007, an estimated 13 percent of federal funding related to HCTC advance payment will be spent for health plan administration, 21 percent will pay IRS administrative costs, and 66 percent will purchase health care. This analysis raises serious questions about the efficiency of using federal income tax credits as a strategy to subsidize health coverage for millions of uninsured Americans.

It is possible that a simpler health insurance tax credit with many more enrollees or a more limited number of participating plans could result in lower administrative costs. However, it is not yet known how much savings could be achieved by such measures.

HCTC Advance Payment Mechanism

General descriptions of the HCTC program and its advance payment component are available elsewhere.[4] For purposes of the current analysis, the following program features may be particularly relevant:

- Each day, State Workforce Agencies (SWAs) submit information to the IRS identifying potentially eligible workers certified as having been displaced by international trade. Each month, the Pension Benefit Guaranty Corporation (PBGC) provides the IRS with similar information about potentially eligible early retirees receiving PBGC payments. Once the IRS receives this information from either source, it mails an HCTC Program Kit to each potentially eligible individual.

- To enroll in HCTC advance payment, workers must apply to between three and five entities, including the IRS, health plans, and other government agencies. Helping applicants through this process is the HCTC Customer Contact Center, operated by Accenture, an IRS contractor.
- Once someone has been accepted into HCTC advance payment, the HCTC Processing Center at the IRS sends that person a monthly invoice for his or her 35 percent premium share. The bill is sent 27 days before the plan's normal due date for monthly premium payments. The worker's payment is due to the IRS 21 days after the HCTC invoice is mailed.
- Once the Processing Center receives the worker's payment, the Treasury Department's Financial Management Service (FMS) combines that payment with the HCTC, which covers the remaining 65 percent premium share. FMS then sends the combined, full premium payment (along with information identifying the beneficiary) to the health plan on or before the plan's regular due date for monthly premium payments. Each premium payment is sent separately. In addition, the IRS mails each participating health plan a monthly report identifying all individual payment transactions. Unless the health plan indicates a contrary preference, the IRS generates an annual form showing advance payments for each enrollee, sending a copy to the enrolled taxpayer.

The advance payment portion of HCTC is administered by the HCTC Program Office within the IRS, which works with a range of stakeholders external to IRS, including the Treasury Department and its component agencies (such as FMS), the U.S. Department of Labor, SWAs in all 50 states, the PBGC, health plans, third-party health plan administrators, and others.

Start-Up Costs

At the IRS, advance payment administrative costs through August 2004—the end of the first year of advance payment—exceeded $75 million, with 91 percent of spending going to private contractors (Table 1).

By August 2004, an additional $7 million was spent by the Department of Labor to help SWAs establish infrastructure to process HCTC applications and interface with IRS, resulting in total federal start-up costs of $82.9 million.[5] During that same period, HCTC advance payments totaled $44.9 million, or slightly more than half (54 percent) of start-up administrative expenses (Figure 1).[6]

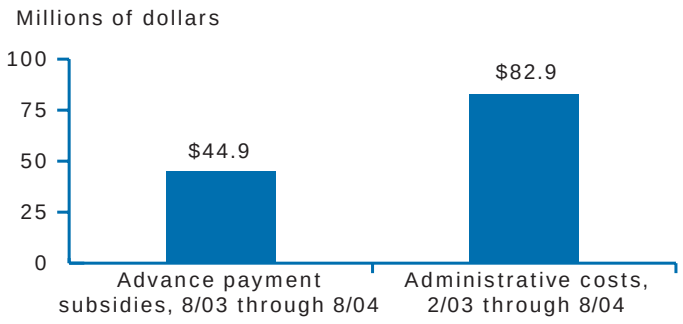
In this context, start-up costs that exceeded first-year subsidy amounts were neither surprising nor troubling. The IRS had never administered anything like the HCTC or made advance payments to entities other than taxpayers. The Trade Act of 2002 required advance payment to begin within a year of legislative enactment. It was foreseeable that creating an unprecedented system within a short time frame would be costly and

