Health Plan Options Under the Health Coverage Tax Credit Program

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Abstract: By March 2006, 40 states, which included 87 percent of potentially eligible individuals, had arranged state-qualified coverage for Health Coverage Tax Credit (HCTC) beneficiaries. High-risk pools provided such coverage in 20 states. Medically underwritten coverage, plans with pure community rating, and plans with modified community rating were each available in nine states. Altogether, 280 state-qualified options were offered. In 36 states, more than one plan was available, and the median state included five options. However, in 26 states, all coverage had individual deductibles of $500 or more, including 12 states where all deductibles were $1,000 or more.

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About Health Management Associates

Health Management Associates is a national research and consulting firm specializing in complex health care program and policy issues. Founded in 1985, in Lansing, Michigan, Health Management Associates provides leadership, experience, and technical expertise to local, state, and federal governmental agencies, regional and national foundations, multi-state health system organizations and single site health care providers, as well as employers and other purchasers in the public and private sectors.

About the Urban Institute

The Urban Institute is a nonprofit, nonpartisan policy research and educational organization established in Washington, D.C., in 1968. Its staff investigates the social, economic, and governance problems confronting the nation, and evaluates the public and private means to alleviate them. The Institute disseminates its research findings through publications, its website, the media, seminars, and forums.

Background

In August 2002, President Bush signed into law the Trade Act of 2002, creating Health Coverage Tax Credits (HCTCs), which subsidize 65 percent of health insurance premiums for certain early retirees receiving pension payments from the Pension Benefit Guaranty Corporation (PBGC) and displaced workers who lost employment because of foreign trade. HCTCs are federal income tax credits that are fully refundable, which means that they are paid in full to all who qualify, including those who owe little or no federal income tax. For premium payments made in December 2002 and later months, beneficiaries have been able to receive HCTCs after filing their annual federal income tax forms. Beginning in August 2003, HCTCs were also available through advance payment directly to recipients' health plans over the course of the year.

Whether obtained in advance or after the end of the year, HCTCs may be used only for qualified health plans, which fall into two categories. First, automatically-qualified plans are available in every state, without any need for state action. These plans include COBRA coverage,[1] individual coverage received by beneficiaries during at least their last 30 days before separation from work, and coverage through a spouse's employer (if the employer pays less than 50 percent of the premium).

Second, state-qualified coverage includes, at state option, so-called "mini-COBRA" plans[2] as well as other private health insurance arranged by a state that meets the following requirements:

- The state-qualified plan may not charge HCTC beneficiaries higher premiums than it would charge other, similarly situated enrollees;
- HCTC beneficiaries may not receive fewer benefits than the plan would provide to other, similarly situated enrollees;
- For HCTC beneficiaries with at least three months of continuous coverage immediately before seeking to enroll, the plan must guarantee issue of a policy; and
- For HCTC beneficiaries with such continuous coverage, the plan may not exclude coverage of preexisting conditions.

Although the target population is relatively small, this refundable, advanceable federal income tax credit - the first such credit targeting the uninsured since the early 1990s[3]- offers a unique opportunity to garner practical lessons about how to design future tax credits aimed at much larger groups of uninsured.

One important health policy question pertains to the health plans for which credits may be used. The HCTC statute takes a novel approach to this question. HCTC's requirements for state-qualified plans depart from generally applicable state insurance regulations, primarily because three months of continuous coverage bring an individual within HCTC's guaranteed issue and preexisting condition requirements. By contrast, federal HIPAA law applies such requirements only to individuals with at least 12 months of continuous coverage. While some states reduce that period to six months, only the HCTC program cuts it to three months.

On the other hand, HCTC departs from a number of other federally subsidized health programs in that HCTC's state-qualified plans are subject to no requirements for covered benefits, no limits on cost-sharing, and no limits on the factors that may be used to determine premiums charged to particular enrollees. The only federal rules on these topics forbid HCTC beneficiaries from being treated more harshly than other enrollees and bar preexisting condition exclusions for individuals with continuous coverage, as noted above. By contrast, Medicare, Medicaid, and SCHIP all have federal rules specifying, to a significant degree, the benefits that are offered and the out-of-pocket costs that may be imposed. Generally, the latter, longstanding federal programs do not permit factors like age, gender, and individual health risk to determine the premiums beneficiaries must pay.[4]

To assess the impact of these unique requirements, this report investigates the state-qualified health plans offered to HCTC beneficiaries as of March 2006, more than two and a half years following initial implementation of HCTC advance payment. We asked two basic questions: how robust was health plan participation? And what coverage options were available to HCTC beneficiaries?

Several related issues are outside the scope of this report. Other than to note individual deductible levels and optional coverage riders that added particular benefits to underlying plans, we did not gather information on the services covered by the many health plans that now participate in HCTC. Moreover, while this analysis shows the factors that were taken into account in determining premiums, we did not gather data about the precise premiums that each plan would charge to enrollees of various ages, genders, etc. These topics have been investigated as to some state-qualified plans[5] but have not been the subject of nationwide surveys.

Methodology

For this analysis, researchers used the IRS HCTC website to gather information about all state-qualified plans listed on that website from August through September 2005, with a follow-up in March 2006.[6] This involved searching online for HCTC plan information and making phone calls to every carrier listed on the IRS HCTC website.

Two sets of state-qualified plans were outside most of the analysis. First, we excluded mini-COBRA plans, which are available only to some HCTC beneficiaries (i.e., those whose former employers are governed by state mini-COBRA laws). Second, we generally excluded plans for which we could not obtain information beyond their listing on the IRS web site.

The information we obtained included plan names, premium variability factors, deductibles, and optional coverage riders. No information about specific premium amounts or specific plan benefits was obtained during the survey, although in cases where carriers provided more than one HCTC plan, we did examine plan benefits to determine if these involved multiple benefit designs.

We classified plans as involving multiple benefit designs if either: (a) benefits differed based on factors other than deductibles (and associated levels of copayments or co-insurance); or (b) plans represented different types of health insurance, such as Health Maintenance Organizations (HMOs), Preferred Provider Organizations (PPOs), Point-of-Service (POS) plans, and indemnity plans.

Specific HCTC plans were unable to be identified for one carrier in Louisiana and four carriers in Idaho. Information for those carriers was gathered based on their individual coverage plans. Due to the lack of clarity as to which of the individual coverage plans would be available to HCTC recipients, we assumed that each of the five carriers had at least one deductible option, one benefit design, and one overall plan option for HCTC recipients. Two of the Idaho carriers did have uniform deductibles for all their individual coverage plans, but since it was unclear whether all the deductibles would be available to HCTC recipients, they were excluded from the detailed deductible analysis, along with the other three carriers in Idaho. However, these same two Idaho carriers also had uniform premium-variability factors as well as plan-type (all individual plans were medically underwritten), so those aspects for the two carriers were included in the analysis.

For purposes of this analysis, the District of Columbia was counted as a state.

By February 2006, Georgia had arranged state-qualified coverage. However, because it was not listed on the IRS web site in March 2006, it was classified as not offering a state-qualified plan. Since March 2006, Massachusetts has announced its plan to offer state-qualified coverage through the state's new "Connector" system, once it becomes operational. For purposes of this survey, however, it was also counted as not offering state-qualified coverage.

