

Take-Up of Health Coverage Tax Credits: Examples of Success in a Program with Low Enrollment

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December 2006

Abstract: Enrollment into HCTC advance payment rose from 4,000 in September 2003 to nearly 16,000 in December 2005. Between 13 and 21 percent of eligible individuals received HCTCs in some form during the latter month. Surveys of beneficiaries and officials confirm that unaffordable coverage and program complexity are the main barriers to enrollment. Nevertheless, West Virginia enrolled between 43 and 59 percent of eligible beneficiaries; a project in Virginia enrolled more than 90 percent of callers who waived confidentiality of tax records; and HCTCs covered 53 percent of eligible Bethlehem Steel retirees. Future credits could be structured to increase enrollment substantially.

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About the Author

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Acknowledgments

The author gratefully acknowledges the generous support of The Commonwealth Fund and the Economic and Social Research Institute, which made this report possible. In addition, the author thanks the following people for their information, insights, and time: John Balzano and Nikki Butto of the Independent Steelworkers Union; Sonia Chambers of the West Virginia Health Care Authority; Sally Richardson of the West Virginia University Institute for Health Policy Research; Lynette E. Hammond, Assistant Secretary of Commerce and Trade for the Commonwealth of Virginia; Anna Rice-Wright of the Virginia Employment Commission; Jack Meyer of Health Management Associates, Inc. (formerly the President of the Economic and Social Research Institute); and Tom Duzak of the United Steelworkers. The views expressed in this report are those of the author alone and should not be attributed to The Urban Institute, The Economic and Social Research Institute, The Commonwealth Fund, or any of those named above.

Introduction

After thousands of theoretical studies examining the possible use of federal income tax credits to subsidize coverage for the uninsured,¹ such credits were finally enacted as part of the Trade Act of 2002. The first example of policies along these lines since the ill-fated “Bentsen child health credits” of the early 1990s, Health Coverage Tax Credits (HCTCs) represent a unique opportunity to learn, from experience rather than speculation, what role federal income tax credits could play (if any) in broader reforms.

Several months after the credits first became available in advanceable form, observers began expressing the concern that few eligible individuals were using HCTCs,² a concern that has been reiterated over time.³ This report reexamines the issue of HCTC take-up from the vantage point of several years experience with the program, to ask the following questions:

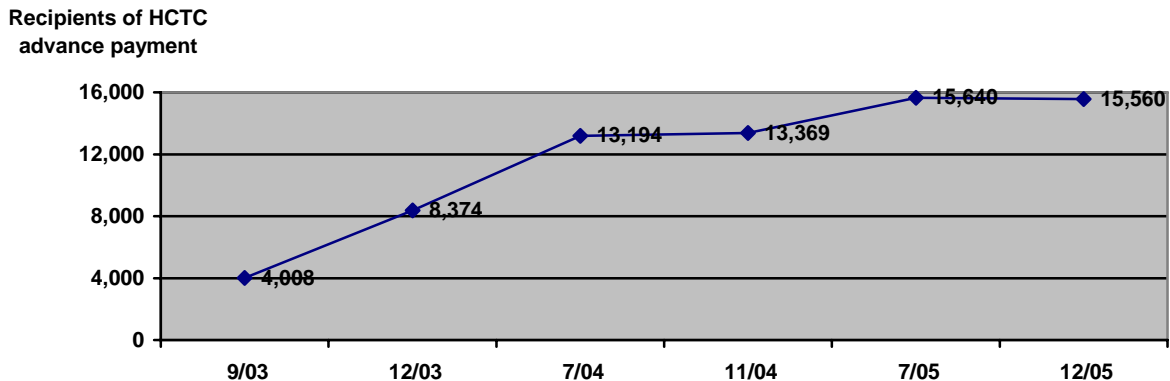
- How many eligible beneficiaries use HCTC to enroll in coverage?
- What are the main factors limiting enrollment?
- Are there any examples of successful HCTC enrollment?
- How could future tax credits or a revised HCTC program be structured and implemented to increase the proportion of eligible, uninsured individuals who use such credits to purchase health coverage?

This report assumes familiarity with the HCTC program. For the reader who desires background information, detailed explanations are available from several sources.⁴

Nationally, HCTC Take-Up Remains Low

The number of advance payment enrollees has increased over time, rising from 4,000 in September 2003 (the second month during which advance payment was available) to nearly 16,000 in December 2005 (figure 1).

FIGURE 1. HCTC ADVANCE PAYMENT ENROLLMENT IN VARIOUS MONTHS, SEPTEMBER 2003 THROUGH DECEMBER 2005



Source: IRS enrollment data, January 2004 through January 2006; GAO, September 2004.⁵ [[UI Style is to place any endnotes in figures, source lines, or figure notes.

Notes: (1) These months have been selected from the enrollment data that have been made publicly available, which exclude a number of months. The publicly available data are listed in full in the accompanying endnote.⁶ (2) These totals are limited to advance payment recipients. They do not include recipients who claim HCTCs only on end-of-year tax forms.

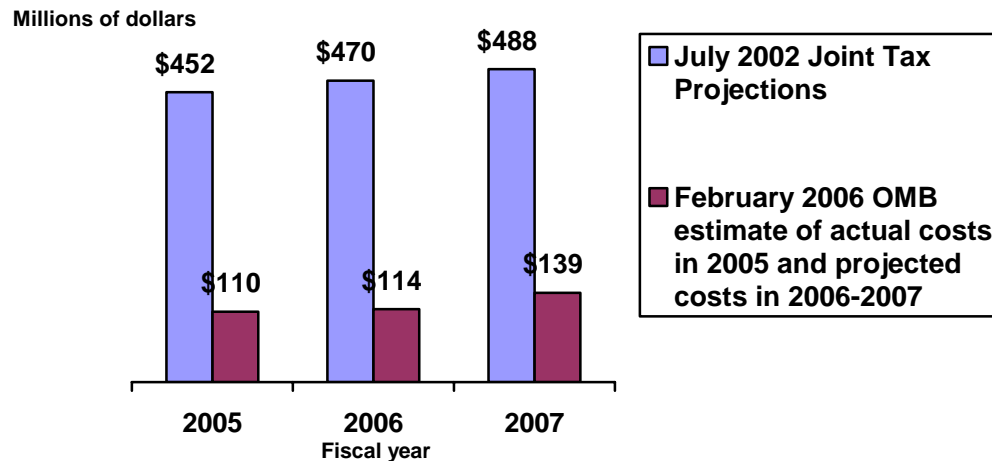
In comparing this enrollment to the pool of potential beneficiaries, two uncertainties make it impossible to state with precision the proportion of HCTC enrollees among all eligible households. The first uncertainty involves the number of households who qualify. For December 2005, State Workforce Agencies (SWAs) and the Pension Benefit Guarantee Corporation (PBGC) identified 249,817 workers or retirees who potentially qualified for HCTC based on their eligibility for Trade Adjustment Assistance (TAA) or their receipt of PBGC payments.⁷ However, that total included an unknown number of households who were ineligible for HCTC because they had other, disqualifying coverage, such as Medicare and certain employer-based insurance.