Table 1. IRS Start-Up Costs for HCTC Program (Millions of Dollars)

Time Period	Type of Expense	Contractor Costs	IRS Costs	Total Costs
2/1/03 to 4/30/04	Design and development of HCTC	$29.5	$3.8	$33.3
5/1/03 to 4/30/04	Initial implementation of HCTC	33.3	2.8	36.1
5/1/04 to 6/30/04	Transition to operational level of service	6.1	0.4	6.5
	Total	**$68.9**	**$7.0**	**$75.9**

Source: U.S. Government Accountability Office (GAO), *Health Coverage Tax Credit: Simplified and More Timely Enrollment Process Could Increase Participation,* Sept. 2004. GAO-04-1029. http://www.gao.gov/new.items/d041029.pdf. Calculations by ESRI, Nov. 2005.

Figure 1. HCTC Advance Payments vs. Federal Administrative Costs During HCTC Start-Up



Source: (GAO), *Health Coverage Tax Credit: Simplified and More Timely Enrollment Process Could Increase Participation*, September 2004. GAO-04-1029; IRS, Health Coverage Tax Credit: Monthly Executive Scorecard, August 2004 – v1.0, September 14, 2004. Note: subsidy amounts include only the 65 percent premium share paid by HCTC.

require significant involvement of outside experts. Further raising such predictable costs was the requirement to coordinate the development of HCTC among the Office of Management and Budget (OMB), three Cabinet-level agencies—Treasury, the Department of Labor, and Health and Human Services—as well as numerous state agencies, private health plans, employers, an independent federal agency (PBGC), the IRS, and other public and private entities.

Moreover, relatively high start-up costs can be defended based on the anticipated use of this novel system. When the HCTC program began, many policymakers saw it as providing a structure that could later be expanded to cover a much larger group of people. For example, the Bush Administration proposed extending similar credits to involuntarily unemployed workers during economic downturns, whether or not their job loss resulted from trade liberalization, and to low-income Americans who do not have access to employer-based insurance.

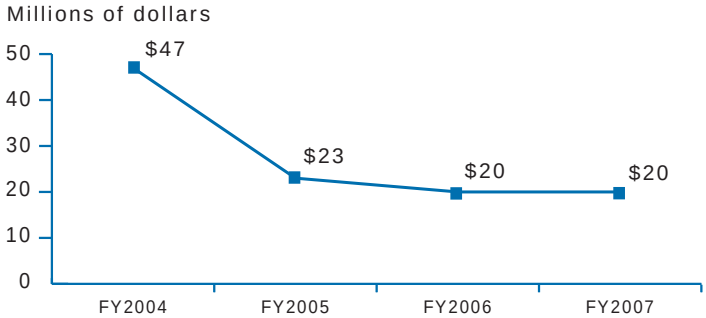
Ongoing Operating Costs

The ongoing administrative costs of the HCTC program fall into two categories: the cost to the IRS of running the advance payment system and health plan administrative costs.

Since program start-up, the cost of IRS administration fell from $47 million in FY 2004 to $20 million a year projected for FY 2006 and FY 2007, with savings coming entirely by reducing spending on private contractors(Figure 2).[7]

In terms of health plan administrative costs, the HCTC statute's approach differs from previous federal coverage programs in that, for some beneficiaries, medically underwritten, non-group coverage qualifies for subsidy. As of December 2005 (the most recent period for which data are available), 18 percent of advance payment enrollees received non-group coverage, 58 percent were enrolled in COBRA plans, and 24 percent were covered through high-risk pools or other state-qualified insurance with fully or partially community-rated premiums.[9] The resulting health plan administrative costs can be conservatively estimated by assuming that: a) for medically underwritten, non-group plans, at least 30 percent of premiums covers insurers' administrative costs; and b) for all other coverage, 14 percent of premiums pays such costs. The latter figure is the national average percentage that administrative costs will comprise for private

Figure 2. IRS Costs to Administer HCTC Advance Payment: FY2004–2007



Source: OMB and IRS, 2004–2006. Note: The cost estimates for FY 2004 and 2005 show actual outlays. The numbers for FY 2006 and FY 2007 show estimated outlays, adjusted to compensate for differences between the federal fiscal year and the contract period for the IRS contractors that help administer HCTC advance payment. If these costs were tracked in terms of budget authority, higher levels would show for FY 2005 and lower levels for FY 2007.