Findings

1. State-qualified coverage was available to the vast majority of beneficiaries, and many carriers participated

As of March 2006, state-qualified plans (other than min-COBRA plans) were offered in 40 states.[7] These jurisdictions included 87 percent of individuals who were identified as potentially eligible for HCTC by state workforce agencies (SWAs) or PBGC (table 1). Altogether, 80 carriers offered state-qualified coverage.[8]

Table 1: Most Workers Who Potentially Qualified for HCTC Had Access to State-Qualified Plans, December 2005–March 2006

	States with qualified plans other than mini-COBRA	States without qualified plans	States where only mini-COBRA plans were qualified
Number of states	40	9	2
Number of potentially eligible workers	218,049	20,725	11,043
Percentage of potentially eligible workers	87%	8%	4%

Sources: Source: ESRI survey of HCTC plans, August-September 2005, March 2006; ESRI calculations from IRS December 2005 HCTC enrollment data and IRS listing of state-qualified plans in March 2006.
Notes: (1) Totals may not equal 100 percent because of rounding. (2) Potentially eligible workers were identified by SWAs or PBGC and mailed HCTC outreach materials. (3) D.C. is counted as one of the states with a qualified plan other than mini-COBRA. (4) 11 out of the 40 states listed as offering a qualified plan other than mini-COBRA also count mini-COBRA plans as state-qualified.

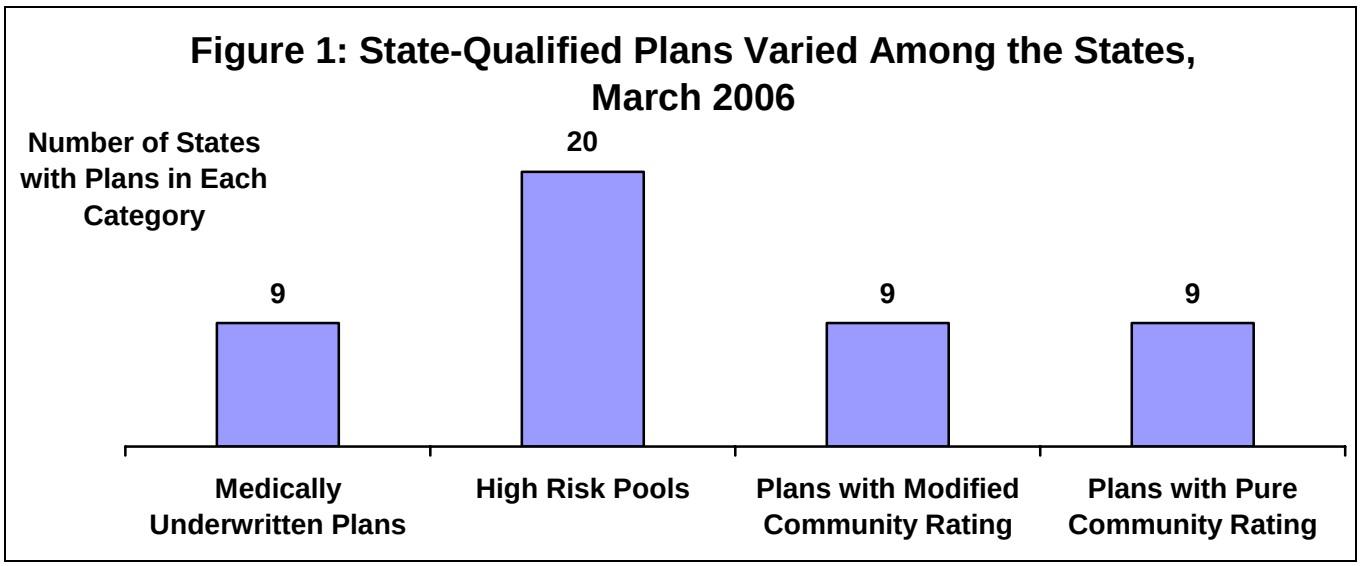
The number of health insurance carriers offering qualified HCTC plans has increased dramatically since the program was first implemented. The first state to arrange state-qualified insurance was Pennsylvania, with coverage available beginning in May 2003 – only three months before advance payment began.[9] Despite significant outreach and promotion by the U.S. Treasury Department and others, 24 states still lacked state-qualified plans by the end of 2003.[10] However, as noted above, only 11 states were without such coverage listed on the IRS website by March of this year.[11]

2. States took diverse approaches to HCTC-qualified coverage

We grouped state-qualified HCTC plans (other than mini-COBRA coverage) into four categories:

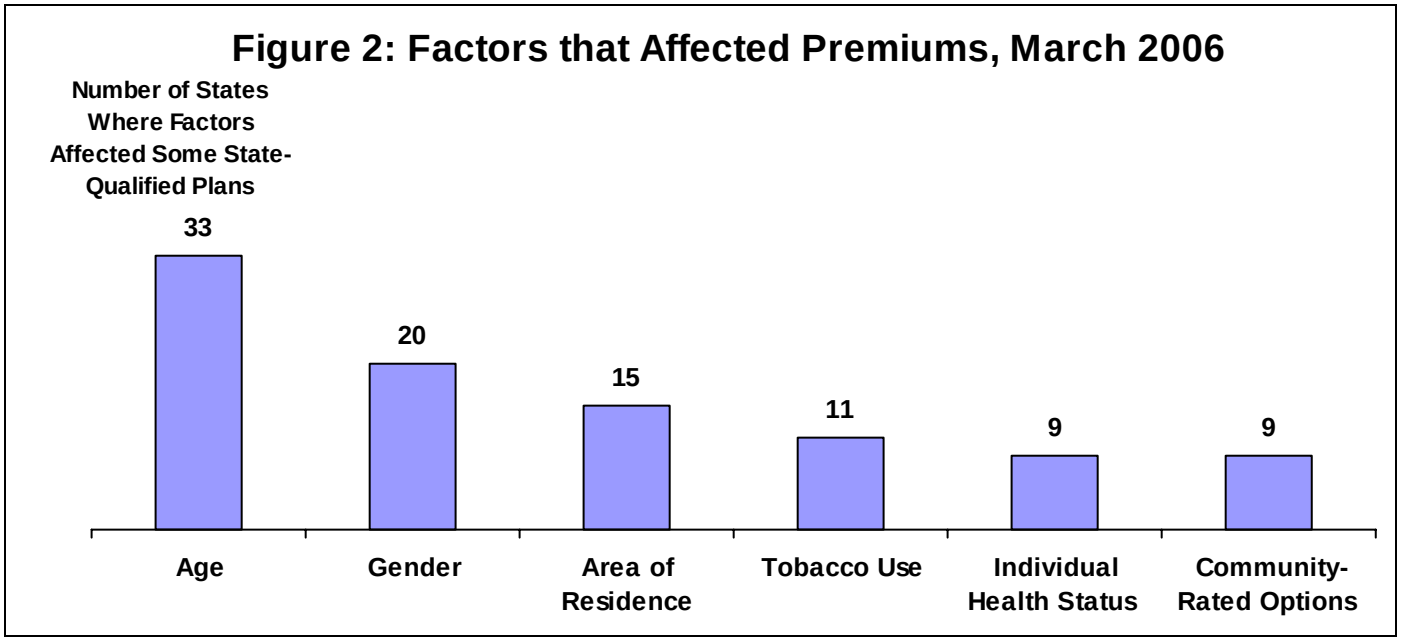
- high-risk pools;
- medically underwritten non-group plans, which varied premiums based on each enrollee's individual health status;
- plans with pure community rating, which charged the same premiums for all individuals; and
- plans with modified community rated plans, which did not conduct individual medical underwriting but varied premiums by factors such as age, gender, county of residence, and tobacco use.