The second uncertainty concerns the number of HCTC beneficiaries. In December 2005, 15,560 individuals received HCTC advance payments. However, an unknown number of additional individuals never received advance payment but instead claimed HCTCs on their end-of-year (EOY) income tax forms for 2005.

Fortunately, “ballpark” estimates are possible to narrow the scope of both uncertainties. Researchers examining various groups of displaced workers and early retirees have found that between 36 and 50 percent of individuals who were identified by SWAs or PBGC as potentially qualifying for HCTC in fact were ineligible because of their receipt of disqualifying health coverage.⁸ Based on those findings, an estimated 127,000 to 165,000 individuals may have qualified for HCTC in December 2005. Second, based on available data for tax years 2003-2005, between 6,100 and 11,000 taxpayers may receive EOY HCTCs for 2005, without participating in advance payment,⁹ bringing the total number of potential beneficiaries for December 2005 between 21,700 and 26,600. Those estimates yield the conclusion that between 13 percent and 21 percent of eligible taxpayers may have used the HCTC program in December 2005.¹⁰

It is thus no surprise that HCTC subsidies in 2005 were only 24 percent of the level anticipated by the Congressional Joint Tax Committee when the Trade Act passed in 2002. Based on projections by the U.S. Office of Management and Budget, that proportion is expected to stay the same in 2006 and rise to 29 percent in 2007 (figure 2).

FIGURE 2. HCTC TAX EXPENDITURE COSTS: JULY 2002 PROJECTIONS VS. FEBRUARY 2006 ESTIMATES AND PROJECTIONS



Sources: Congressional Joint Tax Committee, July 2002;¹¹ OMB, February 2006.¹² Note: The February 2006 estimates combine the revenue and outlay effects identified by OMB. Unlike in prior years, OMB's 2007 budget estimates did not include current-law outlay effects for HCTC beyond the budget year (2007).

Likely Causes of Low Enrollment into HCTC

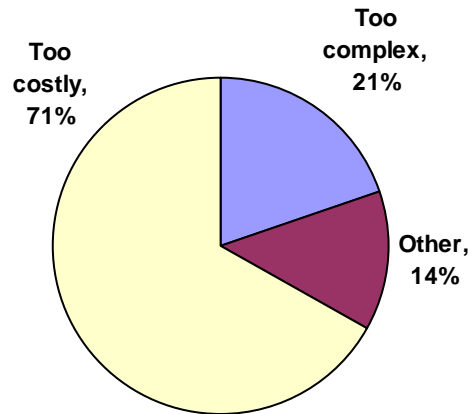
Workers who potentially qualify for HCTC are heterogeneous. They range from highly educated, affluent airline pilots to unemployed, former mill-workers with little schooling and few resources. Accordingly, various features of program design and implementation have unequal effects on different groups of potential beneficiaries. Nevertheless, it is possible to isolate the factors that have most inhibited enrollment, across the general range of HCTC-eligible households. Previous work has identified the following factors as particularly important:¹³

- Many potential beneficiaries are unable to afford their 35 percent share of premiums.
- Workers must pay unsubsidized premiums in full for several months before IRS advance payment begins, except in states operating “gap filler” programs that pay 65 percent of premiums during those initial months. As of October 2005, such programs were available in only 12 states¹⁴ that together included 39 percent of potentially eligible individuals (as identified by SWAs and PBGC).¹⁵
- It is difficult to apply for HCTC advance payment. For example, paperwork must be filed with between three and five separate public or private agencies.
- Many otherwise eligible households experience gaps in coverage of 63 days or more within the three months before they enroll into a state-qualified HCTC plan. Consequently, such plans can exclude coverage of preexisting conditions for up to 12 months, robbing coverage of much of its value to these enrollees.
- HCTC outreach has not incorporated recent “best practices” used for other public and private benefits.

In recent years, two surveys reinforced the importance of these factors in lowering HCTC participation. Between June 2004 and March 2005, the Office of Inspector General of the Department of Labor (OIG/DOL) conducted a survey of individuals who (a) qualified for

HCTC; (b) lived in one of the states that operated a “gap filler” program; and (c) did not participate either in HCTC or their state’s “gap filler” program. Among these non-participants, 71 percent reported that premium cost was the most important reason they did not take advantage of the credit (figure 3). The second most important reason was program complexity.

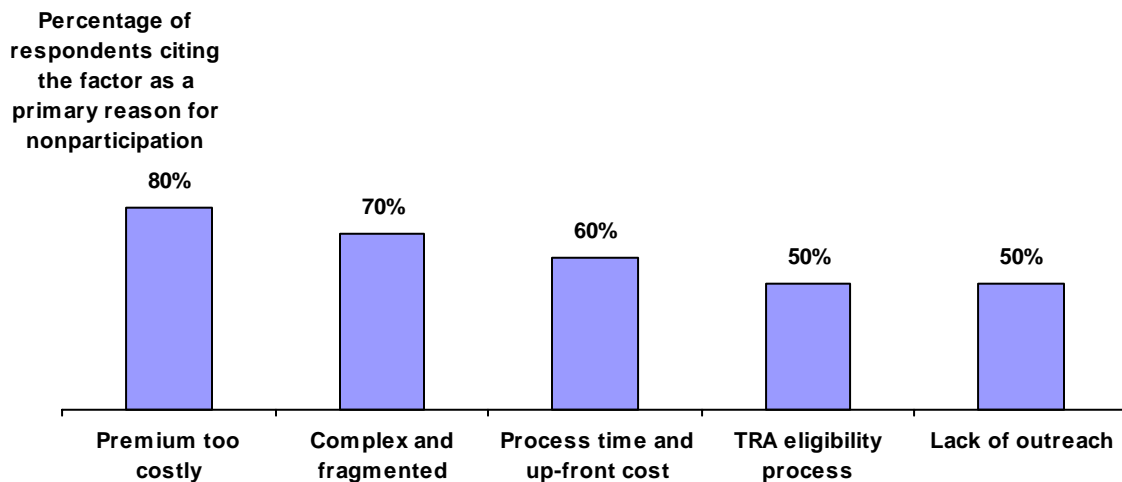
FIGURE 3. MOST IMPORTANT REASONS FOR NOT PARTICIPATING IN HCTC, AMONG ELIGIBLE INDIVIDUALS NOT USING THE CREDIT IN STATES OPERATING GAP-FILLER PROGRAMS: JUNE 2004–MARCH 2005