Table 2. Estimated Advance Payment Enrollment and Subsidy Costs: FY2007

	Estimated Enrollment (thousands of households)	Premium Subsidies (millions of dollars)		
		Total	Health Plan Administrative Costs	Health Care
COBRA Enrollees	8.7	$44.1	$6.2	$37.9
Enrollees into non-group plans	2.7	13.7	4.1	9.6
Enrollees into other coverage	3.6	18.2	2.6	15.7
Total	**15.0**	**76.0**	**12.8**	**63.2**

Sources: IRS and CMS. Calculations by S. Dorn, November 2006. Notes: (1) Totals may not equal 100% because of rounding. (2) This table reflects the following assumptions: (a) The distribution of advance payment enrollees between non-group and other coverage will remain as in December 2005, the most recent month for which pertinent data are available; (b) per capita subsidy amounts since December 2005 will increase consistently with CMS per capita projections for private health insurance nationally; and (c) 30 percent of premiums for non-group coverage and 14 percent for other coverage will be spent for health plan administration.

health insurance in 2007, according to projections by the Centers for Medicare and Medicaid Services (CMS).[10]

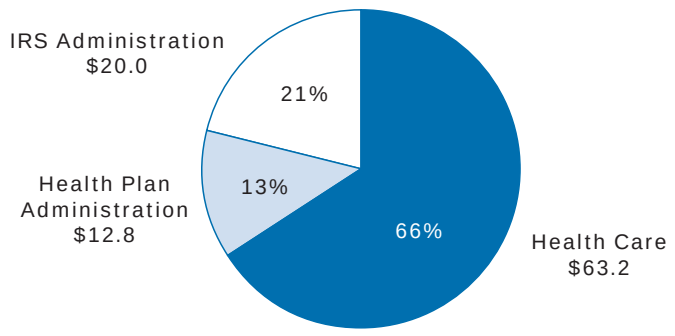
HCTC advance payment subsidy costs in FY 2007 are estimated to reach $76.0 million.[11] If the proportion of advance payment enrollees in non-group coverage continues as in December 2005, then, based on the above assumptions, this $76.0 million will pay $12.8 million for health plan administration and $63.2 million for the purchase of health care (Table 2). Adding $20 million for IRS expenses, administrative costs will consume an estimated 34 percent of federal spending related to HCTC advance payment (Figure 3).

In assessing this finding, several factors are important to consider. First, many of the above-described IRS administrative costs not only help with advance payments, but also help in processing end-of-year HCTC claims.[12] On the other hand, if HCTC had been available only in advanceable form, these administrative costs still would have been incurred.[13] They accordingly need to be taken into account by policymakers considering similar advanceable credits for other groups of uninsured. Second, IRS administrative costs could change, particularly with the planned re-bidding of the main contract for HCTC administration beginning in the current fiscal year (2007).[14]

Third, these estimates are limited to IRS administrative costs and generally applicable levels of health plan administration. Other entities, including unions, health plans (going beyond standard administrative activities), SWAs, community agencies, volunteers, and individual applicants for HCTC, also have incurred significant administrative costs. As noted below, to achieve HCTC take-up rates well above the national average, significant hands-on application assistance has been required, thus adding to administrative costs.

Finally, these estimates are based on reasonable assumptions that attempt to compensate for a lack of recent data concerning HCTC

Figure 3. Federal Spending Related to HCTC Advance Payment: FY2007 (millions of dollars)



Sources: IRS and CMS. Calculations by S. Dorn, November 2006. See notes to Table 2.

advance payment.[15] They should accordingly be viewed as plausible estimates, but more recent and additional information would be needed for greater precision.