High-risk pools comprised the largest number of state-qualified plans. Remaining plans were split evenly between other categories of coverage (Figure 1).



Source: ESRI survey of HCTC plans, August-September 2005, March 2006.
Notes: (1) Since several states had multiple insurance carriers and different types of state-qualified coverage, some states are counted in more than one category. (2) This chart is limited to state-qualified plans other than mini-COBRA. (3) The District of Columbia is counted as a state. (4) For a state-by-state listing of plans in each category, see Table 2. (5) In Washington State, the lowest-income enrollees have access to plans that use pure community rating. Other enrollees have access to plans with modified community rating only. Washington is thus counted in both categories.

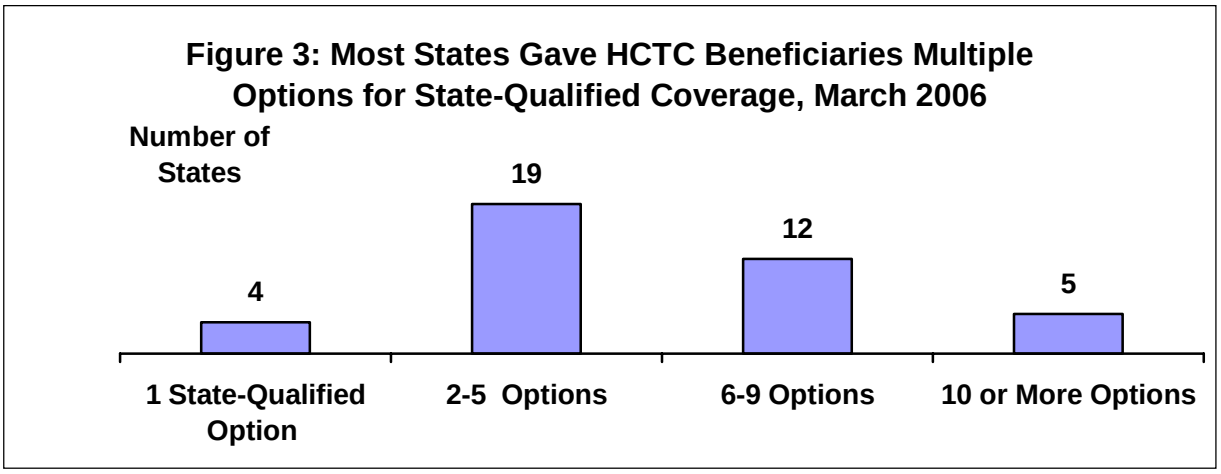
Accordingly, state-qualified plans used a variety of factors to determine premiums. While plans in most states used age to help determine premiums, half used gender, and nearly a fourth of the states included a plan that charged the same premiums for all enrollees (Figure 2, Table 3).



Source: ESRI survey of HCTC plans, August-September 2005, March 2006.
Notes: (1) Many states and carriers used multiple factors to set premiums. Accordingly, some states are included in more than one category of this chart. (2) For a state-by-state listing of rating factors, see table 3. (3) This chart counts the District of Columbia as a state. (4) Some of the 9 states with community-rated options also include state-qualified coverage with premiums that varied based on the other specified factors.

3. Most HCTC beneficiaries had multiple coverage options

Not only have different states made different choices in deploying coverage types across the country, they have also arranged different plans within states. Altogether, in the 40 states with state-qualified plans, 280 different health coverage options were available. Only 4 states limited HCTC beneficiaries to a single state-qualified option. The median state made 5 choices available (Figure 3, Table 4).



Source: ESRI survey of HCTC plans, August-September 2005, March 2006.
Notes: (1) For Louisiana and Idaho, ESRI researchers could not obtain information from the participating carriers about which of their health plans qualified for HCTC. In such cases, these plans were classified as offering the smallest possible number of options, consistent with the information available on the IRS website and from the insurers' websites and publicly available brochures. Accordingly, this analysis probably underestimates the number of choices offered to HCTC beneficiaries. (2) Mini-COBRA plans are not included in this chart. (3) This chart counts the District of Columbia as a state. (4) For state-by-state information, see Table 4.

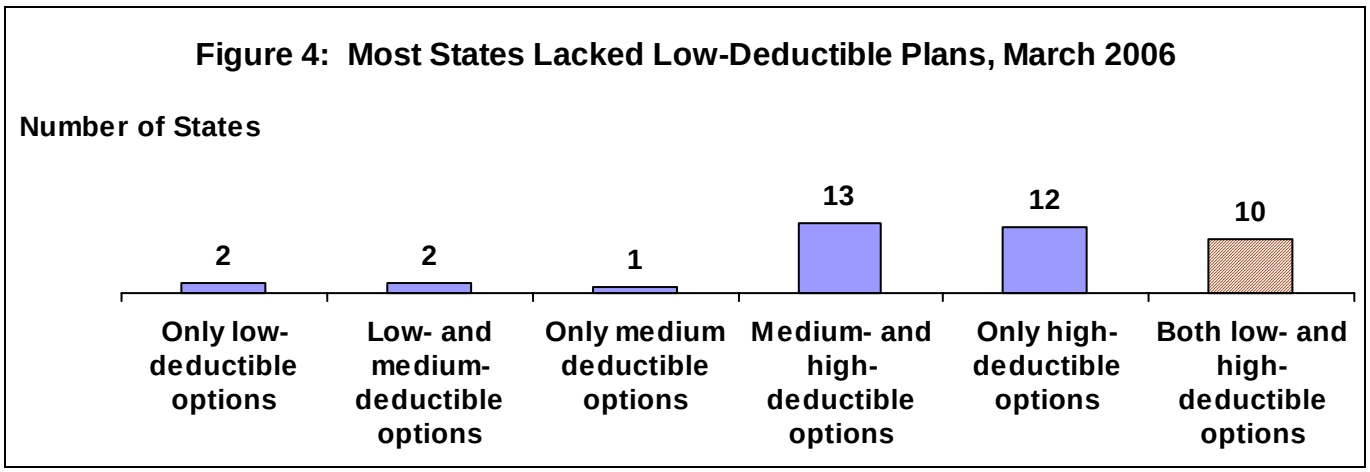
A variety of choices were offered to HCTC beneficiaries, including the following:

- 35 out of the 40 states offered a choice of deductibles;
- 23 states offered multiple benefit designs (such as PPOs vs. HMOs or different packages of covered benefits);
- Plans in 11 states offered particular services (most often maternity care) that could be added to specified benefits packages; and
- In 11 states, state-qualified coverage was offered by more than one carrier.

For more information about the choices offered in each state, see Table 4.

4. In most states, only medium- or high-deductible coverage was available

Only 10 of 40 states offered HCTC beneficiaries a choice between high-deductible plans (that is, those with individual deductibles of $1,000 or more) and low-deductible coverage (with individual deductibles under $500). The remainder provided more limited options. In 26 states (or 63 percent of the states with qualified plans), all available insurance had individual deductibles of $500 or more, including 12 states that offered only high-deductible choices (figure 4, table 5).



Source: ESRI survey of HCTC plans, August-September 2005, March 2006.
Notes: (1) This chart classifies state-qualified plans as follows: individual deductibles under $500 are termed low; deductibles between $500 and $999 are classified as medium; and individual deductibles of $1,000 or more are termed high. (2) The District of Columbia is included as a state. (3) For state-by-state information, see table 5.

