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Report to the Committee on Finance, U.S. Senate

September 2004

HEALTH COVERAGE TAX CREDIT

Simplified and More Timely Enrollment Process Could Increase Participation

GAO-04-1029

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Highlights

Highlights of GAO-04-1029, a report to the Committee on Finance, U.S. Senate

Why GAO Did This Study

Congress enacted the health coverage tax credit (HCTC) in 2002 for certain displaced workers receiving income support through the Trade Adjustment Assistance (TAA) program and for certain retirees receiving pensions from the Pension Benefit Guaranty Corporation (PBGC). The HCTC equals 65 percent of the cost of qualified health coverage, which individuals can receive in advance—the Internal Revenue Service (IRS) pays the credit to the qualifying health plan and the individual pays the remaining 35 percent—or by filing for the credit in their federal tax return. GAO was asked to review the implementation of the HCTC and examined, among other issues, how many individuals received it and factors influencing participation, and the type and cost of coverage they purchased. GAO obtained data from federal and state agencies and private health plans.

What GAO Recommends

GAO suggests that Congress consider amending certain statutory enrollment requirements to expedite individuals' receipt of the HCTC. GAO recommends that IRS, in coordination with other federal agencies, take steps to improve the quality and clarity of enrollment information and the timeliness of enrollment and payment processing. The agencies either agreed with GAO's recommendations or deferred to IRS.

www.gao.gov/cgi-bin/getrpt?GAO-04-1029.

To view the full product, including the scope and methodology, click on the link above. For more information, contact Kathryn G. Allen at (202) 512-7118.

What GAO Found

For 2003, 19,410 individuals received about $37 million in benefits from IRS for the HCTC for themselves and dependents, with 12,594 (65 percent) claiming the credit on their tax returns rather than receiving it in advance. As of July 2004, about 13,200 individuals were enrolled for the advance HCTC, the majority of whom were PBGC beneficiaries. The number receiving the HCTC remains a small portion of the workers and retirees initially identified as potentially eligible. For example, some potentially eligible individuals may have other health coverage that would disqualify them from receiving the HCTC. Several additional factors may have limited participation to date:

- The advance credit only became available beginning in August 2003.
- The enrollment process is fragmented and complex and requires individuals to meet tax, labor, and health coverage criteria before they can become eligible.
- Eligible individuals must pay the entire premium for about 3 to 6 months while completing eligibility and enrollment requirements and until IRS's first payment is made on behalf of these individuals.
- The health coverage may not be affordable both in terms of an individual's ability to pay the entire premium amount while waiting to receive the advance HCTC and the ability to pay the 35 percent share once payment starts.

Individuals can purchase one of several types of qualifying coverage for the HCTC: the coverage they had through their previous employer or insurance coverage options designated by states (primarily high-risk pools or arrangements with insurers). More than half of recipients chose coverage from their previous employer for the advance HCTC and another 40 percent of advance HCTC recipients enrolled in state-designated coverage options, which were available in 35 states and the District of Columbia as of July 2004. The average monthly premiums (representing both the individual and federal shares) for individuals receiving the advance HCTC were $480 for TAA recipients and $661 for PBGC beneficiaries as of April 2004. The tax credit resulted in an average monthly individual share of $168 for TAA recipients and $231 for PBGC beneficiaries. The premiums paid by advance credit recipients varied widely depending on the coverage purchased, including the type of health plan and the number of individuals covered. The cost of HCTC coverage also was affected by the premium-setting practices of qualified health plans.

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Abbreviations

ATAA	alternative trade adjustment assistance
CCR	Central Contractor Registration
CMS	Centers for Medicare & Medicaid Services
COBRA	Consolidated Omnibus Budget Reconciliation Act of 1985
EPO	exclusive provider organization
FFS	fee for service
HCTC	health coverage tax credit
HHS	Department of Health and Human Services
HIPAA	Health Insurance Portability and Accountability Act of 1996
HMO	health maintenance organization
IRS	Internal Revenue Service
PBGC	Pension Benefit Guaranty Corporation
POS	point of service
PPO	preferred provider organization
TAA	Trade Adjustment Assistance

GAO
Accountability * Integrity * Reliability

United States Government Accountability Office
Washington, DC 20548

September 30, 2004

The Honorable Charles E. Grassley
Chairman
The Honorable Max Baucus
Ranking Minority Member
Committee on Finance
United States Senate

The Trade Adjustment Assistance (TAA) Reform Act of 2002 created a health coverage tax credit (HCTC) for certain workers who are eligible to receive income support benefits under the TAA program because their jobs were lost due to foreign competition and for certain retirees whose pensions from a former employer were terminated and are now paid by the Pension Benefit Guaranty Corporation (PBGC).[1, 2] The HCTC equals 65 percent of the premium for qualified health coverage. Several types of qualified health coverage were specified in the TAA Reform Act, including federally guaranteed continuation of coverage from a former employer, known as COBRA continuation coverage,[3] and several state-designated options such as state-sponsored high-risk pools[4] and state arrangements with private insurers.

An important attribute of the HCTC is that it provides eligible individuals with a tax credit that they can receive in advance of filing their tax returns to help them reduce the cost of health coverage. That is, instead of paying for health coverage up front and having to wait until the end of the year to claim the credit on their income taxes, individuals can choose to receive

[1]Pub. L. No. 107-210, Division A, 116 Stat. 933, 935.

[2]For this report, we refer to individuals who qualify for the HCTC because they lost employment as a result of trade agreements as TAA recipients and those who qualify for HCTC because they receive payments from PBGC as PBGC beneficiaries. PBGC beneficiaries are individuals who receive payments from PBGC because their pension plan was terminated.

[3]The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) requires certain employers with 20 or more employees to offer continued coverage for individuals, with certain exceptions, who would have otherwise lost employer-sponsored health coverage. Pub. L. No. 99-272, Title X, 100 Stat. 82, 222 (1986).

[4]High-risk pools traditionally provide health coverage to individuals unable to otherwise obtain private health coverage because of existing health conditions.

the HCTC at the time their premium is due each month, thereby lowering the amount they have to pay out of pocket for health coverage. This advance HCTC option is intended to help make health coverage more affordable for eligible individuals, many of whom have recently lost their primary source of income and health coverage along with their jobs. Individuals also have the alternative of paying the entire premium to the qualifying health plan and claiming the credit when they file their income taxes for that year.[5] The end-of-year HCTC was first available to eligible individuals for December 2002, and the advance HCTC was first made available in August 2003.[6]

The combination of tax, labor, and health coverage requirements for the HCTC necessitates coordination among multiple federal agencies (including the Department of the Treasury, the Department of Labor, the Department of Health and Human Services (HHS), and PBGC); state agencies (including state workforce agencies, which are responsible for administering training and financial assistance benefits for trade-displaced workers, and state departments of insurance); and private health plans. At the federal level, an HCTC program office within the Treasury's Internal Revenue Service (IRS) administers the HCTC with assistance from private contractors. In addition, the TAA Reform Act allowed states to apply to Labor for national emergency grants to help implement the HCTC and created new grants from HHS for states to establish and operate state high-risk pools.

You asked us to examine the early implementation of the HCTC, particularly during the first year of the advance HCTC option. To do so, we answered the following questions.

1. Of those eligible to receive the HCTC, how many received it and what factors have influenced participation in the HCTC?

[5]For this report, we use the term HCTC to encompass both the end-of-year and advance payment options. When we explicitly refer to the end-of-year option, we use the term end-of-year HCTC and when we explicitly refer to the advance payment option, we use the term advance HCTC.

[6]For this report, we use the term HCTC recipient when we discuss information about individuals receiving the end-of-year HCTC or for information that applies to both the end-of-year and advance HCTC. We use the term HCTC enrollee when we discuss information applicable only to the advance HCTC option.

2. Which types of qualified coverage have HCTC recipients purchased, how did benefits differ among these types of coverage, and how much did this coverage cost?

3. What was IRS's experience in implementing the HCTC and how were program responsibilities shared between federal and private sector entities?

4. How many states received national emergency grants and high-risk pool grants and why did some not apply for funds?

To identify the number of people potentially eligible for and the number who received the HCTC, we obtained data from IRS's HCTC program office for both the advance and end-of-year HCTC recipients in calendar year 2003, the number of individuals receiving the end-of-year HCTC for December 2002, and the number of individuals enrolled for the advance HCTC monthly since August 2003.[7] We also obtained demographic data and information on why some potentially eligible individuals were not receiving the advance HCTC from two HCTC program office surveys, conducted in October 2003 and February 2004;[8] surveyed officials in each state workforce agency;[9, 10] and interviewed officials from state workforce agencies and qualified health plans in eight states. We selected California, Illinois, Maryland, New York, North Carolina, Ohio, Pennsylvania, and Texas because they had relatively large potentially eligible populations; had designated different types of state-qualified plans, such as high-risk pools or arrangements with private insurers; and were in different

[7]The number of individuals receiving and the number enrolled for the advance HCTC differ because some individuals had enrolled for the advance HCTC but had not yet had advance payments made to their health plans.

[8]The first survey included individuals who were enrolled for the advance HCTC and potentially eligible individuals who had not enrolled for the advance HCTC. The second survey included only potentially eligible individuals who were not enrolled for the advance HCTC. The overall response rates for the surveys were 59 percent and 61 percent, respectively.

[9]For this report, the District of Columbia is included in our discussion of states, unless otherwise noted.

[10]We conducted a Web-based survey of state workforce agencies in every state and Puerto Rico in 2004. The District of Columbia was not included in this survey. We received an overall response rate of 98 percent; however, the response rates for specific questions in the survey varied. Additional data from this survey are included in GAO, *Trade Adjustment Assistance: Reforms Have Accelerated Training Enrollment, but Implementation Challenges Remain*, GAO-04-1012 (Washington, D.C.: Sept. 22, 2004).

geographic regions of the country. From IRS, we obtained data on which types of plans states had designated as state-qualified coverage options, which types of coverage advance HCTC enrollees purchased, and the cost of coverage purchased by advance HCTC enrollees. IRS provided these data on a monthly basis from August 2003 through June 2004 and on a cumulative basis from August 2003 through April 2004.[11] We obtained information about the benefits available to HCTC recipients from officials at qualified health plans in the eight states we reviewed, COBRA administrators, and the Henry J. Kaiser Family Foundation and the Health Research and Educational Trust's national survey of employers' health benefits. Data on demographic characteristics, types of coverage purchased, premiums paid for coverage, and information on why some potentially eligible individuals did not claim the HCTC were not available for end-of-year HCTC recipients in 2002 or 2003. We obtained information about IRS's implementation of the HCTC from officials at IRS, Labor, HHS, and PBGC; a survey we conducted of officials in each state workforce agency; state workforce, department of insurance, and 10 health plan officials in the eight states we reviewed; and COBRA administrators, representatives from the Blue Cross and Blue Shield Association, and representatives from the United Steelworkers of America, which had members eligible to receive the HCTC. We also interviewed officials from Accenture, the primary contractor responsible for implementing the advance HCTC, and reviewed contract documents. Labor provided us with information on the national emergency grant awards, and HHS's Centers for Medicare & Medicaid Services (CMS) provided us with information on high-risk pool grant awards. We obtained additional information about these grants and why states did not apply for them from our survey of state workforce agencies, officials in the states we reviewed, and officials from the HCTC program office and CMS. We obtained information from IRS officials regarding the data checks and edits they perform on their data and any notable limitations, and determined that the data used in this report were sufficiently reliable for our purposes. We conducted our work from December 2003 through September 2004 in accordance with generally accepted government auditing standards.

[11]We report the most current data made available from IRS. In some instances, analyses of monthly premium data were available for the month of February, April, or May 2004.

Results in Brief

For 2003, 19,410 individuals received about $37 million in benefits for themselves and dependents for the advance and end-of-year HCTC. Specifically, 12,594 individuals received the end-of-year HCTC only, 3,120 individuals received the advance HCTC only, and 3,696 received both forms of the HCTC. As of July 31, 2004, about 13,200 individuals were enrolled for the advance HCTC, the majority of whom (60 percent) were PBGC beneficiaries. The number of individuals receiving the HCTC remains a small portion of those initially identified by states and PBGC as potentially eligible for the HCTC, many of whom may not ultimately meet all of the HCTC eligibility criteria. According to federal, state, health plan, and union officials we interviewed, participation to date in the advance and end-of year HCTC may be limited by several factors. These factors include the newness of the program; the fragmentation and complexity of the eligibility determination and enrollment process, which requires individuals to navigate steps that involve multiple federal and state agencies and to meet specific tax, labor, and health coverage requirements before becoming eligible for the HCTC; the gap of 3 to 6 months that it takes for eligibility determination, enrollment for the HCTC, and IRS's first payment on behalf of the eligible individual to be made, during which time the individual must pay the entire premium; and the ongoing cost to the individual of the 35 percent share of the premium once the advance HCTC payments have begun. For a single person, the ongoing cost for the 35 percent share of the premium represented about 13 percent, and for two people about 25 percent, of the average monthly income support benefits received by trade-displaced workers.