Source: OIG of DOL, September 30, 2005.¹⁶

OIG also surveyed officials in these states to ask for their views about why more individuals did not enroll. Affordability and complexity again were the most frequently mentioned factors, cited by 80 and 70 percent of state respondents, respectively (figure 4).

FIGURE 4. PRIMARY REASONS CITED BY STATE OFFICIALS AS CONTRIBUTING TO LOW HCTC PARTICIPATION: JUNE 2004–MARCH 2005



Source: OIG of DOL, September 30, 2005.

Notes: (1) Surveyed officials were in State Workforce Agencies (SWAs) in states operating gap-filler programs in June 2004. (2) The percentages together exceed 100 percent because respondents could cite multiple factors contributing to low participation. (3) Not included in this chart is the one factor cited by fewer than 50 percent of respondents – namely, slow federal processing of state proposals for DOL’s National Emergency Grants (NEG), which was mentioned by 40 percent of state respondents. (4) “TRA eligibility process” refers to the establishment of eligibility for Trade Readjustment Allowances, which are provided to workers certified as adversely affected by international trade, and which are important to establishing TAA-related HCTC eligibility.

Second, the GAO surveyed workers displaced by trade-related closings at five manufacturing plants in a combination of rural and urban settings in five different states. This survey was conducted from April through June 2005. Among workers who qualified for HCTC but did not use the credit, once again the most commonly reported reasons for non-participation involved cost and confusion (table 1).

TABLE 1. AMONG POTENTIALLY ELIGIBLE WORKERS NOT RECEIVING HCTC, REASONS FOR NONPARTICIPATION REPORTED AT FIVE TRADE-RELATED LAYOFF SITES: APRIL–JUNE 2005 (PERCENT)

	Too expensive	Confusing	Other reasons	No reason
General Mills (MO)	67	25	0	17
Lear (PA)	73	50	3	7
Weyerhaeuser (WA)	75	13	25	0
Toro (MS)	67	50	17	0
Sanmina-SCI (MA)	65	26	29	3

Average of all five sites, weighted by number of affected workers	69	29	14	7
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Source: GAO, January 2006.¹⁷ Calculations by ESRI, July 2006.

Notes: (1) These five sites may not have comprised a nationally representative sample. (2) These percentages show the reasons for nonparticipation cited by trade-affected, displaced workers who (i) knew about HCTC; (ii) chose not to take HCTC; and (iii) were not enrolled in coverage that made them ineligible for HCTC. (3) The percentages together exceed 100 percent, because workers could give more than one reason for nonparticipation.

The GAO survey also found that most displaced workers were unfamiliar with HCTC, despite efforts by SWAs to provide written information and to make in-person presentations. The proportion familiar with HCTC exceeded 46 percent for only one of the five sites, ranging as low as 36 percent at one site, with a weighted average of 43 percent of displaced workers at all five sites.¹⁸

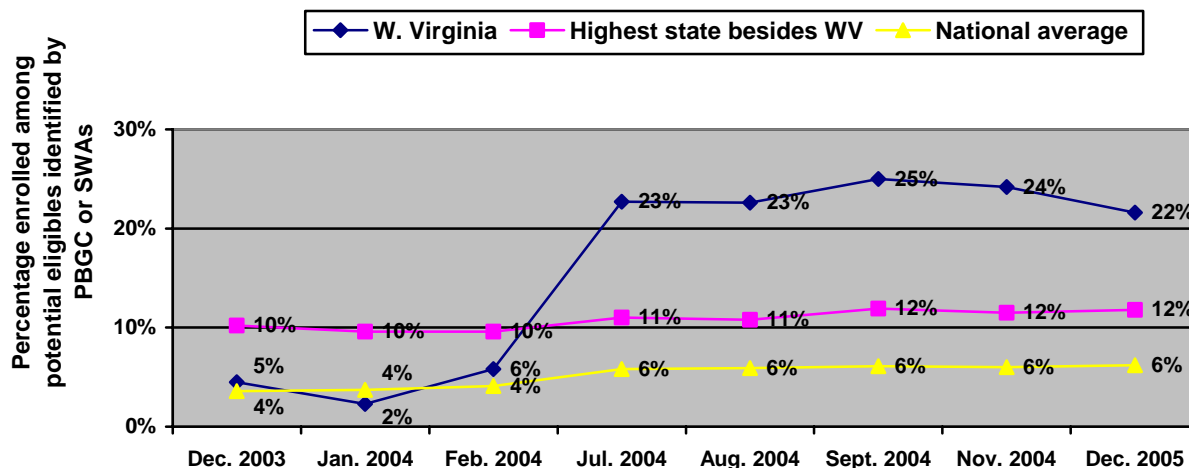
Examples of Higher-than-Average HCTC Enrollment

While the program as a whole has reached only a small proportion of eligible workers, unusual success has been achieved in some places and with some beneficiaries. Three specific examples are explored in turn below: a statewide, ongoing effort in West Virginia; a pilot project that achieved great success for several months in Virginia; and a multi-state effort to help early retirees from Bethlehem Steel. The final section below explores the common factors underlying these three examples.

1. Intensive Union Assistance in West Virginia

Since mid-2004, West Virginia has had the country's highest rate of enrollment into HCTC. During four consecutive months, West Virginia doubled or more than doubled the enrollment rate achieved in the second-highest state (figure 5).