Discussion

This analysis is pertinent to two distinct public policy debates. Throughout the past decade, health insurance tax credits to cover large numbers of uninsured Americans have been proposed by a broad range of national leaders, including both major party candidates for President in 2004. More narrowly, the Trade Act of 2002 (which enacted HCTC) is slated for reauthorization in 2007. Our findings have implications for both these policy contexts.

States, insurers, the IRS, and the Treasury Department have proven capable of surmounting multiple challenges to provide coverage options to tax credit beneficiaries. While few plans participated at first, a large number of insurance carriers now offer qualified HCTC plans, which are available in most states and accessible to the vast majority of potential enrollees.

As noted above, the consumer protection requirements of the HCTC statute differ from those that apply more generally to insurance markets. During program start-up, there was legitimate concern over whether these provisions would hurt the program's ability to attract insurers. At the onset of the program, this may have been a factor in low health plan participation and may continue to play a role in 11 states failing to offer qualified coverage.[12] Accordingly, the Bush Administration has proposed revising the HCTC statute's consumer protection requirements to make them more consistent with HIPAA.[13]

However, other factors may also play a role inhibiting the development of state-qualified options. The relatively small number of potential enrollees reduces the incentives for both health plans and state officials to invest time and effort in developing qualified options. Illustrating the possible importance of this factor, the states without qualified plans have particularly low numbers of potential enrollees. The median such state had 997 potentially eligible residents in December 2005, compared to 3,492 in states offering qualified coverage.[14]

In several of the former states, officials' interest in HCTC may have been further lowered by one additional consideration that reduced the incremental public benefit to be achieved by developing state-qualified plans. Before implementation of HCTC, 4 of these 11 states had unusually generous health subsidy programs that already covered many of those states' most vulnerable residents, including some early retirees and displaced workers.[15]

Finally, the HCTC statute denied state-qualified status to health plans participating in Medicaid or the State Children's Health Insurance Program (SCHIP). This eliminated one readily available option that, without this

restriction, some states officials may have used. In Washington State, for example, state-qualified coverage is comprised of private insurance plans participating in that state's Basic Health Plan (BHP). Like Medicaid BHP provides subsidized health coverage to low-income Washington residents, but because it is a state-funded program outside the HCTC statute's exclusion of Medicaid and SCHIP, that state was able to use it as state-qualified insurance.

Regardless of the reasons for the absence of state-qualified options in a minority of states, the HCTC statute's consumer protection requirements have proven to be consistent with widespread (if not universal) carrier participation. If future tax credits have many more beneficiaries than does the HCTC program, thereby offering insurers stronger incentives to participate, regulatory regimes equal to or stronger than HCTC's may be consistent with significant health plan participation, as has been the case in the past with Medicare, Medicaid, SCHIP, and similar state-funded programs.

Our research also shows that state facilitation of health plan offerings can be consistent with significant consumer choice. The HCTC program's range of consumer choice is far broader than that offered by traditional public programs like Medicaid, Medicare, and SCHIP but much narrower than the full spectrum of choices available in most states' individual insurance markets. This may prove an appealing combination to policymakers who desire the advantages of state-facilitated coverage (such as prevention of marketing fraud and a convenient framework for providing consumer assistance) but who also support significant consumer choice.

According to our research, states made significantly different choices in areas left to their discretion by the HCTC statute. While this may please those who advocate significant state flexibility, it may concern policymakers who are committed to certain types of health coverage. For example, fully community-rated options in some states and medically underwritten health plans in others may each trouble policymakers who prefer the other rating structure. Policymakers who strongly support high-deductible plans as promoting individual responsibility, lowering health care costs, fitting in with broader market trends, and meeting the needs of individuals (like many who qualify for HCTC) who have limited funds to spend on premiums may be unhappy that such options are unavailable in a number of states. On the other hand, the frequent limitation of state-qualified plans to high-deductible options will trouble other policymakers who believe that low cost-sharing is essential to providing satisfactory access to essential medical care. Similarly, policymakers who want consumers to have significant health plan choices may be unhappy that, in some states, few choices or no choices are offered. Overall, the HCTC experience suggests the unsurprising conclusion that, if national policymakers want future health insurance tax credits to provide a certain type of coverage, such preferences may need to be embodied in federal legislation.[16]

Conclusion

Despite challenges that include a small number of beneficiaries and consumer protections that differ from the rules that govern state health insurance markets, public- and private-sector leaders involved with the HCTC program have secured significant participation by private health insurance carriers. As a result, the vast majority of potential beneficiaries have access to state-qualified plans, which typically include multiple health insurance choices.

Those choices vary considerably from state to state, which may cause some disappointment for policymakers who are committed to any particular type of health coverage. Whether one prefers high-deductible or low-deductible coverage, community-rated or medically underwritten insurance, a number of states do not offer the preferred coverage as an option.

These findings yield several lessons for the design of future tax credits. First, particularly in future programs with much larger numbers of beneficiaries, consumer protection requirements comparable to or more

stringent than HCTC's may be consistent with sufficient health plan participation to provide enrollees with access to a range of coverage options. Second, policymakers who want tax credits to facilitate enrollment into a particular type of coverage may need to place incentives or requirements in federal law that encourage provision of the desired insurance. Third, and perhaps most fundamentally, the remarkable expansion in health insurance options – from one option just two months before the start of advance payment to more than a hundred health insurance choices at the time of our survey – illustrates the capacity and commitment of the state, federal, and private-sector leaders who have been involved in administering this tax credit program.

Table 2: Types of State-Qualified Plans Other than Mini-COBRA Coverage, by State, March 2006

	High Risk Pool	Medically Underwritten	Pure Comm. Rating	Modified Comm. Rating
AL			✓	
AK	✓			
AR	✓			
AZ				✓
CA				✓
CO	✓			
CT	✓			
DC				✓
FL				✓
ID		✓		
IL	✓			
IN	✓	✓		
IA	✓			
KS	✓			
KY		✓		
LA	✓			
ME				✓
MD	✓	✓		
MI			✓	
MN	✓			
MT	✓			
NE	✓			
NH	✓			
NJ			✓	
NY				✓
NC		✓		
ND	✓			
OH		✓		
OK	✓			
OR	✓			
PA			✓	
RI		✓		
SC	✓			
TN				✓
TX	✓	✓		
UT			✓	
VT			✓	
VA		✓	✓	✓
WA			✓	✓
WV	✓		✓	
Totals	**20**	**9**	**9**	**9**

Source: ESRI survey of HCTC plans, August-September 2005, March 2006.
Notes: (1) Medically underwritten plans vary premiums based on the individual enrollee's health history and conditions. Community rated plans charge the same premiums for all enrollees. Without assessing individual medical risk, plans with modified community rating vary premiums based on such factors as age and gender. (2) This table is limited to states with state-qualified plans other than or in addition to mini-COBRA coverage.