Implications for Future Policy

The Broader Context for Health Insurance Tax Credits

As policymakers decide whether and, if so, how to incorporate federal income tax credits into broader health coverage expansions, several positive elements of the HCTC track record are worth considering:

- The IRS and the Department of the Treasury have proved effective and nimble in surmounting a number of policy challenges, including the establishment of unprecedented advance payment mechanisms less than 12 months after enactment of HCTC legislation.[16]
- Unlike the country's only previous health insurance tax credit, HCTC implementation has not been accompanied by reports of widespread marketing fraud.[17]
- Consumer protection requirements in the HCTC statute have not stood in the way of significant health plan participation. As of March 2006, 87 percent of potentially eligible individuals lived in the 40 states with participating insurers, which collectively offered 280 state-qualified options.[18]
- In some cases, states and unions have enrolled more than half of potentially eligible workers by providing proactive, intensive application assistance.[19]

On the other hand, previously documented problems with HCTCs include the following:

- According to the Office of Management and Budget (OMB), during 2004 only 11 percent of eligible individuals used the credit either in its advanceable form or by claiming the credit on end-of-year returns.[20]
- Many state-qualified plans do not provide comprehensive coverage, which some policymakers may view as problematic. In 12 of 40 states offering state-qualified insurance in March 2006, each plan had an individual deductible of $1,000 or more.[21] In 11 of 15 states surveyed in 2003, every state-qualified plan either excluded or imposed severe limits on at least two of the following: maternity care, mental health care, prescription drugs, or preventive care.[22]
- When medically underwritten, individual health insurance has been offered as state-qualified coverage, premiums have sometimes increased substantially based on age, gender, and health history. For example, in June 2004, HCTC beneficiaries' 35 percent premium share for average state-qualified coverage in North Carolina was $357 a year for a healthy 25-year-old man, compared with $4,066 for a 55-year-old woman in the highest risk tier.[23]

Similar problems have been prevented or solved with other health coverage programs, such as Medicaid, Medicare, and the State Children's Health Insurance Program. This provides a measure of confidence that these challenges could likewise be overcome by restructuring tax credits.[24] By contrast, the high level of IRS administrative costs documented here is a problem that has not been encountered before, thus increasing the uncertainty about the effectiveness of potential reforms. While structuring future tax credits differently than HCTCs could cut administrative costs, it is not clear whether substantial or only minor savings would result.

Could Future Tax Credits Be More Efficient?

Administrative costs would surely drop, to some degree, with a tax credit that was simpler than HCTCs and served a much larger population. Simplicity could cut transaction costs as well as

the extent of necessary consumer assistance, and more enrollees might provide economies of scale. Health plan administrative costs would likewise drop if credits were not used with medically underwritten, non-group coverage, for which administrative costs are particularly high. (Of course, administrative costs would be only one factor among many that policymakers would need to consider in deciding whether to subsidize non-group coverage.)

A less costly advance payment mechanism also might be possible if future tax credits limited the number of participating health plans and offered each of them a much larger number of tax credit enrollees. This could give federal authorities the leverage to restructure HCTC advance payment so that the IRS would not need to provide a complete premium payment to each health plan for each enrollee in time for the plan's normal monthly billing cycle. Perhaps the IRS could pay health plans the tax credit amounts, rather than full premium payments, and health plans could then bill beneficiaries directly for their premium share. Likewise, plans wishing to participate in a larger tax credit program could be required to meet IRS specifications for data exchange, timelines, and similar factors.[25]

While these and other steps[26] could lower administrative costs for advance payment, the size of the resulting savings is unknown.[27] To obtain a better sense of such savings' potential magnitude, Congress could request information from the IRS about the current cost of each HCTC-related administrative function. Also, federal policymakers could use HCTC reforms to test whether significant administrative efficiencies could be achieved without compromising essential functions.[28]

Conclusion

Despite the great progress made by the IRS in reducing the administrative costs of HCTC advance payment, such costs remain high. It is plausible but by no means certain that current proposals to provide tax credits to a much larger group of uninsured could be structured to substantially lower administrative costs, without undermining program effectiveness. Additional research is needed to shed further light on the sources of these costs and to use the HCTC program to test strategies for reducing them.