FIGURE 5. ENROLLMENT INTO HCTC ADVANCE PAYMENT, WEST VIRGINIA VS. OTHER STATES: DECEMBER 2003–DECEMBER 2005



Source: IRS enrollment data, January 2004 through January 2006. Calculations by ESRI, July 2006.

Notes: (1) These are the only months for which state-specific enrollment data have been made publicly available. (2) The percentages in this chart are not HCTC take-up rates, for two reasons: (a) the enrollment totals are limited to advance payment recipients and do not include recipients who claim HCTCs only on end-of-year (EOY) tax forms; and (b) many individuals whom SWAs or PBGC identify as potentially qualifying for HCTC are in fact ineligible because of enrollment in disqualifying health coverage or other factors.

This chart suggests two questions. First, taking into account EOY HCTC claimants and disregarding individuals who were ineligible for HCTC because of enrollment in disqualifying coverage, what proportion of eligible individuals received HCTC in some form during West Virginia's peak months of enrollment? In other words, what was West Virginia's true HCTC take-up rate?

And second, what changed in West Virginia between February and July 2004? In February, eight other states had higher enrollment rates than West Virginia's;¹⁹ but from July 2004 on, West Virginia reached a substantially higher proportion of potential enrollees than did any other state.

The first question can be answered based on the previous section's estimates for the number of HCTC beneficiaries claiming EOY credits and the proportion of ineligible beneficiaries among those identified by SWAs and PBGC as potentially qualifying for HCTC. If those estimates apply to West Virginia, in September 2004 (at the state's peak enrollment level) between 43 percent and 59 percent of eligible West Virginia residents received HCTC in some form.²⁰

It bears considerable emphasis that this range is even more approximate than are the comparable figures for the national level, since the layoffs and bankruptcies in West Virginia may not be typical of those for the nation as a whole.²¹ A survey in West Virginia would be needed to establish, with precision and full confidence, the HCTC take-up rate in that state. In the absence of such a survey, the estimate presented here may convey an approximate sense of the general order of magnitude of HCTC enrollment in West Virginia.

Second, between February and July 2004, retiree health coverage ended for former employees of Weirton Steel. Headquartered in Weirton, West Virginia, the company had been the country's fifth-largest steel manufacturer as well as a leading producer of tin. After the company declared bankruptcy, PBGC took over the company's pension payments in October 2003. However, retiree health coverage did not terminate until after April 1, 2004, in conjunction with sale of Weirton Steel's assets to the International Steel Group (ISG).²² The community-wide response to this loss in health coverage, which affected thousands of West Virginia residents, included the following steps:

- ISG agreed to offer COBRA coverage indefinitely to retirees from Weirton Steel, without regard to the normal 18-month limitation on former employees' ability to purchase such insurance.
- By December 2003, the state arranged to provide "gap-filler" assistance, funded by a National Emergency Grant (NEG) from the U.S. Department of Labor, so HCTC beneficiaries would not need to pay premiums in full while waiting for IRS to process their applications for advance payment.²³ (In West Virginia, this assistance is called "Bridge" coverage.)

- Mountain State Blue Cross and Blue Shield agreed to offer state-based coverage to HCTC-eligible residents of West Virginia, providing an insurance option to supplement COBRA.²⁴
- State and national officials, health plan staff, and representatives of the Independent Steelworkers Union worked intensively and collaboratively to prevent coverage gaps and assure continuous coverage for HCTC-eligible retirees from Weirton Steel and other potential beneficiaries.

The Union's efforts in this regard were particularly important. Union staff aggressively reached out to retirees affected by the Weirton Steel bankruptcy. Two union officials worked full time for three to four months ensuring that virtually every retiree who came their way enrolled in health coverage. Union staff completed forms for these retirees; Faxed finished forms to the appropriate federal, state, and private officials; arranged conference calls with retirees and state and federal officials when needed to diagnose or remedy coverage "glitches" affecting particular retirees; brought systemic problems to the attention of key officials and worked collaboratively to implement effective solutions; ensured that all invoices and other necessary forms were provided to the necessary public and private agencies; determined the precise premium payments required from households purchasing coverage with HCTC; educated early retirees about the advantages and disadvantages of various coverage options; and took other steps needed for retired steelworkers to obtain subsidized health coverage through this highly complex program. These union officials developed the expertise and tools needed to relieve the retired steelworkers themselves of the need to navigate through HCTC and enroll. They continued this work when further trade-related layoffs brought additional workers within the ambit of the HCTC program via TAA eligibility.²⁵

Union staffers found that, between social security payments, PBGC pension payments, and (in some cases) earnings from new employment, most of the retired steelworkers were able to afford their 35 percent premium share. Typically, these workers were age 50 or older and knew they had health problems for which insurance was required. In some cases, when younger workers lacked the resources to purchase relatively comprehensive coverage available through HCTC, union officials encouraged them to purchase less costly, high-deductible coverage to prevent catastrophic health costs from consuming their families' assets.

2. Consent Report Pilot Project in Virginia

From March through July 2004, workers and retirees who called the HCTC Customer Contact Center (Call Center) were asked the following scripted question:

The HCTC program partners with federal and state agencies. Some of these agencies have programs that may be able to assist you with health coverage payments; however, the HCTC program needs your consent to share your information with these federally recognized government agencies.