Table 3: State-Qualified Plans using Various Factors to Determine Premiums, March 2006

	Premium Variability Factors					
State and Plan	Age	Gender	Geography	Tobacco Use	Health Status	None (pure comm.)
AL						✓
AK	✓					
AR	✓	✓	✓	✓		
AZ	✓	✓	✓			
CA	✓		✓			
CO	✓		✓	✓		
CT	✓	✓				
DC	✓					
FL	✓	✓	✓			
ID-1	✓	✓		✓	✓	
ID-2	✓	✓	✓	✓	✓	
ID-3	✓	✓	✓		✓	
IL	✓	✓	✓			
IN-1	✓	✓	✓	✓	✓	
IN-2	✓	✓	✓			
IA	✓	✓		✓		
KS	✓					
KY	✓	✓	✓		✓	
LA	✓	✓	✓	✓		
ME	✓					
MD-1	✓				✓	
MD-2	✓					
MI						✓
MN	✓			✓		
MT	✓					
NE	✓	✓		✓		
NH	✓			✓		
NJ						✓
NY-1			✓			
NY-2			✓			
NY-3			✓			
NC	✓	✓	✓		✓	
ND	✓					
OH-1	✓	✓			✓	
OH-2	✓	✓			✓	
OK	✓	✓				
OR	✓					
PA-1						✓
PA-2						✓
PA-3						✓
PA-4						✓
PA-5						✓
RI	✓	✓			✓	
SC	✓	✓				
TN	✓	✓		✓		
TX-1	✓	✓	✓	✓		
TX-2	✓	✓	✓	✓	✓	

	Premium Variability Factors					
State and Plan	Age	Gender	Geography	Tobacco Use	Health Status	None (pure comm.)
UT						✓
VT-1						✓
VT-2						✓
VA-1	✓	✓	✓		✓	
VA-2	✓					
WA	✓		✓			✓
WV-1						✓
WV-2	✓	✓	✓			
Total	40	25	20	13	12	13

Source: ESRI survey of HCTC plans, August-September 2005, March 2006.

Notes: (1) States listed in multiple rows arranged state-qualified coverage from multiple carriers, each of which is listed in its own row and assigned a number. In several states where a uniform benefit package following uniform rating rules were offered by a number of carriers, that package is listed on a single row. (2) This table is limited to states with state-qualified plans other than or in addition to mini-COBRA coverage. (3) We were unable to identify premium factors for two carriers in Idaho, as well as one in Louisiana, so those carriers are excluded from this table. (4) In Washington State, coverage is purely community-rated for the lowest-priced plans in each county offered to the lowest-income enrollees. Other plans vary premiums by county; and for other than the lowest-income enrollees, premiums vary based on age as well. Accordingly, Washington is classified as varying premiums based on age and geography as well as varying premiums not at all.

Table 4: HCTC Plan Options Available, March 2006

	Number of carriers	Number of Benefit Designs	Number of deductible options	Optional riders	Total number of options
AL	1	1	1		1
AK	1	2	6		6
AR	1	1	3	M, P	12
AZ	1	3	9		9
CA	1	2	2		2
CO	1	2	7	Rx	8
CT	1	5	5		5
DC	1	1	1		1
FL	1	2	2		2
ID	5	7	10		10
IL	1	1	5		5
IN	2	2	5	M	9
IA	1	1	3	M	6
KS	1	6	6		6
KY	1	1	4	M	8
LA	2	2	5		5
ME	1	1	1		1
MD	2	5	5		5
MI	1	2	2		2
MN	1	1	5		5
MT	1	1	3		3
NE	1	1	8		8
NH	1	5	5	M	7
NJ	1	1	1		1
NY	22	4	3		13
NC	1	2	8		8
ND	1	1	2	C	4
OH	2	2	5		5
OK	1	2	6		12
OR	1	2	4		4
PA	5	1	2		2
RI	1	2	4	D	8
SC	1	1	2		2
TN	1	1	2	M	3
TX	2	2	9		9
UT	1	1	2	D	4
VT	2	2	5		5
VA	2	7	11	M, D, I/P	67
WA	4	1	1		2
WV	2	2	5		5
Total	**80**	**89**	**175**	**14**	**280**

Source: ESRI survey of HCTC plans, August-September 2005, March 2006.

Notes: (1) For optional riders, M = maternity coverage, P = pre-existing condition coverage, D = dental coverage, Rx = pharmaceutical coverage, I/P = immunization and preventive services coverage, and C = chiropractic services coverage. (2) This table is limited to states with state-qualified plans other than or in addition to mini-COBRA coverage. (3) Two factors create a difference in benefit design: first, a difference in (a) covered services or (b) out-of-pocket cost-sharing that does not track a change in deductibles; second, a different model of health insurance, such as HMOs, PPOs, indemnity plans, etc. (4) Following is a state-specific list of factors:

CO: The pharmaceutical coverage optional rider is only available for one deductible of one benefit design.
CT: 2 benefit designs each have 2 deductibles, but these deductibles are based on income, not choice; as such, both these benefit designs are assigned only one deductible and one overall plan option in the table as opposed to two.
ID: No HCTC plan information was determinable for four of the five carriers listed on the IRS website as providing a state-qualified plan in Idaho, so the table assumes each of these four carriers provides a plan with 1 benefit design and 1 total plan option.
IL: Two plans are offered by the carrier in Illinois, but they are based on qualification for the HCTC program. One plan is for HCTC recipients eligible due to the TAA, and the other is for those eligible due to the PBGC.
LA: No HCTC plan information was determinable for one of the two carriers listed on the IRS website as providing a state-qualified plan in Louisiana, so the table assumes the non-determinable carrier provided a plan with 1 benefit design and 1 total plan option.
NY: State-licensed HMOs must offer three plans, two of which are open to all HCTC beneficiaries and one of which is open to those who meet the eligibility requirements for the Healthy New York program. The median county has four such HMOs. In addition, all HCTC beneficiaries have access to HCTC Healthy New York, where at least one carrier operates in each county. Accordingly, this chart indicates that 13 options are available to HCTC beneficiaries in NY, which is the case in the median county.
OR: While three of the four plans offered by Oregon differ only based on deductibles, the fourth is classified as a separate benefit design because, unlike the other three, it has a $1,000 pharmaceutical deductible.
PA: While five carriers provided state-qualified HCTC plans in Pennsylvania, they covered geographically distinct areas, so recipients had access to only one carrier (except for an area near Harrisburg that intersected geographic zones and so was served by 2 state-qualified carriers). As such, in determining the total number of options available within the state, the table classifies PA as having had only one carrier available. Also, while one carrier had two benefit designs and two carriers had one deductible option, for purposes of this table, we list only one benefit design (four of the five carriers had only one), and two deductible options (three of the five carriers had two).
WA: While Washington provided four carriers, access to such plans depended on beneficiaries' county of residence. The plans all had the same benefit design, albeit with differing prescription drug formularies, provider networks, and (in some cases) premiums. The majority of counties had two available health plans. As a result, this table classifies two total options for the state.