Notes

[1] Fully refundable credits go to all eligible individuals, including those who owe little or no federal income tax. For examples of recent coverage expansion proposals that include health insurance tax credits, see America's Health Insurance Plans, *AHIP Announces Proposal to Expand Access to Health Insurance Coverage to Every American,* Nov. 13, 2006, http://www.ahipbelieves.com/Default.aspx?tabid=65; Health Coverage Coalition for the Uninsured, Expanding Health Care Coverage in the United States: A Historic Agreement, Jan. 18, 2007, http://www.coalitionfortheuninsured.org/pdfs/agreement.pdf; John Edwards 08, Universal Health Care Through Shared Responsibility, http://johnedwards.com/about/issues/health-care-overview.pdf. In response to President Bush's proposal for a new tax deduction subsidizing individual health insurance, health insurance tax credits have been recommended by the editorial pages of the *Washington Post* and *New York Times* as well as a range of analysts from the Urban Institute/Brookings Institution Tax Policy Center to the Galen Institute.

[2] The only previous such effort involved the so-called "Bentsen child health tax credits," which operated for one year during the early 1990s.

[3] Kaiser Commission on Medicaid and the Uninsured (KCMU) and the Urban Institute, *Health Insurance Coverage in America: 2005 Data Update,* November 2006. http://www.kff.org/uninsured/upload/2005DataUpdate.pdf.

[4] See, for example, Internal Revenue Service (IRS), *HCTC: Frequently Asked Questions,* undated, http://www.irs.gov/individuals/article/0,,id=109956,00.html; Appendices A and B in S. Dorn, J. Varon, and F. 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, Revised Nov. 3, 2005; prepared for The Commonwealth Fund. http://www.esresearch.org/documents_1-05/HCTC_TakeUp.pdf.

[5] U.S. Government Accountability Office (GAO), *Health Coverage Tax Credit: Simplified and More Timely Enrollment Process Could Increase Participation,* Sept. 2004. GAO-04-1029. http://www.gao.gov/new.items/d041029.pdf.

[6] IRS, *Health Coverage Tax Credit: Monthly Executive Scorecard, August 2004 - v1.0,* Sept. 14, 2004.

[7] As explained in the Treasury Department's proposed appropriation for FY 2006, "The program is fully operational and anticipated costs have been reduced." "Appendix," *Fiscal Year 2006 Budget of the United States Government,* Department of the Treasury (Treasury 2006 Budget), Feb. 2005, http://www.whitehouse.gov/omb/budget/fy2006/pdf/appendix/tre.pdf; U.S. Treasury Department, *Fiscal Year 2006 Congressional Budget Submission,* Department Performance Budget Request (2006 Budget Submission), http://www.treas.gov/offices/management/budget/budget-documents/cj/06/irs.pdf; U.S. Treasury Department, *Fiscal Year 2007 Congressional Budget Submission,* Department Performance Budget Request, 2007 Budget Submission, http://www.treas.gov/offices/management/budget/budget-documents/cj/cj.pdf.

[8] Actual outlay numbers for FY 2004 are from Treasury 2006 Budget, op cit. Actual outlays for 2005 are from "Appendix," *Fiscal Year 2007 Budget of the United States Government*, Department of the Treasury (Treasury 2007 Budget), Feb. 2006, http://www.whitehouse.gov/omb/budget/fy2007/pdf/appendix/tre.pdf. The latter document estimates outlays of $24 million and $14 million for FY 2006 and FY 2007, respectively. However, the latter estimate includes a "funding adjustment [of $5.5 million that] reflects the program's effort to align fiscal year costs with contract year expenditures." 2007 Budget Submission, op cit. Put differently, because some operational costs for 2007 are covered through previous contracts with periods that do not match the annual federal budget cycle, outlays for IRS administration are expected to approximate $20 million in both 2006 and 2007. Officials believe that, in future years, contract periods and annual appropriations should align more closely. David R. Williams, program director, Health Coverage Tax Credit, IRS, personal communication, Feb. 17, 2006.