From the inception of the advance HCTC in August 2003 through April 2004, 56 percent of advance HCTC enrollees purchased COBRA coverage through their former employer, 40 percent purchased state-qualified coverage, and 4 percent continued to purchase the individual market coverage they were enrolled in 30 days prior to the separation from employment that resulted in their becoming eligible for TAA benefits or PBGC payments. Comparable data on the coverage purchased by end-of-year recipients were not available. As of July 2004, 36 states had made state-qualified coverage available to HCTC recipients, primarily through high-risk pools or arrangements with insurers. Although the benefits available to HCTC recipients varied by plan, employer-based COBRA plans generally had lower annual deductibles than state-sponsored high-risk pools and arrangements with insurers, and provided more comprehensive coverage for maternity care, mental health care, and prescription drugs than state-qualified coverage offered through arrangements with insurers in the 8 states we reviewed. The average monthly premiums (representing both the individual and federal shares) were $480 for TAA recipients and

$661 for PBGC beneficiaries receiving the advance HCTC; with the tax credit, the average share of the premium that advance HCTC enrollees paid was $168 for TAA recipients and $231 for PBGC beneficiaries. The amount that advance HCTC enrollees paid for coverage also varied depending on the number of people covered by the plan and the type of coverage purchased. In the 8 states we reviewed, the cost of HCTC coverage also was affected by the way in which qualified health plans set premiums. For example, among plans we reviewed, COBRA coverage charged group rates to HCTC recipients regardless of their health status; high-risk pools charged premiums for all HCTC recipients that were typically 150 or 200 percent of standard premium rates for healthy individuals; and arrangements with insurers charged premiums that varied on the basis of an individual's health and other factors, with some unhealthy, high-risk HCTC recipients paying 500 percent or more of the rates that healthy, low-risk individuals would pay. These premium-setting practices were similar to those used by health plans to determine premiums for non-HCTC enrollees.

IRS's HCTC program office implemented the HCTC within the time frames required by statute, enabling individuals to claim the end-of-year HCTC on their 2002 income tax returns and making the advance credit available on August 1, 2003. To do so, the HCTC program office coordinated closely with other federal agencies, state agencies, and private health plans and used private contractors extensively. These stakeholders generally reported that the collaborative effort to implement the HCTC went well and that the HCTC program office was generally responsive to implementation issues that arose. For example, after discovering that some ineligible individuals claimed and received the end-of-year HCTC in tax year 2002, IRS began recovering these funds and revised its forms and processes to reduce these problems for tax year 2003. The HCTC program office also adapted its processes to address implementation issues for the advance HCTC. For example, certain health plans were unwilling to accept advance credit payments because they did not want to receive electronic payments or because they found the health plan registration process burdensome. The HCTC program office responded by simplifying its registration process and agreed to issue paper checks to health plans that would not accept electronic payments. However, some implementation issues have not been resolved, such as incomplete information from states that the HCTC program office uses to verify the eligibility of advance HCTC enrollees, and delays in health plans' receiving complete payments when the plans' premiums changed during the year. The HCTC program office reported that start-up costs for design, development, and implementation of the HCTC were $69 million from the time work began

in February 2003 through April 2004. For the year starting July 2004, operating costs for the HCTC are expected to be about $40 million. These costs include anticipated costs for enhancements, such as updated software, and reflect a reduction in contractor staff, although contractors will continue to conduct the majority of the administrative and operating tasks.

Most states obtained national emergency grants from Labor, while fewer than half of the states received high-risk pool grants from CMS. As of August 2004, 45 states had received $45 million of the available $90 million in national emergency grants available for infrastructure grants (to help set up mechanisms for administering the HCTC) and for bridge grants (to pay a portion of the HCTC premiums). Specifically, 45 states received about $7 million in infrastructure grants to help establish mechanisms required for the HCTC, and 11 states also received about $38 million in bridge grants to help pay a portion of enrollees' premiums prior to availability of the advance HCTC. Most states that did not apply for bridge grants said they did not have systems in place to implement the grant. While bridge grants were originally used to help individuals with premiums before implementation of the advance HCTC, Labor has expanded the use of bridge grants to allow states to cover the 65 percent share of premiums during the typically 1- to 3-month gap between applicants' enrollment and IRS's payment of the first month's advance HCTC. Twenty-one states received high-risk pool grants from CMS as of August 2004. Specifically, as of August 2004, about $30 million of the $80 million available for operating grants (to offset financial losses from operating a high-risk pool) had been awarded to 16 states, and about $4 million of $20 million available for seed grants (to establish a new high-risk pool) had been awarded to 6 states. CMS officials reported that one reason seed grants were not sought more often is that states were reluctant to take on the continuing financial obligation of a high-risk pool.

We are suggesting that Congress consider amending certain statutory HCTC enrollment requirements and time frames in order to simplify and shorten the enrollment process for the advance HCTC. We are also suggesting that Congress consider providing for retroactive payment of the HCTC from the time that an individual is determined eligible until the first advance payment is received. In addition, we are recommending that the Secretary of Labor, Commissioner of Internal Revenue, Administrator of CMS, and Executive Director of PBGC take various steps to improve the quality and clarity of enrollment information and the timeliness of enrollment and payment processing. We provided a draft of this report to IRS, Labor, PBGC, CMS, and officials in the eight states we reviewed. The

federal agencies either concurred with our recommendations or deferred to IRS as the lead agency in implementing the recommendations. The state agencies that commented on our draft generally concurred with our findings.

Background

The TAA Reform Act established the HCTC to help certain individuals pay for health coverage by establishing a tax credit for 65 percent of the premium cost for qualified coverage. Individuals receive the HCTC in two ways—either in advance on a monthly basis or after the end of the year when they file their federal income taxes. Individuals are not required to itemize deductions or to owe federal income taxes in order to receive the HCTC. IRS provides the end-of-year HCTC to the individual, while tax credits claimed in advance are paid to the health plan in the form of a premium payment. For the advance credit, the HCTC program remits payments directly to the health plan; however, the individual must pay the full premium out of pocket until enrollment is complete. Individuals receiving the HCTC in advance may claim the credit at the end of the year for any months in which they were eligible for the HCTC but did not receive it in advance.

Eligibility for the HCTC

Three groups of individuals may be eligible to receive the HCTC for themselves and their qualified family members:[12]

1. **TAA recipients**. These are individuals who lost their jobs due to imports from or a shift in production to certain foreign countries. For workers to be eligible for TAA, Labor must certify petitions, filed by or on behalf of an employee group, indicating that the workers lost employment as a result of foreign competition.[13] Once Labor has certified the petition, state workforce agencies determine individual worker eligibility for TAA benefits. To be eligible for the HCTC, TAA-eligible workers must first be eligible for a trade readjustment allowance, which extends income support after unemployment

[12]Qualified family members include spouses and individuals who can be claimed as dependents on the eligible individual's federal tax return, provided they are enrolled in qualified health coverage.

[13]Petitions for certification under TAA may be filed by certain groups, such as a group of three or more workers, a labor union that represents the workers, officials from the affected company, or the state dislocated workers unit. Labor investigates and certifies the petition and notifies the petitioners and the state workforce agency.

insurance is exhausted, and as a condition of receiving this income support must enroll in training to develop job skills for reemployment, or must receive a waiver from training.[14] Because the trade readjustment allowance is not available to eligible workers until 60 or more days after the employee group files a petition to receive TAA certification from Labor, trade-affected workers cannot become eligible for the HCTC until this time.[15]

2. A**lternative trade adjustment assistance (ATAA) recipients**. Individuals who qualify for this assistance have lost their jobs as a result of trade-related layoffs and found new jobs within 26 weeks at lower pay and earn $50,000 or less in their new jobs. The ATAA program, initiated in August 2003, provides certain workers who are aged 50 and over and lacking transferable job skills with a wage subsidy to help offset this salary reduction. Labor must certify that an employee group lost employment as a result of foreign competition and that ATAA applicants are included in this group. State workforce agencies are responsible for determining an individual's eligibility for ATAA benefits.[16]

3. **PBGC beneficiaries**. These individuals receive payments from PBGC because their pension plan was terminated when their former employer went bankrupt or experienced other severe financial difficulties.[17] To be eligible for the HCTC, PBGC beneficiaries must be

[14]TAA-eligible workers who meet the qualifying conditions for trade readjustment allowances except for the condition that they have exhausted unemployment insurance benefits are also eligible to receive HCTC. The qualifying conditions include that the worker is enrolled in or has received a waiver from training.

[15]Section 231 of the Trade Act of 1974, as amended, states that a trade readjustment allowance is to be paid to an adversely affected worker, covered by a certification, who applies for the allowance for any week of unemployment that begins more than 60 days after the date on which the petition that resulted in the certification was filed. Pub. L. No. 93-618, §231, 88 Stat. 1978, 2020, as amended by Pub. L. No. 97-35, §2503, 95 Stat. 357, 881 (1981).

[16]Because of the newness of the ATAA program and the small number of individuals participating, we combine any available data on ATAA recipients along with TAA recipients for the remainder of this report and refer to these groups as TAA recipients, unless otherwise noted.

[17]PBGC was established by the Employee Retirement Income Security Act of 1974 to encourage the growth of pension plans, provide uninterrupted payment of pensions, and keep pension premiums to a minimum. PBGC collects premiums from employers that sponsor insured pension plans and can take over and assume payments for insured pension plans of employers that are in severe financial distress.

aged 55 or older and be either currently receiving benefits or have received a lump sum payment from PBGC after August 5, 2002.[18] Unlike TAA-eligible individuals, PBGC beneficiaries do not have to be associated with trade-affected industries in order to receive the HCTC.

In order to be eligible for the HCTC, individuals in these three groups must also be enrolled in qualified health coverage and meet certain other criteria. These criteria include that the individual cannot be eligible to be claimed as a dependent on someone else's tax return; cannot be imprisoned on the first day of the month he or she seeks to receive the HCTC; and cannot be enrolled in other, nonqualified health coverage, such as Medicare or health coverage through the Department of Defense health system.

HCTC Qualified Health Coverage

The TAA Reform Act specifies 10 types of qualifying coverage that are eligible for the HCTC, including 3 automatic options that do not require any action on the part of the states and 7 options that only meet the definition of qualified health plans if a state elects to make them available and ensures that they meet certain criteria.

Automatically Qualified Coverage Options

The TAA Reform Act designates the following three options that are automatically qualified as coverage eligible for the HCTC:

- **COBRA continuation plans**. An eligible individual may use the HCTC for COBRA coverage. Under COBRA, employers with 20 or more employees must offer 18 to 36 months of continued health coverage to former employees and their dependents who lose health coverage under certain circumstances, such as when an employee is terminated or retires.[19] Generally, health plans may charge individuals purchasing COBRA continuation coverage no more than 102 percent of the total premium.
- **Spousal coverage**. An eligible individual may claim the end-of-year HCTC for group market coverage obtained through a spouse's employer, provided the employer contributed less than 50 percent toward the cost of coverage. The advance HCTC cannot be used to purchase coverage through a spouse's employer.

[18]Other individuals aged 55 or older who may be eligible for the HCTC include spouses and former spouses receiving PBGC benefits as a survivor or beneficiary.

[19]See 29 U.S.C. §§1161-1168 (2000), 42 U.S.C. §§300bb-1 through 300bb-8 (2000); see also 26 U.S.C. §§4980B (2000).

- **Individual market plans**. An eligible individual may use the HCTC for individually purchased health coverage, provided that the coverage was purchased at least 30 days prior to the separation from employment that resulted in the individual becoming eligible to receive TAA benefits or PBGC pension payments.