Table 5: HCTC Plans' Deductible Options Available by State, March 2006

State	No Deductible	Low Individual Deductible ($0-499)	Medium Individual Deductible ($500)	High Individual Deductible ($1,000+)
AL				$1,000
AK				$1,000; $1,500; $2,500; $5,000; $10,000
AR				$1,000, $5,000, $10,000
AZ	Yes		$500	$1,000, $2,000
CA	Yes			
CO				$1,000, $2,000, $3,000, $5,000, $7,500, $10,000
CT	Yes	$200	$500	$1,500
DC			$750	
FL			$500	$1,500
ID				$1,000, $2,000, $3,000, $5,000, $5,500, $7,500
IL			$500	$1,000, $1,500, $2,500, $5000
IN			$500	$1,000, $1,500, $2,500, $5,000
IA				$1,000, $1,500, $2,500
KS			$500	$1,000, $1,500, $2,500, $5,000, $7,500
KY			$500	$1,000, $2,500, $4,000
LA				$1,000, $2,000, $3,500, $,5,000
ME				$1,000
MD	Yes		$500	$1,000, $1,200
MI	Yes	$250		
MN			$500	$1,000, $2,000, $5,000, $10,000
MT				$1,000, $2,500, $5,000
NE		$250	$500	$1,000, $1,500, $2,000, $3,000, $4,000, $5,000
NV				
NH				$1,000, $2,250, $2,500, $4,000, $5,000
NJ				$1,500
NY	Yes	$200 ($500 inpatient)		$1,000
NC		$250	$500	a$1,000, $2,500, $5,000
ND			$500	$1,000
OH	Yes		$500	$1,000, $2,500, $5,000
OK			$500	$1,000, $1,500, $2,000, $5,000, $7,500
OR			$500, $750	$1,000, $1,500,
PA			$500, $750	$1,000, $1,500
RI		$400		$2,000, $3,000, $5,000
SC			$500	$1,500
TN			$500	$1,000
TX			$500	$1,000, $1,500, $2,500, $5,000
UT		$250	$500	
VT				$1,000, $2,000, $3,500, $5,000, $7,500, $10,000
VA		$300	$500, $750	$1,200, $1,500, $2,250, $2,500, $3,000, $5,000
WA		$150		
WV		$400	$500, $800	$1,000, $2000

Source: ESRI survey of HCTC plans, August-September 2005, March 2006.

Notes: (1) This table is limited to states with state-qualified plans other than or in addition to mini-COBRA coverage. (2) Deductible options were unclear for four carriers in Idaho and one carrier in Louisiana, so these carriers have been excluded from the table; the states are still presented above as there were carriers in both that did have clear deductible options. (3) The plans with $0 deductibles have other cost-sharing and/or limited provider networks. (5) Other state-specific comments are as follows:

CT: There were two separate $200/$500 deductible plans offered by the carrier, and in both cases, low-income individuals were granted the $200 deductible while other individuals were offered the $500 deductible. This table lists both the $200 and the $500 deductibles for these two plans.
ID: For both the $1,000 and $5,000 deductible options, an additional, not-optional $5,000 maternity care deductible was also in place; the latter deductible is not shown in the table.
NY: The option classified here as $0 deductible had a $100 deductible for prescription drugs. The option classified as $200 ($500 inpatient) had $500 deductibles for inpatient care and a deductible for outpatient care of $200 (plus $75 for facility-based care) or 20 percent coinsurance, whichever was lower, as well as a $100 deductible for prescription drugs.
OR: For the $1,500 deductible option, an additional, not-optional $1,000 pharmaceutical deductible was also in place; the latter deductible is not shown in the table.
VT: One of the carriers in Vermont offered an HMO plan, with a $1,000 deductible for outpatient care and a $2,000 deductible for inpatient care, both of which are shown in the table.
WV: For the $400, $800, and $2,000 deductible options, additional, not-optional $200, $400, and $1,000 pharmaceutical deductibles were also in place, respectively; these additional deductibles are not shown in the table.

Appendix Table 1: HCTC State-Qualified Plans Summary Table: March 2006

State	Carrier	Plan Type	Premium Variability Factors	Plan Name	Deductibles or Copays	Optional Riders	Benefit Designs	Total Options
AL	BlueCross Blue Shield AL	Pure Community Rating		Special Open Enrollment	$1,000		1	1
AK	Alaska Comprehensive Health Insurance Association	High Risk Pool	Age	Traditional	$1,000		2	6
				PPO	$1,000; $1,500; $2,500; $5,000; $10,000			
AR	Arkansas Comprehensive Health Insurance Pool	High Risk Pool	Age, Gender, Tobacco use	CHIP	$1,000, $5,000, $10,000	M, P	1	12
AZ	HealthCareGroup of Arizona	Modified Community Rating	Age, Gender (if single), Geography	Classic Healthstyle HMO	$0, $500, $1,000, $2,000		3	9
				Secure Healthstyle HMO	$0, $500, $1,000			
				Active Healthstyle HMO	$0, $500			
CA	Kaiser Permanente	Modified Community Rating	Age, Geography	TAA/HCTC Plan	$25, $50 plans ($25/$50 for most office visits)		2	2
CO	CoverColorado	High Risk Pool	Age, Geography, Tobacco use	Cover Colorado PPO, HSA	$1,000, $2,000, $3,000, $5,000, $7,500, $10,000		2	8
				Cover Colorado HSA	$,2,000	Rx		
CO	Mini-COBRA							
CT	Health Reinsurance Association of CT	High Risk Pool	Age, Gender	TAA Individual PPO	$1,500		5	5
				TAA Individual SHCP	$200 low-income/$500 non low-income			
				TAA Portability HMO	Varying copays			
				TAA Portability PPO	$1,500			
				TAA Portability SHCP	$200 low-income/$500 non low-income			
CT	Mini-COBRA							
DE	NO PLAN							
DC	Carefirst BlueCross BlueShield	Modified Community Rating	Age	Blue Preferred PPO	Only eligible for $750		1	1
FL	Anthem Blue Cross Blue Shield	Modified Community Rating	Age, Gender, Geography	Blue Choice PPO Plan 3	$500		2	2
				Blue Choice PPO Plan 4	$1,500			
FL	Mini-COBRA							
GA	NO PLAN							
HA	NO PLAN							
ID	Blue Cross of Idaho	Medically Underwritten	Age, Gender, Tobacco use, Health Status	Unclear	At least 1		At least 1	At least 1

State	Carrier	Plan Type	Premium Variability Factors	Plan Name	Deductibles or Copays	Optional Riders	Benefit Designs	Total Options
ID	Regence BlueShield of Idaho	Medically Underwritten (go to state high risk pool if ineligible)	Age, Gender, Geography, Tobacco use, Health Status	Regence Essential	$5,500, $7,500		3	6
				Regence Preferred	$3,000, $5,000 (Also has an additional not-optional $5,000 deductibles for maternity)			
				Regence Classic	$1,000, $2,000 (Also has an additional not-optional $5,000 deductibles for maternity)			
ID	Assurant Health	Medically Underwritten	Age, Gender, Geography, Health Status	Unclear	At least 1		At least 1	At least 1
ID	The MEGA Life and Health Insurance Company	Unclear	Unclear	Unclear	At least 1		At least 1	At least 1
ID	Mid-West National Life Insurance Company of Tennessee	Unclear	Unclear	Unclear	At least 1		At least 1	At least 1
IL	Comprehensive Health Insurance Plan	High Risk Pool	Age, Gender, Geography	CHIP Plan P (PBGC)	$500, $1,000, $1,500, $2,500, $5000		1	5
				CHIP Plan T (TAA)	$500, $1,000, $1,500, $2,500, $5000			
IN	Anthem Blue Cross Blue Shield	Medically Underwritten	Age, Gender, Geography, Tobacco use, Health Status	Blue Access TAA	$500, $1,000, $2,500, $5,000	M	1	8
IN	Indiana Comprehensive Health Insurance Association	High Risk Pool	Age, Gender, Geography	ICHIA	Only Eligible for $1500		1	1
IA	Iowa Comprehensive Health Association	High Risk Pool	Age, Gender, Tobacco use	HIPIOWA Plan B	$1,000	M	1	6
				HIPIOWA Plan C	$1,500	M		
				HIPIOWA Plan D	$2,500	M		
KS	Kansas Health Insurance Association	High Risk Pool	Age	KHIA Plan A	$500		6	6
				KHIA Plan B	$1,000			
				KHIA Plan C	$1,500			
				KHIA Plan D	$2,500 (D - HSA)			
				KHIA Plan E	$5,000			
				KHIA Plan F	$7,500			
KY	Anthem Blue Cross Blue Shield	Medically Underwritten	Age, Gender, Geography, Health status	Blue Access TAA	$500, $1,000, $2,500, $4,000	M	1	8