[9] The estimate in the text combines two groups: enrollees in state-qualified non-group insurance and people who used HCTC to purchase non-group insurance that they had during at least the last 30 days before job loss. IRS, *Health Coverage Tax Credit: Operations Summary for the Period Ending December 31, 2005,* Jan. 2006. (HCTC Dec. 2005 Summary) Calculations by ESRI, Mar. 2006. Coverage that is

fully community-rated does not adjust premiums based on the characteristics of individual enrollees. Coverage that is partially community-rated may vary premiums based on factors such as age, but insurers do not go through medical underwriting, which is a process whereby the individual health history of each applicant for coverage is assessed and a premium is charged or the details of coverage are adjusted based on the insurer's evaluation of the individual's likelihood of incurring health care claims.

[10] One analysis by leading health care economists with quite different theoretical and philosophical perspectives concluded that, in the non-group market, such costs consume between 30 and 40 percent of health insurance premiums. M.V. Pauly and L. Nichols, "The Nongroup Health Insurance Market: Short on Facts, Long on Opinions and Policy Disputes," *Health Affairs* Web Exclusive, Oct. 23, 2002. http://content.healthaffairs.org/cgi/content/full/hlthaff.w2.325v1/DC1. Office of the Actuary at the Centers for Medicare and Medicaid Services, *National Health Expenditure (NHE) Amounts by Type of Expenditure and Source of Funds: Calendar Years 1965–2015,* Feb. 2006. (NHE Projections) http://new.cms.hhs.gov/NationalHealthExpendData/downloads/nhe65-15.zip. Calculations by ESRI, Mar. 2006.

[11] During the most recent month for which enrollment data are available (Dec. 2005), 15,563 households received HCTC advance payments. HCTC Dec. 2005 Summary, op cit. Enrollment for FY 2006 and 2007 was projected to remain stable, averaging approximately 15,000 households. 2006 Budget Submission, op cit. In terms of subsidy amounts per enrollee, during the quarter ending in December 2005, HCTC advance payment subsidies totaled $18.5 million. HCTC Dec. 2005 Summary, op cit. The text's estimated total cost of HCTC advance payment subsidies assumes the projected 8.2 percent growth in health insurance premiums for calendar year 2007. Office of the Actuary at the Centers for Medicare and Medicaid Services, *National Health Care Expenditures Projections: 2005–2015,* http://new.cms.hhs.gov/NationalHealthExpendData/downloads/proj2005.pdf. Calculations by ESRI, Mar. 2006.

[12] For example, lists of potentially eligible individuals that PBGC and SWAs provide to IRS to facilitate advance payment are also used to identify unwarranted claims of HCTCs on annual tax forms. GAO, op cit.

[13] IRS administrative funding for 2006 and 2007 was appropriated specifically as "operating funding to administer the advance payment feature of the Trade Adjustment Assistance health insurance tax credit program." Treasury 2006 Budget and Treasury 2007 Budget, op cit.

[14] In addition, if an increased level of support is needed to improve the operation of HCTC, administrative funding may need to increase.

[15] Ironically, such data are unavailable in part because the HCTC program cut administrative spending. For example, the average number of individuals per household receiving advance payment comes from analyses last performed for June 2004 by The Lewin Group. The Lewin Group did not produce analyses covering subsequent periods because, as part of a broader effort to lower HCTC spending on private contractors, IRS ended Lewin's role in administering HCTC.

[16] S. Dorn and T. Kutyla, *Health Coverage Tax Credits Under the Trade Act of 2002,* The Commonwealth Fund, Apr. 2004, http://www.cmwf.org/publications/publications_show.htm?doc_id=226530.

[17] The Bentsen credits were repealed on a bipartisan basis based on low take-up and reports of widespread marketing fraud. House Ways and Means Committee, Subcommittee on Oversight, *Report on Marketing Abuse and Administrative Problems Involving the Health Insurance Component of the Earned Income Tax Credit*. WMCP: 103-14, 103rd Cong., 1st Sess., June 1, 1993.