State-Qualified Coverage Options

In addition to the three automatic options, the TAA Reform Act allows states to designate seven other coverage alternatives for HCTC recipients. Most states have chosen to designate one or more of the following three state-qualified options:

- **Arrangements with insurers or other plan administrators**. States may make arrangements with issuers of health insurance coverage (that is, health insurers), group health plans, employers, or other plan administrators to provide coverage eligible for the HCTC. States electing to provide state-qualified HCTC coverage through an arrangement with a health insurer may designate insurers offering either individual market or group health plans.[20]
- **State high-risk pools**. Some states have established high-risk pools to provide health coverage to individuals unable to purchase coverage elsewhere, typically because of a preexisting health condition. To qualify for the HCTC, high-risk pools must (1) cover, without preexisting condition limits, individuals leaving group coverage who are eligible for guaranteed coverage under the Health Insurance Portability and Accountability Act of 1996 (HIPAA); and (2) offer premium rates and covered benefits consistent with the National Association of Insurance Commissioners Model Health Plan for Uninsurable Individuals Act in effect as of August 21, 1996.
- **State-based continuation coverage, or mini-COBRA**. Because the COBRA provisions only apply to plans maintained by employers with 20 or more workers, some states have enacted so-called mini-COBRA laws requiring insurers providing coverage to plans maintained by employers with fewer than 20 workers to offer continuation coverage to such plans.

[20]State-qualified individual market coverage differs from the automatically qualified individual market coverage in that the latter is coverage purchased by an individual more than 30 days prior to the separation from employment that results in the individual's becoming eligible for TAA benefits or PBGC pension payments. In contrast to the state-qualified coverage, automatically qualified individual market coverage is not restricted to particular plans sold by insurers with which states have entered into an arrangement to provide HCTC coverage.

The other four types of coverage that states can designate as qualified plans are (1) a health coverage program for state employees, (2) a state-based health coverage program comparable to that offered for state employees, (3) an arrangement with a private-sector health care coverage purchasing pool (that is, a cooperative of employers or other groups or individuals that negotiate with one or more health plans), and (4) a state-operated health plan that does not receive any federal financial participation (thereby excluding Medicaid and the State Children's Health Insurance Program).

These seven state-qualified coverage options must provide qualified individuals—that is, individuals who have at least 3 months of prior creditable coverage at the time they seek to enroll in a state-qualified HCTC plan—four consumer protections.[21] These consumer protections are (1) guaranteed issue, whereby insurers must guarantee enrollment and must permit the individual to remain enrolled as long as he or she pays premiums;[22] (2) the prohibition of preexisting condition restrictions; (3) nondiscriminatory premiums, such that the premiums charged to HCTC enrollees may not be greater than the premiums for similar individuals not receiving the HCTC; and (4) benefits that are substantially the same as coverage provided to similar individuals who are not receiving the HCTC.[23] While the fourth consumer protection requires the benefits to be similar to coverage offered to non-HCTC individuals, it does not specify what benefits must be included.

[21]Creditable coverage includes most health coverage, including group coverage from an employer or other employee organization, individual health insurance, Medicaid, or Medicare. Creditable coverage excludes coverage that consists solely of excepted benefits such as dental or vision.

[22]These consumer protections may differ from existing federal health coverage or state health insurance law. For example, HIPAA-eligible individuals are also guaranteed the issuance of coverage if they have creditable prior coverage; however, to receive this protection under HIPAA the applicant must have had creditable coverage for 18 months, while HCTC-eligible individuals must only have had creditable coverage for 3 months.

[23]Generally, an HCTC recipient for whom there is a break in coverage of 63 days or more is not considered a qualified individual and therefore does not have to be provided these consumer protections by a state-qualified HCTC plan. Nonqualified individuals, however, may still use the HCTC to enroll in a state-qualified health plan without the consumer protections applying; alternatively, a state-qualified plan may choose to extend some or all of these consumer protections to all HCTC recipients.

State Grants

The TAA Reform Act authorized states to use national emergency grants to help with costs related to the implementation of the HCTC and established grants to promote high-risk pools.

- **National emergency grants**. To help with HCTC expenses, states can apply for two types of national emergency grants: bridge grants and infrastructure grants.[24] Bridge grants could be used to pay for up to 65 percent of the cost of health coverage for eligible individuals until the federal advance HCTC became available in August 2003. After August 2003, states were permitted to use remaining bridge grant funds to assist eligible individuals with paying their premiums during the HCTC enrollment process. Infrastructure grants were intended to assist states with start-up and administrative costs related to the HCTC.
- **High-risk pool grants**. To promote high-risk pools, states were offered new grants, called seed grants, to provide funds for the establishment of qualified high-risk pools, and operating grants, to reimburse states for up to 50 percent of losses incurred by high-risk pools meeting certain criteria.[25] Seed grants also can be used to convert an existing high-risk pool to a qualified high-risk pool—that is, one that meets the requirements contained in the Public Health Service Act for individuals eligible for protections under HIPAA.[26]

Federal, State, and Private Entity Roles in Implementing the HCTC

Although IRS is responsible for administering the HCTC program, three federal departments—Treasury, Labor, and HHS—share responsibility for implementing the HCTC and grants to states contained in the TAA Reform Act. (See table 1.) To implement and administer the HCTC, Congress appropriated to IRS $70 million for fiscal year 2003, to remain available through fiscal year 2004, and $35 million for fiscal year 2004, to remain

[24]National emergency grants are discretionary awards made by the Secretary of Labor. These grants are made in response to significant events leading to the dislocation of workers and creating a sudden need for assistance that cannot reasonably be expected to be accommodated within the ongoing operations of existing programs. National emergency grants are intended to temporarily expand service capacity for providing benefits to dislocated workers at the state and local levels by providing time-limited funding assistance.

[25]These criteria include (1) restricting premiums to no more than 150 percent of the standard risk rate (the premium charged a comparable individual in good health in the private market), (2) offering a choice of two or more coverage options, and (3) having a mechanism to continue to fund high-risk pool losses after the receipt of the grant.

[26]July 1, 1944, ch. 373, §2744, as added by Pub. L. No. 104-191, §111a, 110 Stat. 1986 (1996) (codified as amended at 42 U.S.C. §300gg-44).

available through fiscal year 2005.[27] Separate funding was provided for HCTC payments. In addition, PBGC—a federal corporation created by the Employee Retirement Income Security Act of 1974—is responsible for submitting, on a monthly basis, the names of PBGC beneficiaries potentially eligible for the HCTC to the HCTC program office. State responsibilities include identifying TAA individuals who are potentially eligible for the HCTC and, if the state so chooses, making state-qualified health coverage options available.

[27]IRS generally receives the majority of its funding through multiyear appropriations.

Table 1: Overview of Federal, State, and Private Entities' Involvement with the HCTC

Entity	Responsibility or action
Federal agencies	
Treasury	• Has primary responsibility for implementing the HCTC, with assistance from private contractors • Created HCTC program office within IRS to implement and administer the credit • Pays end-of-year HCTC to individuals and advance HCTC to health plans • Reviews states' selection of qualified health plans
Labor	• Certifies trade-affected groups as meeting TAA criteria • Administers national emergency grants
PBGC	• Mails information about HCTC to PBGC beneficiaries • Submits names of potentially eligible individuals to HCTC program monthly
HHS	• CMS administers the high-risk pool grants
State agencies	
State workforce agency	• Provides information about HCTC to trade-affected workers • Certifies workers for TAA benefits • Submits names of potentially eligible individuals to HCTC program daily
State department of insurance	• Certifies state-qualified plans, if state elects to make additional coverage options available • Submits list of state-qualified plans to HCTC program
Private entities	
Health plans, plan administrators	• Automatic options (COBRA, individual market coverage): accept advance HCTC payments from IRS if the plan elects to participate • State-qualified options: meet consumer protection requirements and accept advance HCTC payments from IRS

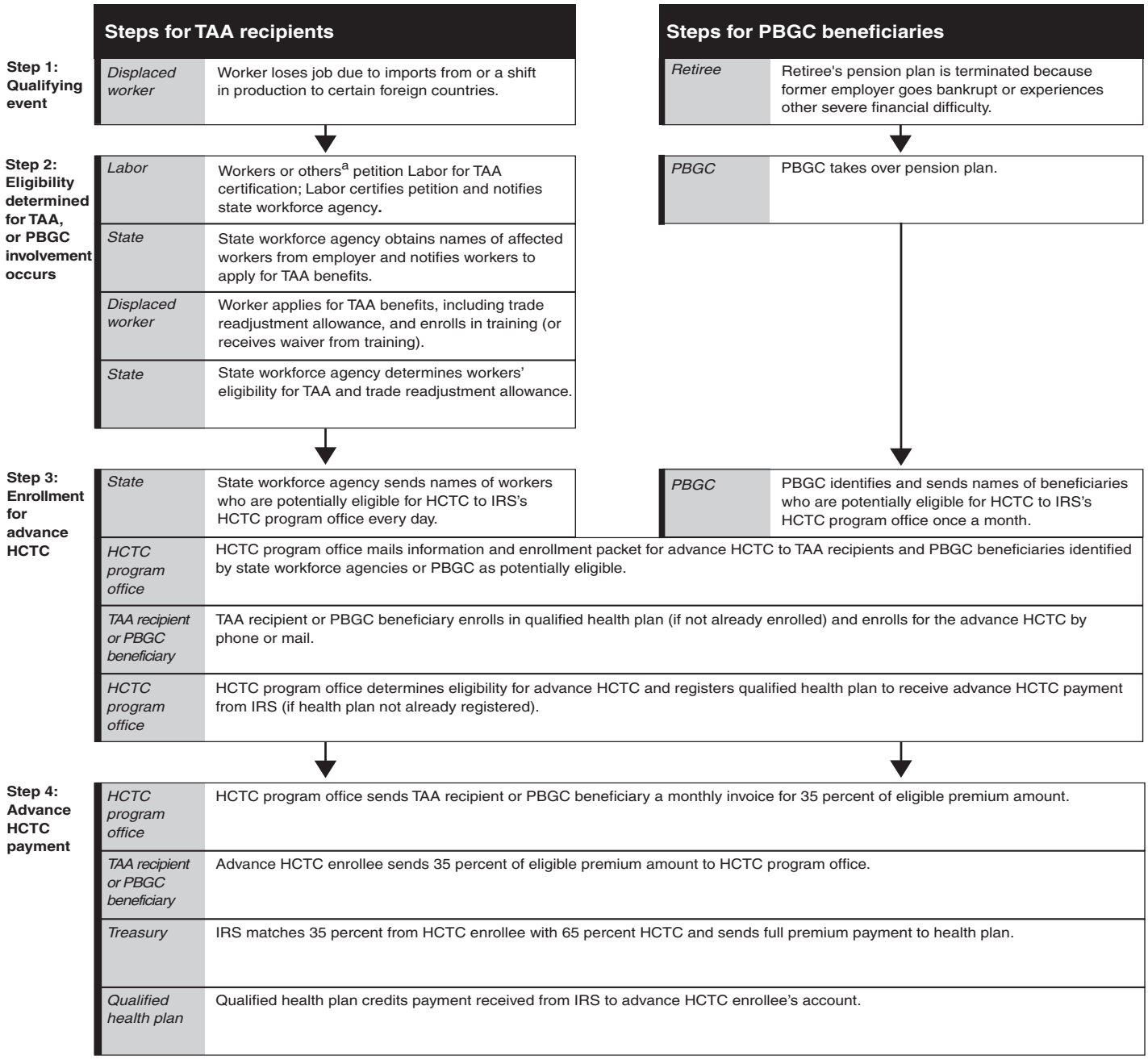
Sources: HCTC program office documents and interviews with officials from IRS's HCTC program office, Labor, PBGC, HHS, state agencies, and health plans.

Process for Enrolling for Advance HCTC and Claiming End-of-Year HCTC

Enrolling for the advance HCTC involves multiple entities, including federal agencies, a state workforce agency, and health plans. Potential eligibility begins with a qualifying event—either a worker loses employment as a result of foreign competition or a retiree's pension plan is terminated. These individuals must then undergo an eligibility determination process for TAA or have PBGC assume payment of their pension.