State	Carrier	Plan Type	Premium Variability Factors	Plan Name	Deductibles or Copays	Optional Riders	Benefit Designs	Total Options
KY	Mini-COBRA							
LA	Louisiana Health Plan	High Risk Pool	Age, Gender, Geography, Tobacco use	Plan A	$1,000		1	4
				Plan B	$2,000			
				Plan C	$3,500			
				Plan D	$5,000			
LA	Blue Cross Blue Shield of Louisiana	Unclear	Unclear	Unclear	At least 1		At least 1	At least 1
ME	State of Maine Employee Health and Benefits Department	Modified Community Rating	Age	Blue Choice PPO	$1,000		1	1
MD	Maryland Health Insurance Plan	High Risk Pool	Age	EPO Network Plan	$0		4	4
				$500 PPO plan	$500			
				$1,000 PPO plan	$1,000			
				High Deductible Health Plan	$1,200			
MD	Carefirst BlueCross BlueShield	Medically Underwritten	Age, Health Status	Blue Preferred Qualified Tax	$800		1	1
MA	NO PLAN							
MI	Blue Cross Blue Shield of Michigan	Pure Community Rating		Community Blue PPO	$250		2	2
				Blue Value	Various copays (including 70% for general services)			
MN	Minnesota Comprehensive Health Association	High Risk Pool	Age, Tobacco use	$500 Deductible Plan	$500		1	5
				$1,000 Deductible Plan	$1,000			
				$2,000 Deductible Plan	$2,000			
				$5,000 Deductible Plan	$5,000			
				$10,000 Deductible Plan	$10,000			
MS	NO PLAN							
MO	Mini-COBRA							
MT	Montana Comprehensive Health Association	High Risk Pool	Age	Portability Plan Option I	$1,000		1	3
				Portability Plan Option II	$2,500			
				Portability Plan Option III	$5,000			
NE	Nebraska Comprehensive Health Insurance Pool	High Risk Pool	Age, Gender, Tobacco use	CHIP PPO	$250, $500, $1,000, $1,500, $2,000, $3,000, $4,000, $5,000		1	8
NE	Mini-COBRA							
NV	NO PLAN							
NH	New Hampshire	High Risk Pool	Age, Tobacco use	Indemnity Plan Option A	$2,250	M	5	7

State	Carrier	Plan Type	Premium Variability Factors	Plan Name	Deductibles or Copays	Optional Riders	Benefit Designs	Total Options
	Health Plan			Indemnity Plan Option B	$4,000			
				Managed Care Plan Option A	$1,000	M		
				Managed Care Plan Option B	$2,500			
				Managed Care Plan Option C	$5,000			
NH	Mini-COBRA							
NJ	Aetna New Jersey HCTC Discretionary Plan	Pure Community Rating		Aetna New Jersey HCTC Plan	$1,500		1	1
NJ	Mini-COBRA							
NM	NO PLAN							
NY	Aetna, AmeriChoice of NY, Atlantis Health Plan, CDPHP, CIGNA HealthCare of New York, ConnectiCare of NY, Empire HealthChoice, Excellus Health Plan, GHI EPO, GHI HMO, Health Net of New York, HealthNow, HIP Health Plans, Horizon HealthCare NY, Independent Health, Managed Health, MDNY HealthCare, MVP HealthCare, Oxford Health Plans, Preferred Care, United HealthCare of NY, Univera, Vytra Health Plans[a]	Modified Community Rating	Geography	Healthy NY (note: only available to HCTC beneficiaries meeting certain requirements)	$500 inpatient, $100 prescription drugs, $200 (or 20% coinsurance, whichever is cheaper) plus $75 facility for outpatient		1	Numerous – 4 in median county
NY	Statewide: Group Health Incorporated Central NY: Excellus Health Plan Western NY: Univera Health Plan	Modified Community Rating	Geography	HCTC Healthy NY	500 inpatient, $100 prescription drugs, $200 (or 20% coinsurance, whichever is cheaper) plus $75 facility for outpatient		1	At least 1
NY	See list for Healthy New York (two rows above this row)	Modified Community Rating	Geography	Direct pay HMO and POS options	$100 prescription drugs, $1,000 for POS		2	Numerous – 8 in median

State	Carrier	Plan Type	Premium Variability Factors	Plan Name	Deductibles or Copays	Optional Riders	Benefit Designs	Total Options
	above this row)							median county
NY	Mini-COBRA							
NC	Blue Cross Blue Shield of North Carolina	Medically Underwritten	Age, Gender, Geography, Health status	Blue AdvantAge Plan A	$250, $500, $1,000, $2,500		2	8
				Blue AdvantAge Plan B	$500, $1,000, $2,500, $5,000			
ND	Comprehensive Health Association of North Dakota	High Risk Pool	Age	Qualified Comprehensive Health Benefit Plan	$500, $1,000	C	1	4
OH	Anthem Blue Cross Blue Shield	Medically Underwritten	Age, Gender, Health status	Anthem Blue Access TAA	$500, $1,000, $2,500, $5,000		1	4
OH	Kaiser Permanente	Medically Underwritten	Age, Gender, Health status	State Qualified HCTC Plan	Various Copays		1	1
OH	Mini-COBRA							
OK	Oklahoma Health Insurance High Risk Pool	High Risk Pool	Age, Gender	Original High Risk Pool Policy	$500, $1,000, $1,500, $2,000, $5,000, $7,500		2	12
				Alternate High Risk Pool Policy	$500, $1,000, $1,500, $2,000, $5,000, $7,500			
OR	Oregon Medical Insurance Pool	High Risk Pool	Age	Medical Plan 500	$500		2	4
				Medical Plan 750	$750			
				Medical Plan 1000	$1,000			
				Medical Plan 1500	$1,500 (has an additional $1,000 pharmaceutical deductible)			
PA	Highmark Blue Cross Blue Shield	Pure Community Rating		Classic Blue Traditional Health Coverage Tax Credit	$500		1	1
PA	Highmark Blue Shield	Pure Community Rating		Classic Blue Comprehensive HCTC	$750, $1,500		1	2
PA	Independence Blue Cross	Pure Community Rating		Traditional Blue Cross Blue Shield HCTC Option 1	$500		2	2
				Traditional Blue Cross Blue Shield HCTC Option 2	$1,000			
PA	Blue Cross of Northeastern Pennsylvania	Pure Community Rating		Nongroup Cooperative/BS 100	$500 (for major medical, only)		1	1
PA	Capital Blue Cross	Pure Community Rating		HCTC Comprehensive	$750, $1,500		1	2