Do you agree to allow the HCTC program to share your Social Security Number, contact information, and HCTC eligibility and enrollment status only with government agencies recognized by the HCTC program that may be able to assist you with health coverage payments?²⁶

For Maryland and Virginia callers, the Call Center would forward, every two weeks, contact information about consenting individuals to state officials who administered gap-filler programs. Consent to disclosure was given by 83 percent and 75 percent of callers from Virginia and Maryland, respectively.²⁷ For March and April, the consent program forwarded to state officials information about nearly 630 and 279 individuals in Virginia and Maryland, respectively.²⁸

Because only the Virginia gap-filler program was fully operational throughout the pilot, the remainder of this analysis is limited to Virginia. According to Virginia officials, more than 90 percent of displaced workers and early retirees who consented to have their contact information shared with Virginia agencies received health coverage, either through HCTC or other sources; in the final month of the pilot project, every such individual received health coverage.²⁹

State officials used the consent forms to provide intensive assistance, as follows:

- When consenting individuals were not found on the list of applicants for Virginia’s gap-filler program, state officials contacted such individuals, determined their eligibility, and enrolled them into the state program, as appropriate. This intervention was particularly important for PBGC-eligible workers, whose identities typically were unknown to the state agency before the pilot project.
- Conversely, many enrollees in the gap-filler program did not apply for IRS advance payment, under the misimpression that, by applying for the gap-filler program, they had already applied for the IRS tax credit. Because of the consent form, state officials could obtain information from IRS about the status of consenting individuals’ applications for HCTC. This permitted a rapid identification of gap-filler recipients who had not applied for HCTC. State officials then contacted these individuals and ensured that they promptly applied for HCTC.
- When particular HCTC applications ran into trouble, the consent forms allowed state officials to obtain from IRS the information needed to diagnose problems and resolve them. For example, with information from those forms, state officials detected and remedied information technology (IT) glitches that caused the IRS to misread state-provided data about TAA-eligible workers. Before the consent program, state officials did not know what happened when their data reached IRS.
- Because the consent process allowed the tracking of individual HCTC applications in “real time,” state officials could prevent the development of gaps in coverage. Under the HCTC statute, a 63-day gap in coverage allows state-qualified plans to exclude preexisting conditions. Officials believed that preventing such gaps was essential to take-up, since preexisting condition exclusions make coverage of such little value to affected workers that it is rarely seen as worth the 35 percent premium share. Officials noted, for example, that mailings to workers who were longstanding benefit recipients and therefore may have experienced a gap in coverage received less than a five percent response rate. By contrast, face-to-face Rapid Response teams meeting with displaced workers on the job site yielded response rates above 66 percent.³⁰ State officials worked hard to expedite both such meetings and enrollment in the gap-filler program so that the first payment under that program could reach workers’ health plans before the workers lost their COBRA election rights.

- Frequently, displaced workers and early retirees participating in HCTC did not understand the transition between the gap filler program and the full tax credit. For example, the invoice and bill payment schedule changes when individuals transition between programs. At that point, many enrollees wrongly conclude that they have already paid for a given month of coverage, when in fact they still owe their 35 percent premium share. Because of information provided through the consent waiver, state officials could correct that misimpression and prevent beneficiaries from losing coverage subsidies by mistake.
- The consent process allowed state officials to learn when gap-filler beneficiaries were found eligible for HCTC, permitting rapid termination of the state subsidy after it was no longer needed.

Not only did this project increase the number of eligible individuals who enrolled in HCTC, it avoided duplicative payment of federal and state subsidies, thereby conserving state resources. These goals were achieved because state officials could frequently transition individuals from the gap-filler program to HCTC advance payment in two months, rather than four months, as was often the case before the consent pilot project; and because state officials could prevent the federal program and the state program from making duplicative payments covering the same month's coverage. Put differently, efficiency and program integrity were promoted, along with enrollment.

This work required a full-time commitment from one state employee. As a result, in virtually all cases, the only individuals who did not take up HCTC advance payment were those who enrolled in disqualifying coverage or chose to claim their HCTCs only at the end of the year. Together, those groups comprised roughly 15 to 20 percent of all people who participated in the consent pilot project.

The forms of coverage available in Virginia ameliorated many of the affordability problems HCTC-eligible households experienced elsewhere in the country. In Virginia, the companies that experienced mass layoffs continued to be subject to COBRA, in the vast majority of cases affecting HCTC-eligible workers. COBRA premiums were based on the cost of serving all of a company's enrollees, including both current and former workers and dependents. The same premiums were charged to all, regardless of age or health condition. In effect, HCTC's 65 percent premium subsidy was joined with a cross-subsidy from lower-risk enrollees in employers' health plans, making the cost of coverage for high-risk HCTC beneficiaries affordable, relative to the value of comprehensive coverage. In some cases, households went into debt or made other sacrifices to pay premiums.

Potential HCTC beneficiaries who were younger and healthier, on the other hand, could take advantage of access to medically underwritten, non-group coverage offered by Anthem Blue Cross and Blue Shield. While many such individuals would not have paid 35 percent of the premiums charged by COBRA plans, they could afford 35 percent of the discounted premiums charged by Anthem to low-risk enrollees.

Several contextual points are important here. First, beneficiaries did not have to make this analysis in a vacuum. State officials were extremely active in counseling potential HCTC beneficiaries and helping them understand the trade-offs involved in using the credit in each context. Second, the coverage choices available to HCTC beneficiaries in

Virginia—namely, access to community-rated, comprehensive benefits through COBRA for high-risk individuals coupled with access to medically underwritten, nongroup coverage that was particularly appealing to younger and healthier individuals—helped make coverage affordable to these needy individuals, but it would probably be an inherently unstable system if it were applied to a much larger group of people. If numerous high-risk enrollees disproportionately chose one, community rated plan and numerous low-risk enrollees disproportionately chose another plan, the former plan could easily experience a destructive “feedback loop” of escalating premiums and risk levels. Third, by definition, individuals calling the HCTC consumer center exhibited some interest in health coverage, suggesting a level of predisposition towards enrollment that may not have been present among potentially eligible individuals as a whole.

After July 2004, the consent form project ended because of IRS concerns about taxpayer confidentiality. However, state officials in Virginia were not aware of any examples of such confidentiality being compromised. Their impression was that the pilot project terminated because of generalized privacy concerns, rather than any particular breach.

3. Early Retirees from Bethlehem Steel

In May 2006, the Kaiser Family Foundation published a survey of retired steelworkers whose pensions were taken over by PBGC after their former employers, LTV Corporation and Bethlehem Steel, filed for bankruptcy.³¹ Retirees from the latter company were surveyed in Indiana, Maryland, and Pennsylvania. Because of the timing of these bankruptcies, only Bethlehem Steel retirees could benefit fully from HCTCs. Among the Bethlehem Steel retirees age 55 to 64, 34 percent used HCTC to retain health coverage. However, data in the Kaiser report imply that approximately 36 percent of surveyed retirees may have been ineligible for HCTC because of enrollment in disqualifying coverage.³² If so, then among Bethlehem Steel retirees *who were eligible for HCTC*, 53 percent took up the credit. As a result, only 35 percent of Bethlehem Steel retirees were uninsured at any point following the bankruptcy, compared to 62 percent of LTV retirees.