The enrollment process for HCTC can begin once a state sends to the HCTC program office the names of individuals receiving or eligible for income support through the trade readjustment allowance or PBGC sends a list of names of beneficiaries aged 55 or older. The HCTC program office mails an HCTC package to each of these individuals. Individuals may enroll for the advance HCTC if they meet the eligibility criteria, which include purchasing qualified health coverage. Once an individual successfully enrolls for the advance HCTC, the HCTC program office sends an invoice for the individual's 35 percent share of the premium, and, when this payment is received, the remaining 65 percent is added and the full premium amount is forwarded to the participating health plan. Figure 1 provides an overview of the steps required for TAA recipients and PBGC beneficiaries to enroll for the advance HCTC and to have payments made to the qualifying health plan in which they enroll.

Figure 1: Steps for TAA Recipients and PBGC Beneficiaries to Qualify for, Enroll in, and Receive the Advance HCTC



Sources: GAO analysis based on interviews with IRS, PBGC, Labor, and state workforce agency officials.

[a]Groups eligible to file a petition for TAA certification include three or more workers, a labor union that represents the workers, officials from the affected company, and the state dislocated workers unit.

End-of-year HCTC recipients must complete many, but not all, of the steps outlined above for advance HCTC enrollees. They must experience a qualifying event, be determined eligible for the trade readjustment allowance or PBGC payments, have their names sent to the HCTC program office by a state workforce agency or PBGC, and have qualified health coverage. Instead of enrolling with the HCTC program office, however, individuals claiming the end-of-year HCTC must submit required documents, which include proof of premium payment and a form designed for the HCTC, to the IRS along with their federal tax return. In addition, individuals who receive the advance HCTC may also claim the end-of-year HCTC for the months that they did not receive the advance HCTC, including months prior to August 2003, when the advance credit was first made available, and the months during the enrollment process before advance payments are made to their health plans.

More Than 19,000 Individuals Received HCTC for 2003, but Participation May Have Been Limited by Several Factors

For 2003, 19,410 individuals received about $37 million in payments for themselves and dependents for the advance and end-of-year HCTC, the majority by filing for the credit on their end-of-year tax return. For July 2004, enrollment for the advance HCTC was about 13,200, about 60 percent of whom were PBGC beneficiaries. An HCTC program office survey in October 2003 (early in the implementation of the advance HCTC) indicated that advance HCTC enrollees were, on average, older and had lower incomes and educational attainment than nonenrollees, but both groups reported similar health status. Comparable data for end-of-year HCTC recipients and nonrecipients were not available. According to officials from states, qualified health plans, and a union, several factors may have limited the participation in the advance and end-of-year HCTC to date. These factors include the newness of the program, the fragmentation and complexity of the TAA certification and HCTC eligibility determination and enrollment processes, the length of time—typically 3 to 6 months—that the individual must pay the full premium while establishing eligibility for and enrolling in the advance payment, and the ongoing cost of the individual's share of the premium once the advance HCTC payments have begun.

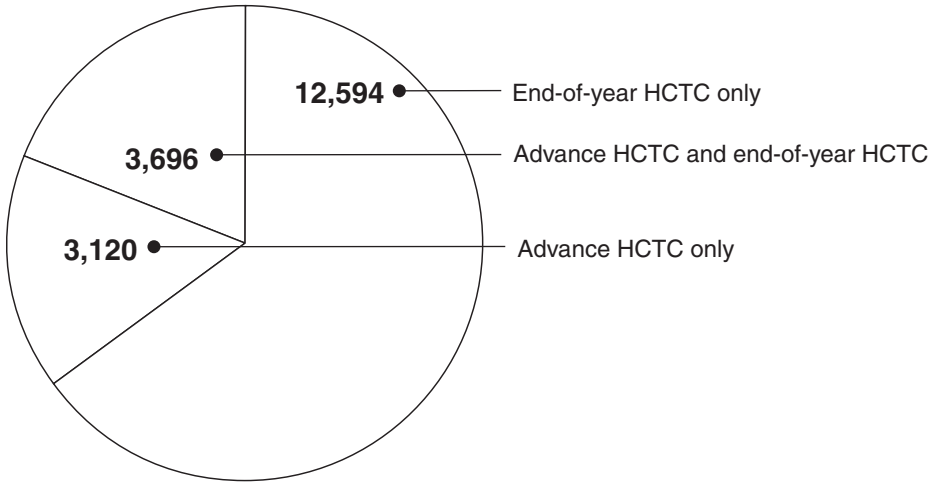
More Than 19,000 Individuals Received HCTC Benefits Totaling $37 Million in 2003

For 2003, about $37 million was paid on behalf of 19,410 HCTC recipients, most of whom (12,594 individuals) claimed the HCTC solely on their end-of-year tax return. Many of these individuals may have received the HCTC to pay for qualified health insurance covering dependents as well as themselves, but data were not available on the number of dependents covered by the end-of-year HCTC. The advance HCTC became available in

August 2003, and 3,696 individuals received both the advance HCTC—for the months beginning on or after August—and the end-of-year HCTC—for the months they paid 100 percent of their insurance premium. Another 3,120 individuals received the HCTC only in the form of an advance payment.[28] (See fig. 2.) Of the $37 million paid, about $23.8 million was paid on behalf of those who filed solely for the end-of-year HCTC, $2.8 million for those receiving the advance HCTC only, and $10.7 million for those who claimed both forms of the credit. According to the HCTC program office, for 2003, about 24,000 taxpayers filed claims for the end-of-year HCTC, and about 8,000 of these claims were denied. Some of the individuals whose claims for the end-of-year credit were denied were not on the list of potentially eligible individuals prepared by the state workforce agencies and PBGC. In addition, some of those denied were age 65 or older.

[28]The number of individuals reported to have received the HCTC in 2003 excludes those who enrolled in December 2003 but received the advance HCTC payment after December 11, 2003—these payments were considered credits for January 2004 premiums—and those whose tax returns were not processed by May 28, 2004, including those with tax filing extensions for the 2003 tax filing season.

Figure 2: Number of Individuals Receiving the End-of-Year HCTC, Advance HCTC, and Both Forms of the HCTC for Themselves and Dependents, 2003



Source: IRS's HCTC program office.

Note: Data for tax year 2003 were reported by IRS as of May 2004 and could change for later filers, amended returns, or further changes resulting from ongoing audits. In addition, some individuals were enrolled for advance payments and might have been sent an invoice for their 35 percent premium share, but the payments had not yet been made. Payments made after December 11, 2003 were considered to be credits for January 2004 premiums and not included in the totals received for 2003.

Enrollment for Advance HCTC Was 13,200 in the Month of July 2004

Enrollment for the advance HCTC increased from about 4,000 individuals at the start of the program to about 13,200 individuals in July 2004.[29] (See table 2.) In this month, roughly 40 percent of enrollees were TAA recipients, while the remaining 60 percent were PBGC beneficiaries. Individuals also used the advance HCTC to cover their qualified family members. In May 2004, approximately 12,900 individuals were enrolled to receive the advance HCTC for themselves and about 7,800 family members.

[29]Approximately 17,900 people had enrolled for the advance HCTC at some time from August 2003 through July 2004.

Table 2: Monthly HCTC Potentially Eligible Population and Enrollment for the Advance HCTC, September 2003 through July 2004

	Potentially eligible population[a]			
	TAA	PBGC	Total	Total enrollment[b]
September 2003[c]	85,908	113,666	199,574	4,008
October 2003	89,709	139,210	228,919	5,826
November 2003	90,111	142,057	232,168	7,131
December 2003	91,593	143,149	234,742	8,374
January 2004	94,936	154,399	249,335	9,318
February 2004	95,799	154,181	249,980	10,246
March 2004	89,628	158,662	248,290	11,344
April 2004	91,220	155,182	246,402	12,166
May 2004	89,491	146,443	235,934	12,896
June 2004	87,777	147,452	235,229	13,222
July 2004	81,362	147,682	229,044	13,194

Source: IRS's HCTC program office.

Note: Approximately 17,900 individuals had enrolled for the advance HCTC at some time from August 2003 through July 2004.

[a]Not all individuals initially identified as potentially eligible will meet all eligibility criteria for the HCTC.

[b]Includes individuals who have completed the advance HCTC enrollment process but for whom advance payments have not started.

[c]The number of potential eligibles for September includes partial data for the month of August—the first month the program was operational—thereby overstating the number of potentially eligible individuals in September by approximately 10 percent.

Nationwide, as of July 2004, Pennsylvania had the highest number of individuals enrolled for the advance HCTC (2,265), followed by North Carolina (1,636) and Ohio (1,090). Most individuals enrolled for the advance HCTC were clustered in nine states—Illinois, Indiana, Maryland, Michigan, North Carolina, Ohio, Pennsylvania, Virginia, and West Virginia. These nine states accounted for two-thirds of all individuals enrolled for the advance HCTC, although fewer than half of all potentially eligible individuals resided in these states. Several of these states recently experienced large trade-related layoffs at steel and textile companies. For example, Pillowtex, a household textile manufacturer headquartered in North Carolina, closed manufacturing and distribution facilities in North Carolina and Virginia and terminated more than 4,500 employees in July 2003. In April 2003, PBGC assumed pension plan payments for 95,000 workers and retirees from the Pennsylvania-headquartered Bethlehem

Steel Corporation. (See app. I for the number of individuals enrolled for the advance HCTC by state.)

Determining the actual rate of participation in the HCTC is difficult because reliable data on the total number of individuals actually eligible for the HCTC are not available. States and PBGC are responsible for identifying and reporting individuals who are eligible for TAA and PBGC benefits, while the responsibility for assessing the health coverage and tax eligibility HCTC criteria lies with the HCTC program office. Therefore, individuals identified by states and PBGC are considered only potentially eligible for the HCTC because IRS also needs to determine that they meet health coverage and tax criteria before receiving the HCTC. Some of the individuals identified by states and PBGC as potentially eligible may have other health coverage that would disqualify them from receiving the HCTC. For example, the October 2003 HCTC program office survey found that about half of those identified as TAA recipients or PBGC beneficiaries, but who were not enrolled for the advance HCTC, were in fact ineligible because they had other coverage, such as Medicare or through a spouse's employer. Similarly, in the HCTC program office's February 2004 survey, many respondents reported multiple reasons that made them ineligible for the HCTC, including being claimed as a dependent on someone else's tax return, not meeting the age eligibility criteria, or having other health coverage from sources such as the military or the Federal Employees Health Benefits Program.

Advance HCTC Enrollees Were Older and Had Lower Income Than Nonenrollees

Based on an HCTC program office survey of 1,200 respondents conducted in October 2003, advance HCTC enrollees were, on average, older, were less likely to have children, and had lower income than potentially eligible nonenrollees.[30] Both groups, however, reported similar health status. Specifically, advance HCTC enrollees were an average of 4 years older than nonenrollees, had 12 percent lower household pretax income, and lower educational attainment than nonenrollees. There was no statistically significant difference in self-reported health status between enrollees and nonenrollees in the advance HCTC program. Seventy-four percent or more of enrollees and nonenrollees reported being in good health, while 3 percent of enrollees and 6 percent of nonenrollees rated their health as poor. (See table 3.) Demographic data for those who received the end-of-year HCTC were not available at the time of our analysis.

[30]The survey was conducted with a statistically valid sample of HCTC-eligible individuals.

Table 3: Demographic Characteristics of the Advance HCTC Potentially Eligible Population, October 2003

Characteristic	Enrolled individuals	Nonenrolled individuals[a]
Average age	58	54
Average age for PBGC	60	59
Average age for TAA	51	47
Average household size	2	2.3
Percentage with children in their household	14	30
Pretax median household income	$30,000	$34,000
Percent with at least some college education	42	48
Percentage employed	17	37
Self-reported health status (percentage)		
Good	77	74
Fair	19	20
Poor	3	6

Source: IRS's HCTC program office survey.

Note: In October 2003, the HCTC program office surveyed 603 individuals enrolled for the advance HCTC and 604 individuals reported by the state workforce agencies and PBGC as potentially eligible but not enrolled for the advance HCTC. The survey response rate was 59 percent.

[a]In February 2004, the HCTC program office conducted a second survey of 600 individuals who were potentially eligible, but not enrolled, for the advance HCTC. Although the 2004 survey had a higher proportion of PBGC beneficiaries, the demographic characteristics of those not enrolled for the advance HCTC in 2003 and 2004 were similar in most respects.

Several Factors May Limit the Number of Individuals Who Receive the HCTC

According to officials we interviewed from states, participating qualified health plans, and a union representing affected workers, the number of individuals receiving the HCTC was lower than expected. We identified several factors that may help explain the limited number of individuals receiving the advance and end-of-year HCTC to date. In addition to the newness of the advance payment option, these factors included the fragmentation and complexity of the eligibility and enrollment process, the gap in time before the advance payments are available, and the affordability of the individual's share of the premiums.