[18] F. Pervez and S. Dorn, *Health Plan Options Under the Health Coverage Tax Credit Program,* Health Management Associates and Urban Institute, Dec. 11, 2006, http://www.urban.org/UploadedPDF/411389_Health_Plan_Options.pdf.

[19] S. Dorn, *Take-Up of Health Coverage Tax Credits: Examples of Success in a Program with Low Enrollment,* Urban Institute, Dec. 11, 2006, http://www.urban.org/UploadedPDF/411390_Take-Up_of_Health.pdf.

[20] Office of Management and Budget, *Detailed Information on the Internal Revenue Service Health Care Tax Credit Administration Assessment,* Fall 2006; http://www.whitehouse.gov/omb/expectmore/detail/10004107.2006.html. See also Dorn, *Take-Up of Health Coverage Tax Credits*.

[21] Pervez and Dorn, *Health Plan Options*.

[22] Dorn and Kutyla, *Health Coverage Tax Credits Under the Trade Act of 2002.*

[23] S. Dorn, T. Alteras, and J. A. Meyer, *Early Implementation of the Health Coverage Tax Credit in Maryland, Michigan, and North Carolina: A Case Study Summary,* The Commonwealth Fund, Apr. 2005. http://www.cmwf.org/publications/publications_show.htm?doc_id=271904.

[24] For example, reducing enrollees' premium costs and simplifying application procedures have greatly increased enrollment in Medicaid and the State Children's Health Insurance Program (SCHIP). Dorn, Varon, and Pervez, op cit.

[25] By the same token, with fewer participating plans, IRS could be more flexible in addressing each plan's needs. As often happens with Medicaid and SCHIP, an insurer participating in such a reconfigured tax credit system would know that, even if a particular month's payments ran short, the health plan would eventually be made whole. Of course, reducing the number of health plans, by itself, would not lower operating costs per enrolled beneficiary. Only if such a reduction allowed a more efficient redesign of the advance payment mechanism could savings be achieved. Moreover, fewer participating health plans could translate into fewer beneficiary choices, which may trouble some policymakers.

[26] Another, more sweeping strategy would shift from advanceable credits to assignable credits. The latter approach could allow state-based programs to contract with health plans to cover tax credit beneficiaries, based on the guarantee that the beneficiaries' tax credits would ultimately be paid to such state programs.

[27] Some administrative expenses are needed for effective program operation. For example, many applicants need individual assistance to navigate even streamlined application procedures. Enrolling a child into Medicaid or SCHIP in New York City, for instance, which involves a much simpler application process than that required for HCTCs, cost an average of $282 per child in 2002. Even with additional simplification, such expenses would not have fallen below $166, according to one analysis. G. Fairbrother, M. J. Dutton, D. Bachrach et al., "Costs of Enrolling Children in Medicaid and SCHIP," *Health Affairs,* Jan./Feb. 2004 23(1):237-43, http://content.healthaffairs.org/cgi/reprint/23/1/237.

[28] Of course, HCTC simplification would require an upfront investment, which would be recouped in administrative savings only after several years. On the other hand, HCTC simplification could provide an important, short-term benefit by informing policymakers whether future tax credits could be structured for substantially more efficiency.

About the Author

Stan Dorn, J.D., is a senior research associate at the Urban Institute. He has been involved in health policy at the state and national levels for 20 years, focusing on low-income consumers, Medicaid, the State Children's Health Insurance Program (SCHIP), and the uninsured. Previously, Dorn was a senior policy analyst at the Economic and Social Research Institute (ESRI), director of the Health Consumer Alliance, and director of the Health Division of the Children's Defense Fund, where he led the health policy team in CDF's campaign that helped enact SCHIP in 1997. Before his work at CDF, Dorn directed the Washington, D.C., office of the National Health Law Program and served as a staff attorney in its Los Angeles headquarters. He is a graduate of Harvard College and the Boalt Hall School of Law at the University of California, Berkeley.

Note: The majority of work on this Issue Brief was done while the author served as senior policy analyst at ESRI.

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