Intensive involvement by union staff appeared to have a significant impact in bringing about this level of enrollment. Fully 81 percent of Bethlehem Steel retirees were aware of HCTC, compared to less than half at most of the sites surveyed by GAO in 2005, as noted above. Among Bethlehem Steel early retirees who were familiar with HCTC, 71 percent learned about HCTC from union officials.³³ By contrast, in the 11 states surveyed by the DOL OIG, all of which ran “gap filler” programs, only 35 percent of HCTC participants learned about the program from union representatives.³⁴

Union officials scheduled numerous meetings in each affected geographic area to work with individual Bethlehem Steel retirees and help them receive available services. Before those meetings, union staff conducted outreach by working with numerous agencies serving retirees, both within and outside the union movement. This outreach was so successful that, in some cases, roads had to be closed off to all other traffic. At the meetings, a critical focus was helping retirees take advantage of HCTC to retain health coverage. In addition to union staff, present at these meetings were officials from IRS, from participating health plans, and from state agencies. Application forms were completed on behalf of retirees, who were required to do very little; it was the impression

of union staff that if these individuals had been left to navigate the system on their own, very few would have had the understanding and skills to complete the enrollment process and obtain coverage.

4. Common Features of These Examples

While each of these examples is unique, they have important common elements.

First, each involved intensive outreach. Committed staff assumed personal responsibility for making sure that each potentially eligible individual who came to their attention was enrolled in health coverage. These staff became quite knowledgeable about this complex program and took over most of the work required to navigate each individual through to health coverage. Either through consent to disclosure, as was the case in Virginia, or through three-party conference calls, as in West Virginia, expert staff could obtain information from IRS needed to resolve emerging problems. As a result, potential beneficiaries could receive coverage without themselves becoming experts in this complex health insurance subsidy system. (Of course, such “hands on” enrollment assistance generates administrative costs.)

Second, the agencies that took responsibility for enrollment knew who the potential beneficiaries were. In Virginia, that information was provided through consent to disclosure. In the other examples, the unions knew their members.

Third, in each example, older and sicker workers could purchase coverage without paying premiums that were increased based on insurers’ assessment of enrollees’ individual health status. For COBRA coverage in all states as well as for state-qualified plans in West Virginia and Pennsylvania, premiums were fully community-rated and did not vary based on age, gender, or individual health status. Moreover, state-qualified coverage included high-risk pools in Maryland and Indiana that varied premiums based only on such factors as age and gender.³⁵ In effect, the absence of medical underwriting and, in some cases, the presence of full community rating provided a level of cross-subsidy that supplemented HCTC’s 65 percent credit and allowed coverage to be purchased at a relatively affordable price by those who knew they were likely to need care.³⁶

Fourth, many of the pertinent states operated gap-filler programs that avoided any need for beneficiaries to pay premiums in full before the start of advance payment.

Fifth, policymakers and stakeholders in each state worked intensively and collaboratively to prevent potential beneficiaries from experiencing gaps in coverage. As noted above, gaps of more than 62 days can limit HCTC enrollees to insurance that excludes preexisting conditions.

Sixth, many of the beneficiaries in these examples were retired steelworkers. Although PBGC’s assumption of their pensions reduced their income, in many cases they nevertheless had more resources than were available to HCTC-eligible individuals elsewhere, such as workers displaced by trade-related closings of textile mills.

Finally, state-qualified coverage was available with deductibles as low as \$500 in each example. In addition, COBRA coverage typically involved even lower deductibles. As a result, beneficiaries were not limited to high-deductible plans that some consumers may find to have modest value.

Conclusion

While the HCTC program as a whole has not enrolled most eligible individuals, the obstacles to enrollment appear surmountable in future tax credits or a revised version of HCTC, as illustrated by the handful of cases in which comparatively high take-up rates have been achieved.

The steps needed to increase take-up, whether for HCTC or future tax credits, are straightforward:

- Credits need to be sufficiently large that the target population can afford coverage.
- Applicants cannot be required to pay premiums in full while administrative agencies are determining their eligibility for credits. To accomplish this goal, enrollment in qualified coverage cannot be an element of eligibility for credits.
- Application systems need to be simple and streamlined.
- Outreach needs to be proactive, with expert staff empowered to identify and contact potential beneficiaries, to gather all pertinent information, and to act on applicants' behalf to solve problems and assure receipt of coverage. This may require adding privacy waiver provisions in future tax credit statutes.
- Potential beneficiaries require access to coverage they view as valuable because it meets their foreseeable health care needs, without raising premiums substantially for those who are most likely to require care. This may limit the future role of preexisting condition exclusions, medically underwritten coverage, and high-deductible plans in viable tax credit systems that cover the bulk of the uninsured.

In several places around the country, a sizable proportion of eligible displaced workers and early retirees have used HCTC to enroll in coverage, despite the program's acknowledged limitations. In an improved tax credit program, higher levels of enrollment could be within reach that may turn out to be comparable to those already achieved by older health subsidy programs like Medicaid and SCHIP.

Notes

Mr. Dorn was a senior policy analyst at the Economic and Social Research Institute (ESRI) when most of the work on this paper was done. Founded in 1987, ESRI was a nonpartisan, nonprofit research organization headquartered in Washington, D.C. Specializing in health and social policy research, ESRI conducted studies aimed at enhancing the effectiveness of social programs, improving the ways in which health care services are organized and delivered, and making high-quality health care accessible and affordable.