State workforce agency and health plan officials reported that the process for trade-displaced workers to become eligible and enroll for the HCTC was fragmented and complex. Between the time workers lost employment and the time they enrolled for the advance HCTC, they interacted with two different federal agencies (Labor and IRS), their state's workforce agency,

and a health plan. Each entity performed a discrete part of the eligibility determination and enrollment process, without any single entity being responsible for overall coordination. In four of the eight states we reviewed, workforce officials reported that displaced workers seeking help with the advance HCTC often had to make multiple calls to different federal and state agencies. For example, a state workforce agency official reported that displaced workers who called the HCTC program office about the advance HCTC—prior to their name being sent from the state—were referred to Labor, which in turn referred them back to the state workforce agency.[31] An official from another state workforce agency reported that the state workforce agency does not deal with health coverage issues, so displaced workers who called with questions or difficulties about their health plan were referred to the HCTC program office or the health plan. State and union officials reported that this level of fragmentation could be difficult to navigate, especially for individuals with limited education or those who worked in large companies and were accustomed to centrally coordinated benefits administration.

Currently, individuals must navigate the eligibility and enrollment process largely on their own. State and health plan officials suggested developing a coordinated outreach strategy to help individuals who have difficulty with the advance HCTC enrollment process. For example, officials reported that HCTC information sessions attended by representatives from the PBGC, state workforce agencies, HCTC program, and qualified health plans were held in some states that had experienced large layoffs. According to officials, these information sessions helped bring all the key players together in one location and enabled individuals to walk from one station to the next and complete the enrollment process on the same day, if they chose to.

State officials reported that the requirement that individuals first qualify for the trade readjustment allowance—income support available under the TAA program after unemployment insurance is exhausted—added to the time and complexity of the advance HCTC eligibility and enrollment process and could limit participation. Individuals cannot qualify for the trade readjustment allowance until at least 60 days after the petition for TAA certification has been filed with Labor. In addition, in order to qualify

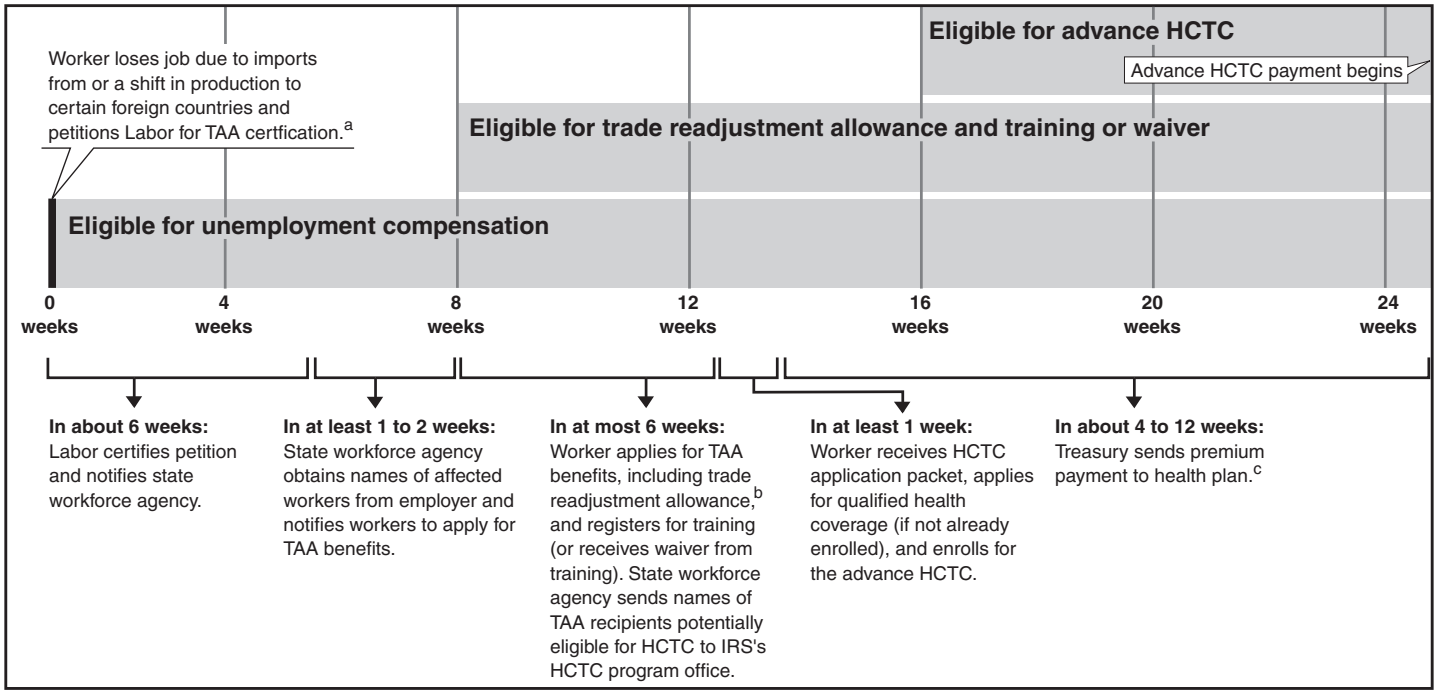
[31]The HCTC program office maintains a call center that is available to potentially eligible individuals once they have had their names forwarded from states or PBGC. The call center provides referrals to the Department of Labor's Help Line or state workforce agencies as appropriate.

for this benefit, individuals must be in training or have a waiver from training, which must be recertified monthly by the state workforce agency.[32] State officials said that removing the requirement to first qualify for the trade readjustment allowance would expedite the enrollment process and could enable additional dislocated workers to receive the advance HCTC.

Another factor that complicates and could limit participation in the advance HCTC is the time required to enroll for the advance HCTC. In our survey of state workforce agencies conducted in March 2004, 30 states responded that TAA recipients had difficulty receiving the HCTC, and 17 of these 30 states reported that it took too long for eligible individuals to receive the advance HCTC because of the way the enrollment process was structured. The multiagency, multistep process for eligibility determination and enrollment resulted in a significant gap between the time individuals lost employment or their retirement plan was terminated and the time they began receiving the advance HCTC. It typically took from 4 to 6 months for newly displaced trade-affected workers to become eligible for and receive the first advance payment. (See fig. 3.) For new PBGC beneficiaries, the time required to become eligible for and receive the first advance payment typically was 3 to 6 months.

[32]We found that the number of training waivers issued by the states increased from about 21,000 in fiscal year 2002 to more than 30,000 in fiscal year 2003 and that state officials reported that a major reason for the increase in training waivers was to facilitate enrollment in the HCTC. See GAO-04-1012.

Figure 3: Estimated Typical Timeline for Trade-Affected Workers to Receive Advance HCTC



Sources: GAO analysis based on interviews with Labor, IRS, and state workforce agency officials.

Note: The time frames for each step may vary beyond the estimates shown above.

[a]Groups eligible to file a petition for TAA certification include three or more workers, a labor union that represents the workers, officials from the affected company, and the state dislocated workers unit. Petitions for certification are not typically filed at the same time individuals lose their jobs. In some cases, workers may already be covered by a certification when they lose their jobs or the petition may be filed weeks or months after their employment ends.

[b]Individuals do not qualify for the trade readjustment allowance until at least 60 days after the petition for TAA certification has been filed with Labor.

[c]The number of weeks it takes to receive the advance payment depends in part on how quickly individuals provide the HCTC program office with all information needed to enroll for advance payment and whether the health plan is already registered to receive advance payments.

The elapsed time in becoming eligible and enrolling for the advance HCTC also meant that in some instances individuals potentially eligible for the HCTC were required to make certain decisions that would affect future health coverage for themselves or their spouse before they knew whether they would be eligible to receive the advance HCTC. For example, some displaced workers are offered the option of paying for COBRA coverage at the time of separation from their employers, and individuals who enroll in COBRA may use the advance HCTC to pay 65 percent of their COBRA

premiums once they have completed the advance HCTC enrollment process, which typically can take 3 to 6 months.[33] Eligible individuals who decline COBRA coverage—such as for affordability concerns—or do not have COBRA as an option and become uninsured for more than 63 days risk losing guaranteed access to state-qualified health coverage and other consumer protections.[34] Because it typically takes 3 to 6 months after losing employment before beginning to receive the advance HCTC, maintaining coverage for this 63-day period can be very expensive for displaced workers, and some may opt not to pay for this coverage in part because they have difficulty affording it. In our survey of state workforce agencies, 20 of the 30 states that said that TAA recipients had difficulty receiving the HCTC reported that breaks in coverage of 63 days or more are causing individuals to lose access to one or more consumer protections, such as guaranteed access to coverage or no preexisting condition exclusions. However, officials we interviewed from five state-qualified HCTC health plans reported that they have voluntarily extended one or more consumer protections to individuals with more than a 63-day break in coverage, for example offering all HCTC applicants guaranteed access to coverage and in some cases waiving preexisting condition exclusions for enrollees. Some of these health plan officials indicated that the decision to offer all HCTC applicants the same consumer protections was made for ease of administration, and this practice may be revoked in the future at the discretion of the plan.

State, health plan, and union officials also expressed concern about gaps in HCTC program eligibility rules that can affect the spouses and other dependents of PBGC beneficiaries who enroll in Medicare. Specifically, when a PBGC beneficiary enrolls in Medicare, the beneficiary loses eligibility for the HCTC. According to current eligibility rules, the spouses and other dependents of these individuals also lose eligibility for the HCTC even if they are not yet eligible for Medicare. A union official reported that

[33]Eligible individuals can also receive the HCTC at the end of the year to help offset 65 percent of the cost of their COBRA premiums, once they qualify for the HCTC.

[34]Whereas individuals losing coverage from an employer typically have one opportunity to elect COBRA continuation coverage at the time they lose their coverage, the TAA Reform Act provides TAA recipients with a second opportunity to purchase COBRA coverage. This second opportunity is a 60-day period that begins the first day of the month in which they become eligible to receive TAA benefits. To qualify for this second election period, no more than 6 months must have elapsed between the date individuals lost health coverage as the result of the trade-related layoff that made them eligible for TAA and the date they seek to purchase COBRA coverage. COBRA administrators reported that only a small percentage of HCTC recipients have used this second election period to purchase coverage.

when some PBGC beneficiaries attended an HCTC information session and became aware of this rule, they expressed reservations about enrolling in the HCTC, stating that they needed more time to think about whether to apply.

According to state workforce officials, health plan officials, and union representatives we contacted, the affordability of qualified HCTC coverage was another factor affecting participation rates. HCTC-eligible individuals have either lost employment, often involving a reduction in income, or retired and are receiving a fixed pension from PBGC. Research indicates that as premiums consume an increasing share of income, participation rates decline. For example, one study found that, among populations with incomes up to 300 percent of the federal poverty level,[35] more than half of the target population would participate when premiums represent 1 percent of income, but only one-sixth would participate when premiums represent 5 percent of income.[36]

The affordability of qualified health coverage options can be problematic even with the HCTC. During the 1- to 3-month period before the health plan receives the first premium payment from the HCTC program, HCTC enrollees are required to pay 100 percent of the premium out of pocket, which for a single person would represent 36 percent and for two persons would represent 72 percent of the average monthly unemployment insurance benefit of about $1,128.[37] The ongoing 35 percent share of the average HCTC premiums in mid-2004 for a health plan covering a single individual and a plan covering a single individual and one other family member would have required 13 percent and 25 percent, respectively, of the average monthly unemployment insurance benefit. In addition to these

[35]The average household income for HCTC nonenrollees surveyed in 2003 was $34,000 compared to $36,300 for a family of two at 300 percent of the federal poverty level in the same year.

[36]See Leighton Ku and Teresa A. Coughlin, *The Use of Sliding Scale Premiums in Subsidized Insurance Programs* (Washington, D.C.: The Urban Institute, Mar. 1, 1997).

[37]These percentages were even higher for PBGC beneficiaries. For example, the average two-person monthly HCTC premium was almost three times the median pension payment received by PBGC beneficiaries in 2003.

premium costs, HCTC enrollees must pay any deductibles, coinsurance, or copayments that are required by their health plan.[38]

In our survey of state workforce agencies, 24 of 30 states reporting that TAA recipients had difficulty receiving the HCTC said that the ability to pay premiums while waiting to receive the advance HCTC was a factor contributing to this difficulty. In addition, 22 of the 30 states indicated that the lack of affordable health coverage was a reason individuals may be having difficulty participating in HCTC. The state workforce, health plan, and union officials we interviewed reported that, even with a 65 percent subsidy, the remaining 35 percent share might cost too much to be affordable for many displaced workers and retirees.