State	Carrier	Plan Type	Premium Variability Factors	Plan Name	Deductibles or Copays	Optional Riders	Benefit Designs	Total Options
RI	Blue Cross Blue Shield of Rhode Island	Medically Underwritten	Age, Gender, Health status	HealthMate Coast-to-Coast Direct Plan 400/800	$400	D	2	8
				HealthMate Coast-to-Coast Direct Plan 2000/4000	$2,000	D		
				HealthMate for HSA Direct Plan 3000/6000	$3,000	D		
				HealthMate for HSA Direct Plan 5000, 10000	$5,000	D		
RI	Mini-COBRA							
SC	South Carolina Health Insurance Pool	High Risk Pool	Age, Gender	South Carolina Health Insurance Pool	$500, $1,500		1	2
SD	NO PLAN							
TN	Blue Cross Blue Shield of Tennessee	Modified Community Rating	Age, Gender, Tobacco use	Personal Health coverage Guaranteed Issue H31	$500		1	3
				Personal Health coverage Guaranteed Issue H32/H32M	$1,000	M		
TX	Texas Health Insurance Risk Pool	High Risk Pool	Age, Gender, Geography, Tobacco use	Plan I	$500		1	4
				Plan II	$1,000			
				Plan III	$2,500			
				Plan IV	$5,000			
TX	Blue Cross Blue Shield of Texas	Medically Underwritten	Age, Gender, Geography, Health status, Tobacco use	Texas Blue Alliance	$500, $1,000, $1,500, $2,500, $5,000		1	5
UT	State of Utah Department of Workforce Services	Pure Community Rating		IHC Care	$250, $500	D	1	4
UT	Mini-COBRA							
VT	MVP Health Plan, Inc.	Pure Community Rating		MVP Comp Care	HMO (w/ various copays) and a $1,000 outpatient deductible and $2,000 inpatient deductible		1	1
VT	Blue Cross Blue Shield of Vermont	Pure Community Rating		Vermont Freedom Option A	$3,500		1	4
				Freedom Option B	$5,000			
				Freedom Option C	$7,500			
				Freedom Option D	$10,000			
VT	Mini-COBRA							
VA	Anthem BlueCross	Medically	Age, Gender, Geography,	Keycare Preferred	$300, $750, $1,500	D	6	66

State	Carrier	Plan Type	Premium Variability Factors	Plan Name	Deductibles or Copays	Optional Riders	Benefit Designs	Total Options
	BlueShield	Underwritten, Modified Community Rating (VA Standard)	Health status (VA Standard doesn't use health status)	Basic KeyCare	$300, $750, $1,500	M, D		
				Essential KeyCare	$500, $1,500, $2,500	D, I/P		
				KeyCare HSA	$1,200, $2,250, $3,000, $5,000	M, D		
				Basic BlueCare	$300, $750, $1,500	M, D		
				Virginia Standard	$750, $1,500	M, D		
VA	Carefirst BlueCross BlueShield	Modified Community Rating	Age	Blue Preferred Qualified Tax Credit Program	$750		1	1
WA	Columbia United Providers, Community Health Plan of WA, Group Health Cooperative, Kaiser Permanente, Molina (availability depends on county of residence)	Modified Community Rating	Age, Geography	Basic Health Plan	$150		1	23 counties have 2 carriers; 3 counties have 3 carriers; 15 counties have 1 carrier
WV	Mountain State Blue Cross and Blue Shield	Pure Community Rating		HCTC Plan	$500, $1,000		1	2
WV	Access WV	High Risk Pool	Age, Gender, Geography	Plan A	$400 (has an additional $200 pharmaceutical deductible)		1	3
				Plan B	$800 (has an additional $400 pharmaceutical deductible)			
				Plan C	$2,000 (has an additional $1,000 pharmaceutical deductible)			
WI	Mini-COBRA							
WY	NO PLAN							

Source: ESRI survey of HCTC plans, August-September 2005, March 2006.
Notes: (1) Optional riders are denoted above as follows: M = Maternity coverage, D = Dental coverage, C = Chiropractic services coverage, I/P = Immunization and Preventive services coverage, Rx = pharmaceutical coverage. (2) Shaded rows indicate either Mini-COBRA plans or states that offered no state-qualified coverage.
a. These listings and the corresponding analysis of the number of state options in New York are for 2005, taken from Podrazik M., Takach J., "Report on the Healthy NY Program 2005," EP&P Consulting, Inc., prepared for State of New York Insurance Department, December 31, 2005.

Notes

Most of the research for this report was completed when Mr. Pervez and Mr. Dorn worked at the Economic and Social Research Institute (ESRI). 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. Federal law (COBRA) requires large- and medium-size companies to offer insurance to certain former employees and dependents who pay the firms' full premium costs, plus a small administrative fee.
2. Some states extend COBRA's requirements to firms too small to be subject to COBRA. The term "mini-COBRA" refers to the insurance offered to former employees and dependents under these state laws.
3. At that time, so-called "Bentsen child health tax credits" were offered to subsidize children's health coverage. They were repealed after only one year, based on reports of widespread marketing fraud and low enrollment.
4. The Deficit Reduction Act of 2005 granted state Medicaid programs new flexibility to provide different benefits to different populations. For example, states can provider more limited benefits to parents with incomes above cash assistance eligibility levels in 1996 than to parents with incomes below such levels.
5. Dorn S, Kutyla T., "Health Coverage Tax Credits under the Trade Act of 2002," The Economic and Social Research Institute (ESRI), prepared for The Commonwealth Fund and The Nathan Cummings Foundation, April 2004; Dorn S., Alteras T., Meyer J.A., "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.
6. Such plans were listed at http://www.irs.gov/individuals/article/0,,id=110016,00.html.
7. As noted above, this report counts the District of Columbia as a state. It is one of the 40 states that offer state-qualified plans.
8. This estimate counts each carrier in each state separately. We did not attempt to reduce the number to account for plans in multiple states that may have common ownership and control.
9. Stephen Finan, U.S. Department of the Treasury, personal communication, June 29, 2006.
10. Dorn and Kutyla, 2004.
11. Once Massachusetts implements its above-described plan for state-qualified coverage, only 9 states will lack such insurance, and states with qualified plans other than mini-COBRA will include 94 percent of all potentially eligible households. Calculations by ESRI, July 2006, based on IRS data for December 2005.
12. These 11 states include 2 that offer only mini-COBRA plans as state-qualified coverage.
13. "Description of Revenue Provisions Contained in the President's Fiscal Year 2006 Budget Proposal." Joint Committee on Taxation Staff, March 2005.
14. When the varying size of each state's total population is taken into account, a similar disparity persists. Although the total numbers are quite small, workers potentially eligible for HCTC represent, on average, a 32 percent smaller share of the total population in the 11 states that do not offer state-qualified plans than in the 40 that do. IRS, "Health Coverage Tax Credit: Operations Summary for the Period Ending December 31, 2005," January 2006; U.S. Census Bureau, "Annual Population Estimates 2000 to 2005," December 31, 2005; Calculations by ESRI, June 2006.
15. These states were Delaware, Hawaii, Massachusetts, and Wisconsin.
16. For example, a proposed amendment to the HCTC statute in May 2004 would have required each state's qualified plans to include at least one option that was either a high-risk pool, state employee insurance, coverage that resembled plans serving state employees, or a group health plan. If a state did not provide such an option within two years, the U.S. Office of Personnel Management (which runs the Federal Employees Health Benefits Program) would have been authorized to establish such an option for state residents. The amendment received 54 votes on the Senate floor, but failed because 60 votes were required. Amendment 3109 to S. 1637, 108th Congress. For the original text of amendment, see Congressional Record, May 3, 2004, page S4771 (health coverage provisions begin at page S4774); for the final version of the amendment, see Congressional Record, May 4, 2004, page S4806 (health coverage provisions begin at page S4810). For the roll call vote, see Congressional Record, May 4, 2004, page S4820.