1. Before August 6, 2002, when the Trade Act was signed into law, at least 7,415 documents had been published on the Internet with the words “health insurance tax credit,” “health coverage tax credit,” “tax credit for the uninsured,” or similar language. Ask.com, ESRI search, July 9, 2006. In scholarly journals, at least 560 articles had been published by 2002 that discussed “tax credits” and the “uninsured.” Scholar.google.com, ESRI search, July 9, 2006.
2. Robert Pear, “Sluggish Start for Offer of Tax Credit for Insurance,” *New York Times*, January 25, 2004.
3. See, e.g., 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*, Economic and Social Research Institute (ESRI) and Northwest Health Law Advocates, Revised November 3, 2005, prepared for The Commonwealth Fund, http://www.esresearch.org/documents_1-05/HCTC_TakeUp.pdf; Karen Pollitz and Stephanie Lewis, *The Health Coverage Tax Credit for Trade Dislocated Workers and Retirees: Lessons from Maine’s Early Experience*, Georgetown University Health Policy Institute, prepared for the National Academy of State Health Policy with support from the Maine Health Access Foundation April 2004, http://www.nashp.org/Files/NASHP_HCTC_paper_final_4-5-04.pdf; Edwin Park, *Substantial Flaws In Trade Health Insurance Tax Credit Need To Be Addressed Before Consideration Of An Expansion*, Center on Budget and Policy Priorities, Revised March 23, 2004, <http://www.cbpp.org/3-22-04health.htm>.
4. See, e.g., 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 Dorn, Varon, and Pervez 2005.
5. 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>.
6. The following are all the publicly available numbers of advance payment enrollees, by month: 9/03, 4,008 enrollees; 10/03, 5,826; 11/03, 7,131; 12/03, 8,374; 1/04, 9,318; 2/04, 10,246; 3/04, 11,344; 4/04, 12,166; 5/04, 12,896; 6/04, 13,222; 7/04, 13,194; 8/04, 13,493; 9/04, 13,562; 11/04, 13,369; 7/05, 15,640; 12/05, 15,560.
7. IRS, *Health Coverage Tax Credit Summary*, January 2006.
8. This range reflects four reports. First, a survey of retired steelworkers affected by two bankruptcies of major manufacturers found that 26 percent used HCTC; and that of the remainder who were aware of the credit, 50 percent were ineligible because of their receipt of other coverage. Kaiser Family Foundation, *Retired Steelworkers and Their Health Benefits: Results from a 2004 Survey*, May 2006, <http://www.kff.org/insurance/upload/7518.pdf>. If the latter

proportion applied to non-users of HCTC who were unaware of the credit, then between 36 and 37 percent of all such early retirees would have been ineligible for HCTC because of enrollment in other coverage. (See the discussion of Bethlehem Steel retirees in the text below.) Second, GAO described an internal IRS survey finding that, in October 2003, other coverage disqualified approximately 50 percent of individuals not participating in HCTC despite their identification by SWAs or PBGC as potential eligibles. GAO 2004. Taking into account the small number of individuals who, at that early point in the program, used HCTC advance payment, other coverage disqualified 49 percent of individuals whom SWAs or PBGC had identified as potentially eligible. Third, a report by the Office of Inspector General at the U.S. Department of Labor found that, in states administering “gap filler” programs in June 2004, 52.5 percent of non-participants who were aware of HCTC were ineligible and/or did not need the credits because of enrollment in other coverage; and that only 4.8 percent of eligible displaced workers had enrolled. Office of Inspector General, U.S. Department of Labor, *Performance Audit Of Health Coverage Tax Credit (HCTC) Bridge And Gap Programs*, Date Issued: September 30, 2005, Report Number: 02-05-204-03-330, <http://www.oig.dol.gov/public/reports/oa/2005/02-05-204-03-330.pdf>. Calculations by ESRI, July 2006. If the proportion of enrollees in other coverage was the same for respondents whether or not they knew of HCTC, then such coverage was in place for 50 percent of all individuals whom SWAs or PBGC identified as potentially eligible for the credit. Fourth, a recent GAO study examined HCTC enrollment in five layoff sites. Among those who had heard of HCTC, the percentage of displaced workers with disqualifying coverage ranged from 36 percent to 59 percent, with a weighted average of 43 percent at all five sites. GAO, *Trade Adjustment Assistance: Most Workers in Five Layoffs Received Services but Better Outreach Needed on New Benefits*, GAO-06-43, January 2006, <http://www.gao.gov/new.items/d0643.pdf>. The range in the text does not incorporate the one location where 59 percent of displaced workers had disqualifying coverage, as the text attempts to estimate the range that applies to potentially HCTC-eligible workers and retirees in the nation as a whole.

9. As of May 2004, 12,594 EOY HCTC claims had been paid for 2003 taxpayers who did not participate in advance payment. IRS, *Monthly Executive Scorecard, September 2004 – v1.0*, October 13, 2004; GAO 2004. “Repeat customers” – those who obtained EOY payments for both 2003 and 2004 and so were unlikely to have received advance payments in 2004 – totaled 5,747 taxpayers. IRS 2006. Another 9,201 received EOY payments for the first time in 2004, but a large proportion of such payments were for individuals who also received advance payments. That proportion presumably would have been no greater than in tax year 2003, when advance payment was available only for the months beginning in August. Based on that proportion (50 percent), a maximum of 4,616 additional taxpayers may have received EOY credits but not advance payment during tax year 2004, resulting in a total estimate between 5,747 and 10,363 taxpayers. Early tax filing statistics suggest that HCTC claims in 2005 may be 7 percent above 2004 levels. IRS, *Tax Year 2005 Taxpayer Usage Study, Report Number 14* (Analysis of returns filed through May 5, 2006, compared to returns filed through May 6, 2005), <http://www.irs.gov/pub/irs-soi/05tp14tb.xls>. Calculations by ESRI, July 2006. The numbers in the text assume a proportionate increase in the number of EOY credit recipients for tax year 2005 who did not participate in advance payment. This estimate may be too low because the May 2004 estimate of the number of EOY-only

recipients did not include recipients whose tax forms for 2003 were processed after that date. On the other hand, the estimate may be too high because it may understate the reduction in the proportion of EOY-only claims in 2004, when advance payment was first available year-round; and because some EOY-only recipients for 2004 may have claimed the credits only for months before December.

10. This range is somewhat lower than the estimated 22 percent take-up rate found in 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*, Economic and Social Research Institute and Northwest Health Law Advocates, prepared for The Commonwealth Fund, Revised November 3, 2005, http://www.esresearch.org/documents_1-05/HCTC_TakeUp.pdf. This change reflects methodological differences in arriving at an estimated take-up rate, not any drop in enrollment levels. These differences resulted from the above-described data about EOY HCTC in tax years 2004 and 2005 and new research into the percentage of ineligible individuals among those identified by SWAs and PBGC as potentially qualifying for HCTC.