Majority of Advance HCTC Enrollees Purchased COBRA; Benefits and Costs Varied with Type of Qualified Coverage

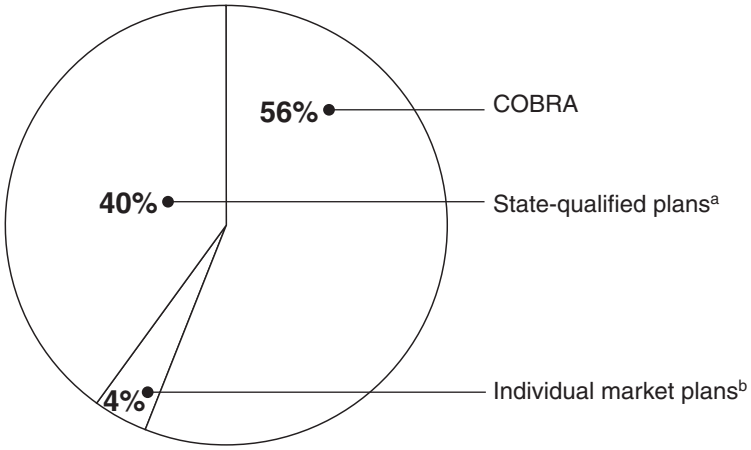
From August 2003 through April 2004, 60 percent of advance HCTC enrollees obtained coverage through automatically qualified health plans, primarily COBRA, and 40 percent of individuals receiving the advance HCTC purchased coverage through a state-qualified plan. Comparable data on the coverage purchased by end-of-year recipients were not available. More than two-thirds of the states designated state-qualified plans, with most states choosing to provide coverage through arrangements with insurers or high-risk pools. The types of benefits available for purchase with the HCTC varied both within and across the different automatic and state-qualified coverage options. For example, COBRA plans, which were a continuation of employer-sponsored group market coverage, tended to offer lower deductibles than state-qualified high-risk pools and more comprehensive benefits than the coverage provided through arrangements with insurers, most of which were individual market plans. The cost of HCTC coverage for advance credit enrollees varied widely depending on the number of people covered, the type of coverage purchased, and whether the HCTC enrollee was a TAA recipient or a PBGC beneficiary. The cost of HCTC coverage was also affected by the different ways in which premiums are set in the group and individual market.

[38]Health plans typically require enrollees to pay for a portion of the cost of their medical care. These cost-sharing arrangements include deductibles, which are fixed payments enrollees are required to make before coverage applies; copayments, which are the fixed payments that enrollees are required to make at the time benefits or services are received; and coinsurance, which is a percentage of the cost of benefits or services that the enrollee is responsible for paying directly to the provider.

Majority of Advance HCTC Enrollees Purchased Automatically Qualified Coverage, and 40 Percent Enrolled in State-Qualified Plans

Cumulatively, from the time the advance credit became available in August 2003 through April 2004, the majority (60 percent) of advance HCTC enrollees obtained coverage through one of the automatically qualified coverage options specified in the TAA Reform Act. Most HCTC enrollees (56 percent) used the advance HCTC to purchase COBRA coverage, while 4 percent remained enrolled in the individual market plans they held 30 days prior to the separation from employment that resulted in their becoming eligible for TAA benefits or PBGC payments (see fig. 4).

Figure 4: Percentage of Advance HCTC Enrollees with COBRA, Individual Market, and State-Qualified Plans, through April 2004



Source: IRS's HCTC program office.

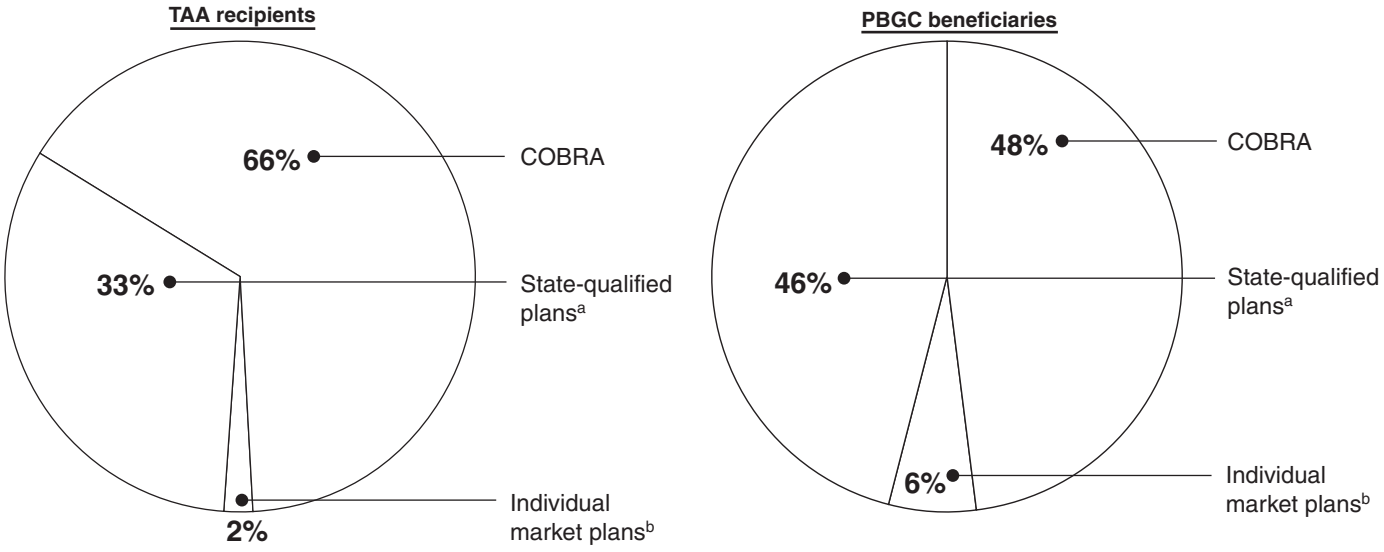
Note: Percentages represent the cumulative number of individuals enrolled for the advance HCTC from August 2003 through April 2004.

[a]IRS's HCTC program office could not provide data separately for state-qualified high-risk pools, arrangements with insurers, or mini-COBRA plans.

[b]Refers to automatically qualified individual market coverage.

Nationwide, about two-thirds of TAA recipients enrolled for the advance HCTC purchased COBRA coverage, whereas about one-half of PBGC beneficiaries enrolled for the advance HCTC selected COBRA plans and one-half selected state-qualified plans. Only a small percentage of advance HCTC enrollees of either type purchased automatically qualified individual market coverage. (See fig. 5.)

Figure 5: Percentage of Advance HCTC TAA Recipients and PBGC Beneficiaries with COBRA, Individual Market, and State-Qualified Plans, by Eligibility Type, through April 2004



Source: IRS's HCTC program office.

Notes: Totals may not add to 100 percent because of rounding. Percentages represent the cumulative number of individuals receiving advance HCTC from August 2003 through April 2004.

[a]IRS's HCTC program office could not provide data separately for state-qualified high-risk pools, arrangements with insurers, or mini-COBRA plans.

[b]Refers to automatically qualified individual market coverage.

More than Two-Thirds of States Designated State-Qualified HCTC Plans

As of July 2004, 36 states had designated state-qualified HCTC coverage options, and about 84 percent of all individuals identified as potentially eligible to receive the HCTC lived in these states. Most states providing state-qualified coverage did so through arrangements with one or more insurers (18 states) or high-risk pools (17 states). Three states (Indiana, Maryland, and Texas) designated both their high-risk pool and an arrangement with an insurer as state-qualified HCTC plans. Thirteen states designated mini-COBRA plans, and in 4 of these 13 states (Kentucky, Missouri, New Jersey, and Wisconsin) mini-COBRA plans were the only state-qualified coverage option available. Federal officials reported that few individuals eligible to receive the HCTC had access to mini-COBRA coverage because the number of TAA recipients and PBGC beneficiaries whose former employer had fewer than 20 employees—thereby making them eligible for mini-COBRA coverage—was estimated to be very small. (See app. II for a list of state-qualified HCTC coverage options by state.)

According to the HCTC program office, 15 states—whose combined population represented less than one-fifth of all individuals potentially eligible to receive the HCTC—had yet to make a state-qualified HCTC plan available as of July 2004. Three of these states—Arizona, Idaho, and Washington—have designated state-qualified plans, but these plans were not open to enrollment as of July 2004. Among states that have not designated a state-qualified plan, California had the largest number of potentially eligible individuals. State workforce and insurance department officials in California reported that because no health plans in the state had agreed to participate in the HCTC program, potentially eligible individuals without access to COBRA or another automatically qualified coverage option were unable to use the HCTC because they could not purchase qualified coverage.

In the 15 states that did not make a state-qualified HCTC plan available, some potentially eligible individuals may not have been able to use the HCTC to purchase automatically qualified coverage. Although the extent to which this has occurred is unknown, there are several reasons why potentially eligible individuals in these states may be unable to receive the HCTC. First, if a former employer discontinued its employee health coverage, individuals potentially eligible for the HCTC would not likely have access to a COBRA plan. According to a Commonwealth Fund study, federal officials estimate that between 40 percent and 60 percent of individuals eligible to receive the HCTC likely do not have access to COBRA coverage.[39] In addition, individuals who have COBRA coverage and are eligible to receive the HCTC for longer than the 18 to 36 months that COBRA is available will also need to enroll in another form of qualified coverage when their COBRA benefits expire in order to maintain the HCTC. Second, individuals with coverage through their spouses' employer may not qualify for the HCTC because many companies that offer health coverage contribute more than 50 percent toward the cost of their workers' health coverage premium—both for the cost of coverage for an individual worker and for the cost of family coverage. In 2003, for example, the average percentage of total premiums paid by employers for family coverage was 73 percent.[40] Third, HCTC program office officials

[39]See Stan Dorn and Todd Kutyla, *Health Coverage Tax Credits Under the Trade Act of 2002: A Preliminary Analysis of Program Operation* (New York, N.Y.: The Commonwealth Fund, April 2004).

[40]See Henry J. Kaiser Family Foundation and Health Research and Educational Trust, *Employer Health Benefits 2003 Annual Survey* (Menlo Park, Calif., and Chicago: 2003).

reported that only a small percentage of individuals were likely to have purchased coverage in the individual market at least 30 days prior to the separation from employment that resulted in their becoming eligible for TAA benefits or PBGC payments. While these officials could not provide a precise estimate, a national survey reported that fewer than 6 percent of all working Americans purchased individual market coverage in 2002.[41]

Benefits Varied Across and Within HCTC Coverage Options

The benefits offered to HCTC recipients varied across coverage types and from plan to plan. In the seven states we reviewed that designated state-qualified health plans, we found that COBRA coverage generally included lower deductibles than high-risk pools and offered more comprehensive benefits than arrangements with insurers. When health plans offered a choice among benefit packages or deductible amounts, HCTC recipients typically selected more comprehensive benefits and lower deductibles.

COBRA benefits are typically identical to the benefits provided to working individuals covered by an employer's group market health plan. The majority of health plans offered by employers in 2003 provided coverage for mental health services and prescription drugs, with preferred provider organization (PPO) health plans having an average annual deductible of $275.[42] (See table 4.) In addition, the Pregnancy Discrimination Act requires employers with 15 or more employees to cover expenses for maternity services on the same basis as coverage for other medical conditions.[43]

[41]See Paul Fronstin, *Sources of Health Insurance and Characteristics of the Uninsured: Analysis of the March 2003 Current Population Survey* (Washington, D.C.: Employee Benefit Research Institute, December 2003).

[42]We selected PPO plans as a point of comparison because the majority of state-qualified coverage options in the seven states we reviewed, including both high-risk pools and arrangements with insurers, were also PPO plans, although health maintenance organization (HMO), exclusive provider organization (EPO), unrestricted fee for service (FFS), and point of service (POS) plans were available in some states. A PPO is a type of managed care plan that offers a choice of health care providers but offers financial incentives to use preferred health care providers. HMOs and EPOs are types of managed care plans that typically provide coverage only for services through health care providers within the managed care plan's network. POS plans are similar to HMOs, but allow use of nonnetwork providers at a higher cost to participants. Unrestricted FFS plans do not differentiate coverage or cost-sharing requirements for preferred or nonpreferred health care providers.

[43]Pub. L. No. 95-555, 92 Stat. 2076 (1978).

Table 4: Benefits Most Commonly Included in Employer-Sponsored Group Market PPO Coverage, 2003

Benefit	Description
Annual deductible	$275 average annual deductible for in-network services.[a] • 79 percent had a deductible of $499 or less. • 93 percent had a deductible of $999 or less.
Mental health	99 percent provided coverage for both inpatient and outpatient mental health services. • 72 percent covered at least 21 days of inpatient care per year. • 65 percent covered at least 21 outpatient visits per year.
Prescription drugs	99 percent provided coverage for prescription drugs. • 92 percent did not require a separate deductible for prescription drugs.[b] • Average copayments for prescription drugs were $9 for generic products, $19 for preferred brand-name products, and $29 for nonpreferred brand-name products.[b]

Source: Henry J. Kaiser Family Foundation and Health Research and Educational Trust, *Employer Health Benefits 2003 Annual Survey* (Menlo Park, Calif., and Chicago: 2003).

[a]Average deductible for one-person coverage.

[b]Information applies to all employer-sponsored health plans and is not specific to PPO plans.

The majority of the 36 states that designated state-qualified health plans did so through arrangements with one or more insurers selling individual market coverage. Of the 7 states we reviewed with state-qualified health plans, 6 provided state-qualified HCTC coverage through an arrangement with one or more insurers, all of which sold coverage in the individual market (see table 5).[44]

[44]According to an official at the Ohio Department of Insurance, a large percentage of the individual health insurance coverage sold on the open market in Ohio is written as group coverage as a result of Ohio's health insurance laws. Health insurers in Ohio, including those offering state-qualified plans, create associations or trusts to sell individual health insurance coverage. This coverage is technically group coverage and is therefore subject to certain group health insurance laws, but is also regulated in part under Ohio's individual health insurance laws. The benefits and premium-setting practices resemble those typically observed in the individual, rather than group, coverage market.

Table 5: State-Qualified Coverage Types for HCTC Recipients in Seven States

State	High-risk pool	Arrangement with one or more insurers	Mini-COBRA[a]
Illinois	√		
Maryland	√	√	
New York		√	√
North Carolina		√	
Ohio		√	√
Pennsylvania		√	
Texas	√	√	

Source: IRS's HCTC program office.

Note: The eighth state we reviewed, California, did not designate any state-qualified coverage for HCTC recipients.

[a]According to federal officials, few individuals eligible to receive the HCTC likely had access to mini-COBRA coverage.

Health coverage purchased in the individual market typically includes more restrictions on covered benefits and higher deductibles than group market coverage offered through an employer.[45] In the six states we reviewed that designated arrangements with insurers as state-qualified plans, we typically found higher deductibles and one or more restrictive benefit limitations for maternity care, mental health coverage, and prescription drugs than would be typical for employer-sponsored group market coverage, including COBRA plans. Limitations on these benefits included lower maximums on annual or lifetime coverage, higher cost sharing, or, in some cases, no coverage at all. For example:

- One state-qualified HCTC health plan in Texas did not offer any coverage for maternity care except for treatment of pregnancy-related complications.
- One state-qualified HCTC plan in Ohio limited mental health coverage to 10 days of inpatient coverage and 10 outpatient visits per year.
- State-qualified health plans in Maryland, New York, and Pennsylvania required a separate deductible for prescription drug coverage, while one

[45]Whereas individual market coverage is regulated almost exclusively at the state level, employer-sponsored benefits are regulated by the federal government. For example, federal law includes certain minimum benefit requirements for employers that choose to offer mental health, mastectomy, and maternity benefits.

state-qualified health plan in Ohio did not provide coverage for brand name prescription drugs.

Appendix III provides more information on the variation in benefits across state-qualified HCTC plans in the seven states we reviewed that had state-qualified plans.

State-qualified HCTC plans provided through arrangements with insurers in four of these six states offered HCTC recipients a choice of deductibles—ranging from $250 to $5,000—while plans with no deductible were available in New York and some counties in Pennsylvania. When offered a choice among deductible amounts, the majority of HCTC recipients in these four states generally purchased coverage with the lowest deductibles available, typically $1,000 or less. (See table 6.)

Table 6: Deductible Amounts in Selected Plans in Six States with State-Qualified Arrangements with One or More Insurers

State[a]	Minimum deductible offered	Maximum deductible offered	Deductible most commonly selected by HCTC recipients
Maryland	$800	$800	[b]
New York	[c]	[c]	[c]
North Carolina[d]	250	2,500	$250
Ohio	500	5,000	500
Pennsylvania	750	1,500	750
Texas	500	5,000	1,000

Sources: Interviews with health plan officials and reviews of health plan Web sites, brochures, and benefit summaries.

Notes: Deductible options are for one-person coverage and apply to services received within the health plan's network, if applicable. Of the eight states we reviewed, California did not designate a state-qualified plan and Illinois did not designate an arrangement with an insurer as a state-qualified plan.

[a]Some states provided state-qualified HCTC coverage through arrangements with more than one insurer. In these instances, we selected the insurer with the highest HCTC enrollment, except in New York. In New York, HCTC enrollment data were not available for each insurer; we reviewed plans offered by an insurer that served areas in which companies had closed and HCTC-eligible individuals would likely have resided. The insurer with the largest HCTC enrollment in Pennsylvania sold coverage in both the central and western regions of the state. Only the coverage offered in the central region offered a choice of deductibles.

[b]The selected state-qualified plan in this state did not offer a choice in deductible amounts.

[c]None of the three state-qualified plans in New York that we reviewed had annual deductibles for services received within the plan's coverage network.

[d]North Carolina offered a choice between two different benefit packages, each with differing deductible options, sold by the same insurer. The data reported are for the benefit package most commonly purchased by HCTC recipients.

Three of the seven states we reviewed that had state-qualified health plans designated their high-risk pools as state-qualified plans. These state-qualified high-risk pools generally offered benefits similar to those offered in the employer-sponsored group market, but almost always required higher deductibles. Compared with the average $275 deductible for employer coverage in 2003, the high-risk pool deductibles available to HCTC recipients in the states we reviewed generally ranged from $500 to $5,000. All of the qualified high-risk pools in these states provided HCTC recipients with a choice of deductibles, with the majority of HCTC recipients selecting the lowest option available in two of the three states. (See table 7.)

Table 7: Deductible Amounts in Selected Plans in Three States with State-Qualified High-Risk Pools

State-qualified high-risk pool	Minimum deductible offered	Maximum deductible offered	Deductible most commonly selected by HCTC recipients
Maryland			
PPO option	$1,000	$1,000	[a]
EPO option[b]	[b]	[b]	[b]
Illinois	500	5,000	$500
Texas	500	5,000	2,500

Sources: GAO interviews with health plan officials and reviews of health plan Web sites and benefit summaries.

Note: Of the eight states we reviewed, California did not designate a state-qualified plan and New York, North Carolina, Ohio, and Pennsylvania designated an arrangement with one or more insurers rather than a high-risk pool as the state-qualified plan.

[a]This plan option did not offer a choice in deductible amounts.

[b]Exclusive provider organizations (EPO), like HMOs, often use a physician as a gate keeper and have a limited provider network. Members of an EPO must typically remain within this network to receive benefits. Maryland's EPO did not have a deductible.

In addition to a choice of deductibles, state-qualified HCTC plans in three states (Maryland, North Carolina, and Pennsylvania) offered enrollees a choice of benefit packages. HCTC recipients in these three states typically selected the option providing more generous coverage, as in the following examples:

- The Maryland high-risk pool offered two plan options—a PPO plan with a $1,000 deductible and 20 percent coinsurance for most services, and an exclusive provider organization (EPO) plan with no deductible and $20, $30, and $250 copayments for physician visits, specialist visits, and

hospital admissions, respectively. The majority of HCTC recipients (56 percent) selected the EPO plan.

- North Carolina provided state-qualified coverage through an arrangement with an insurer, which offered a choice between two benefit packages—one with more comprehensive coverage that included lower copayments for physician and hospital care and no separate deductible for prescription drugs, and a second option with higher copayments for physician and hospital care and a separate $200 prescription drug deductible. Most (80 percent) HCTC recipients selected the more comprehensive coverage.
- In western Pennsylvania, the state-qualified plan provided coverage for hospital and surgical expenses and certain preventive services with no deductible and no coinsurance.[46] HCTC recipients also had the option to purchase a separate plan that added coverage for prescription drugs and physician and specialist visits, with these benefits subject to a $750 deductible and 20 percent coinsurance. Almost 90 percent of HCTC recipients purchased the optional coverage.

Cost of HCTC Health Coverage Varied Depending on Coverage Purchased

The cost of qualified coverage for advance HCTC enrollees varied according to the number of individuals covered, whether the advance HCTC enrollee was a TAA recipient or a PBGC beneficiary, and the type of qualified coverage purchased. For example, in April 2004, the average total monthly premium for advance HCTC coverage—representing both the individual and federal share—was $404 for one person and $812 for two people. In the eight states that we reviewed, the cost of coverage for HCTC recipients was partly determined by the premium-setting practices of qualified health plans.

Cost of Advance HCTC Coverage Affected by Number of Individuals Covered, Type of Enrollee, and Type of Coverage

The amount paid for qualified coverage by advance HCTC enrollees nationwide varied according to the number of individuals covered as well as whether the enrollees were eligible for the HCTC because they received TAA benefits or because they received PBGC payments. For example, the national average total advance HCTC premium—representing both the enrollee's 35 percent share and the government's 65 percent contribution—for a qualified plan covering one individual in April 2004 was $404, versus $812 for a qualified plan that covered two individuals. PBGC beneficiaries, who were on average older than TAA recipients, typically paid more for advance HCTC coverage, both for COBRA as well as state-qualified plans. The average total premium for TAA recipients

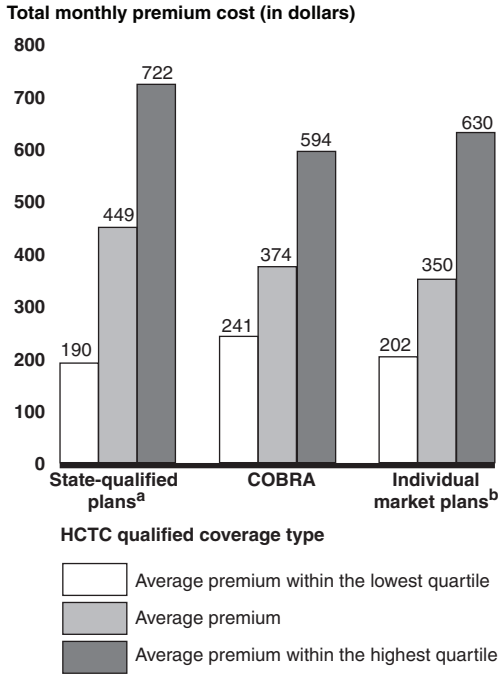
[46]The first 6 days of inpatient care received in a hospital were subject to a $100 per day copayment, with no cost sharing required thereafter.

receiving the advance HCTC in April 2004 was $480, compared to $661 for advance HCTC enrollees receiving PBGC pension payments. Receipt of the advance HCTC reduced the share of the premium paid by enrollees, on average, to $168 for TAA recipients and $231 for PBGC beneficiaries. (App. IV provides average total monthly premiums by state for TAA recipients and PBGC beneficiaries receiving the advance HCTC.)

Monthly advance HCTC premium costs ranged widely nationwide, depending on the type of qualified coverage purchased (see fig. 6). State-qualified HCTC coverage was, on average, more expensive than COBRA for plans that covered one individual or an individual and one other family member.[47] However, when more than three individuals were covered on a plan, COBRA coverage was more expensive, on average, than the state-qualified options. These premium comparisons do not reflect differences in benefits among the different types of coverage.

[47]According to the HCTC program office, most advance HCTC enrollees purchased coverage for one or two individuals.

Figure 6: National Range of Monthly Advance HCTC Premium Costs for One-Person Coverage, by Plan Type, May 2004



Source: IRS's HCTC program office.

Note: The most current data available from IRS on the range of monthly advance HCTC premium costs were from May 2004.