11. Joint Committee on Taxation (Joint Tax). *Estimated Budget Effects of the Revenue Provisions Contained in the Conference Agreement for H.R. 3009, The Trade Adjustment Assistance Reform Act of 2002 (TAA)*, July 29, 2002, JCX-84-02.

12. U.S. Office of Management and Budget (OMB), *Analytical Perspectives on the Budget, 2007*, February 2006, <http://www.whitehouse.gov/omb/budget/fy2007/pdf/spec.pdf>; OMB, *Budget of the United States Government, Fiscal Year 2007 – Appendix, “Department of the Treasury,”* February 2006, <http://www.whitehouse.gov/omb/budget/fy2007/pdf/appendix/tre.pdf>. Calculations by ESRI, July 2006.

13. Dorn, Varon, and Pervez 2005.

14. This assistance is funded by National Emergency Grants (NEG) from the U.S. Department of Labor. The states that operate gap filler programs are Florida, Illinois, Kentucky, Maine, Maryland, Minnesota, North Carolina, Ohio, Utah, Virginia, Washington, and West Virginia. IRS, *State-Level Temporary Assistance for the HCTC National Emergency Grant (NEG) Bridge Program*, October 2005, http://www.irs.gov/pub/irs-utl/neg_contact_information_10-2005.pdf.

15. IRS January 2006. Calculations by ESRI, July 2006.

16. OIG, DOL, *Performance Audit Of Health Coverage Tax Credit (HCTC) Bridge And Gap Programs*, Report Number: 02-05-204-03-330, September 30, 2005, <http://www.oig.dol.gov/public/reports/oa/2005/02-05-204-03-330.pdf>.

17. GAO 2006.

18. OIG’s June 2004 survey of non-participating workers in the 11 states then operating “gap filler” programs found that 66 percent of such workers knew about HCTC. This higher awareness may have reflected a greater level of overall state engagement. Presumably, the same state leaders who are motivated enough to operate “gap filler” programs are also likely to institute particularly vigorous outreach efforts.

19. At that time, Maryland and Montana each enrolled into HCTC advance payment 9.6 percent of individuals whom PBGC or SWAs had identified as potentially eligible. That proportion was 8.4 percent in Pennsylvania; 7.0 percent in North Carolina; 6.9 percent in Minnesota; 6.4 percent in Michigan; 6.2 percent in Indiana; 6.0 percent in Virginia; and 5.8 percent in West Virginia. IRS, *Executive Scorecard July 2004—v 1.0*, August 11, 2004. Calculations by ESRI, July 2006.

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20. The above national analysis was applied to West Virginia by distributing estimated EOY enrollees among all states in proportion to the number of potential HCTC-eligible individuals identified in each state by SWAs and PBGC.
21. Additional uncertainties involve EOY claimants. West Virginia may have had more than its proportionate share because of the unusually intensive outreach efforts undertaken within the state. On the other hand, it would have had less than its proportionate share if those outreach efforts led to advance payment enrollment by individuals who, in other states, would have filed only EOY claims.
22. Vicki Smith, "Health Benefits For Weirton Steel Retirees To End April 1," *The Charleston Gazette*, March 16, 2004, Page 1D.
23. DOL, "Labor Secretary Elaine L. Chao Announces Grant to Help Trade-Impacted Workers in West Virginia," *ETA News Release*, Dec. 22, 2003.
http://www.doleta.gov/whatsnew/new_releases/WEST%20VIRGINIA%20--%20FINAL%20--%202012-22-03.cfm.
24. Beginning on August 1, 2004, state-qualified coverage was also available from the state's new high risk pool, AccessWV. *AcademyHealth Stateside*, October 7, 2005,
<http://news.statecoverage.net/ahstsd/textonly/printall.php?id=ahstsd20051007>.
25. John Balzano and Nikki Butto, personal communication, July 10, 2006.
26. Julie R. Crom, Accenture, personal communication, October 20, 2004.
27. One factor contributing to the higher consent rate among Virginians was that Virginia officials regularly encouraged displaced workers to call the HCTC Call Center and give their consent. Lynette Hammond, personal communication, July 12, 2006.
28. IRS, *HCTC-NEG Bridge Pilot*, July 2004.
29. Lynette Hammond and Anna Rice-Wright, personal communication, June 30 and July 5, 2006.
30. IRS 2004.
31. Kaiser Family Foundation, *Retired Steelworkers and Their Health Benefits: Results from A 2004 Survey*, May 2006, <http://www.kff.org/insurance/upload/7518.pdf>.
32. 26 percent of all surveyed steelworkers age 55-64 used HCTC, and approximately 3 percent were not sure whether they had used HCTC. Among respondents who were familiar with HCTC but chose not to use it, 50 percent reported that they were ineligible because of enrollment in disqualifying coverage. If that same percentage applied to those who were unaware of HCTC, then of the 71 to 74 percent of surveyed steelworkers age 55-64, half—or between 36 percent and 37 percent—were ineligible for HCTC.
33. The total exceeds 100 percent, because respondents could list more than one source of information.
34. Among those who knew about HCTC but decided not to participate, 15 percent learned about the credit from union staff. DOL OIG, 2005.
35. Fouad Pervez and Stan Dorn, *Health Plan Options Under the Health Coverage Tax Credit Program*, Health Management Associates and the Urban Institute, prepared for The Commonwealth Fund (publication pending).
36. The contrast with North Carolina is illuminating. In that state, an extraordinary community-wide, public- and private-sector effort was mounted to enroll all eligible workers into HCTC. Following the sudden collapse of Pillowtex, one of the state's largest textile mills, COBRA coverage was unavailable to most potential beneficiaries, and state-qualified coverage took the form of medically underwritten

nongroup coverage. As a result, older workers and those with a history of illness could not realistically purchase coverage, even with a 65 percent tax credit. Accordingly, when 3,200 such workers were helped to go all the way through the application process and received their medically underwritten premium quotes, 69 percent at that point abandoned their HCTC applications; and the rate of abandonment was highest for the individuals whom the insurer classified in the highest risk tiers. Stan Dorn, *Health Coverage Tax Credits in North Carolina: Heroic Efforts, Modest Results*, Economic and Social Research Institute for The Commonwealth Fund and the Nathan Cummings Foundation, August 2004, http://www.esresearch.org/documents_1-05/HCTC_NC.pdf.