[a]IRS's HCTC program office could not provide premium data separately for state-qualified high-risk pools, arrangements with insurers, or mini-COBRA plans.

[b]Refers to automatically qualified individual market coverage.

Even with the tax credit, most advance HCTC enrollees paid more for their 35 percent share of qualified coverage than individuals purchasing health coverage through an employer. For instance, in July 2004, the average advance HCTC enrollee paid $137 for the 35 percent monthly share of COBRA coverage for one person or contributed $293 toward family coverage. In comparison, according to a 2003 national survey on employer benefits, the average employee paid $42 per month to purchase one-person coverage or $201 per month for family coverage purchased through their

employer.[48] However, without the 65 percent subsidy provided by the HCTC, the average advance HCTC enrollee continuing COBRA coverage would likely have had to pay the entire $390 per month for one-person coverage or $837 per month for family coverage.

Cost of State-Qualified HCTC Coverage Affected by Premium-Setting Practices

The cost of coverage for HCTC recipients within and across the eight states we reviewed was partly determined by health plans' premium-setting practices. As they do for non-HCTC applicants, state-qualified health plans in the majority of states we reviewed that had designated such plans adjusted premium rates to take into account enrollees' demographic characteristics, including their health status. Other premium-setting practices affecting the cost of state-qualified HCTC coverage included raising premiums to compensate for offering coverage on a guaranteed issue basis and, in some cases, automatically charging HCTC recipients higher premiums than what would typically be charged for healthy individuals for whom they are not required to offer coverage on a guaranteed issue basis. Although most state-qualified health plans had not analyzed the extent to which HCTC recipients utilize services, preliminary evidence suggested that insurers have not found the majority of these individuals to be in poor health.

Health plans' premium-setting practices depended on the type of state-qualified coverage offered. In four of the six states we reviewed where state-qualified HCTC coverage was provided through arrangements with insurers offering individual market plans (Maryland, North Carolina, Ohio, and Texas), insurers took each applicant's health status and medical history into account when determining premiums, a process known as medical underwriting.[49] The other two states (New York and Pennsylvania) charged the same rates for all enrollees. High-risk pools in the states we reviewed generally charged enrollees different rates based on their age

[48]These employee contributions represent the overall average contributions made by employees to purchase health coverage through an employer, regardless of the type of health plan. The average employee contributions for PPO coverage were similar to these overall averages, with employees contributing $44 toward the cost of one-person coverage and $210 toward the cost of family coverage purchased through an employer. See Kaiser Family Foundation, *Employer Health Benefits 2003 Annual Survey*.

[49]Although the TAA Reform Act specifically prohibited insurers from charging HCTC recipients higher premiums than those charged similarly situated non-HCTC-eligible persons, this provision has not prohibited the medical underwriting of HCTC applicants if the insurer uses the same premium-setting practices for all eligible persons who apply for the same coverage. One state department of insurance official raised a concern about the clarity of the current federal guidance regarding this provision.

(Illinois, Maryland, Texas), gender (Illinois, Texas), or county of residence (Illinois, Texas). One high-risk pool (Texas) also charged tobacco users higher premiums than nontobacco users.

Unlike COBRA or other group market coverage, where premiums are based on the history of medical costs and demographic characteristics associated with a group of individuals who are employees of a company or related companies, eligibility and premiums in the individual market in many states are based largely on each individual's health status and risk characteristics. Typically, the extent to which insurers selling coverage in the individual market can raise premiums for older individuals or those with existing health conditions is determined by each state.[50] While the premiums charged by insurers selling coverage in the individual market may vary substantially, the premiums charged by state high-risk pools are generally set between 125 percent and 200 percent of the standard premium that an individual in good health would typically pay for coverage in the individual market. Regardless of health status, HCTC recipients purchasing COBRA coverage would be charged the same rate as the rest of the employee group, while those purchasing coverage through a high-risk pool would pay from 125 percent to 200 percent of the standard premium charged to healthy individuals. HCTC recipients purchasing coverage through an arrangement with an insurer would likely be charged varying premiums based on their health status and other demographic characteristics, with some unhealthy, high-risk individuals paying more, and in some cases substantially more, than 200 percent of the rates charged to individuals in good health. For example, in one state we reviewed, the insurer offering qualifying coverage to HCTC recipients charged individuals rated in their poorest health category 580 percent of the premium charged to those rated in their healthiest category.

[50]The degree of premium regulation varies by state. Not all states limit the extent to which insurers may vary premiums based on factors such as age and health status. Among those that do, a few states such as New York, require insurers to charge the same premium to all enrollees, regardless of age, health status, or any other factor, a practice known as community rating. Other states require modified community rating, which permits insurers to adjust premiums based on demographic characteristics such as age and gender, but not health status. States may also impose rating bands, which limit the amount to which premiums can vary based on health status, age, and other factors. See, for example, GAO, *Private Health Insurance: Access to Individual Market Coverage May Be Restricted for Applicants with Mental Disorders*, GAO-02-339 (Washington, D.C.: Feb. 28, 2002) and Beth C. Fuchs, *Expanding the Individual Health Insurance Market: Lessons from the State Reforms of the 1990s* (Princeton, N.J.: Robert Wood Johnson Foundation, June 2004).

For state-qualified HCTC insurers, particularly those in the individual market, having to provide guaranteed issue coverage to certain HCTC recipients presents additional risk. For example, if an individual applicant with 3 months of prior creditable coverage has a costly chronic medical condition, such as juvenile-onset diabetes or heart disease, which would otherwise typically result in that applicant being denied coverage, the cost to the insurer may outweigh the premium paid, resulting in a loss to the insurer. To compensate for this additional risk posed by the guaranteed issue requirement, federal officials have granted permission for state-qualified HCTC health plans to charge higher premiums to individuals rated in the poorest health categories—individuals who would otherwise be turned down for coverage—as long as the additional premiums are actuarially justified and pass state insurance department review.

One insurer we interviewed that sold state-qualified coverage in multiple states, including one of the states we reviewed, used differing practices in setting premiums for HCTC recipients in these states. In the state we reviewed, this insurer reported that it had originally planned to offer coverage on a guaranteed issue basis to all HCTC enrollees, regardless of whether they had 3 months of prior creditable coverage, and to automatically charge them 200 percent of the standard premium that it would typically charge a healthy applicant.[51] After the state department of insurance rejected this premium-setting practice, the health plan set up a two-tier pricing system whereby healthier individuals who passed medical underwriting were charged the standard premium, while those who did not pass underwriting were charged 200 percent of this rate. Although this insurer modified its pricing method in the state we reviewed, the insurer said that it continued to automatically charge all HCTC recipients a higher-than-standard premium in two other states where it sold state-qualified coverage. Thus, although the guaranteed issue provision ensures that qualified individuals will have access to HCTC coverage, regardless of age or health status, it also means that the healthiest HCTC recipients may pay more for such coverage than they otherwise would in the individual market without guaranteed issue. Without this consumer protection, however, HCTC recipients with certain preexisting medical conditions

[51]The TAA Reform Act specifically prohibited insurers from charging HCTC recipients higher premiums than similarly situated non-HCTC-eligible individuals. This health plan regarded non-HCTC enrollees who were eligible for guaranteed coverage under HIPAA as the similarly situated population. The plan also charged people eligible for coverage under HIPAA up to 200 percent of the standard premium rate.

would likely be unable to purchase coverage from state-qualified health insurers selling individual market health plans.

Two states we reviewed (Maryland and Texas) offered state-qualified HCTC coverage through both the state high-risk pool and through an arrangement with an insurer. Because of the way health plans in these states set premiums, less healthy HCTC recipients were likely to find the high-risk pool coverage to be the less expensive of the two state-qualified options, while healthier HCTC recipients were generally able to purchase less expensive coverage through the arrangement with an insurer. For example:

- In Maryland, the health plan offered through an arrangement with an insurer charged less healthy HCTC recipients 200 percent of the standard premium typically charged an applicant in good health, whereas the state high-risk pool charged all applicants 150 percent of the standard rate.
- In Texas, high-risk pool rates were set at 200 percent of the standard premium, while the state-qualified HCTC plan offered through an arrangement with an insurer charged HCTC recipients rated in the poorest health category 4.7 times as much as those rated in the average health category and 5.8 times as much as those rated in the healthiest category.

Most of the state-qualified plans in the seven states we reviewed that had such plans reported that they have not analyzed the extent to which HCTC recipients utilize services, which would be one indicator of the health status of the population receiving the HCTC. Officials from some of these plans stated that they are collecting health service utilization data for individuals receiving the HCTC but that they will need at least a full year's worth of data before drawing any conclusion as to the overall health status of the TAA and PBGC populations. However, on the basis of preliminary medical underwriting data that were provided by HCTC state-qualified plans in two of the states we reviewed, more HCTC recipients have been placed into the healthy or standard risk categories than into the poorest health categories designated for this population. One health plan indicated that fewer than half of its enrollees receiving the HCTC were placed in below-average rating categories, while the other reported that one-fifth of its HCTC enrollees were categorized as worse-than-average risks.

IRS Implemented the HCTC on Time and Is Addressing Some Early Implementation Issues

IRS's HCTC program office met the statutory time frames for implementing the HCTC, enabling individuals to claim the end-of-year HCTC for December 2002 on their income taxes and making the advance HCTC available on August 1, 2003. To meet these time frames, the HCTC program office coordinated closely with other federal agencies, state agencies, and private health plans and used private contractors extensively. These stakeholders generally reported that the collaborative effort to implement the HCTC went well and that the HCTC program office was responsive to implementation issues that arose. For example, these implementation issues included instances where individuals who were not eligible for the credit claimed and received the end-of-year HCTC for 2002, while others who were eligible and claimed it did not receive the payment. IRS has been recovering payments made in error and revised its forms and processes to reduce these problems for the end-of-year HCTC for 2003. Implementation issues for the advance HCTC included the unwillingness of certain health plans to accept advance credit payments; delays in health plans' receiving correct payments when premiums changed; and inaccurate state eligibility lists that jeopardized individuals' receipt of the advance HCTC. The HCTC program office reported that, from February 2003, when work began to set up the advance HCTC, through April 2004, start-up costs for design, development, and implementation of the HCTC were about $69 million. After restructuring the HCTC program office to transition from implementation activities to operating activities, costs for the HCTC were expected to be about $40 million for the year starting July 1, 2004, and reflected a reduction in contractor staff, although contractors will continue to perform the majority of the administrative and operational work.

End-of-Year and Advance HCTC Available on Time

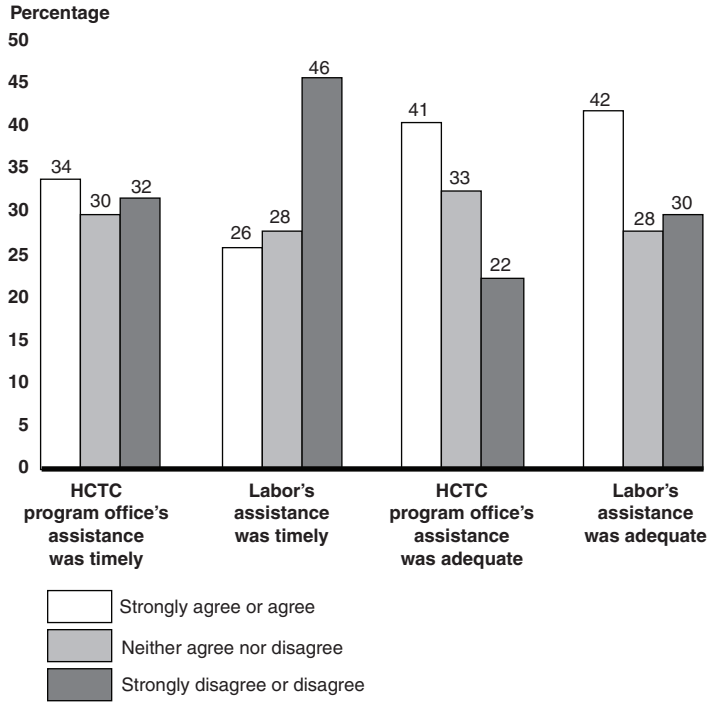
According to federal officials, in order to implement the HCTC on time, IRS's HCTC program office coordinated closely with federal agencies, state agencies, and health plans and received extensive support from private contractors. Implementation efforts for the end-of-year and advance HCTC met the statutory deadlines contained in the TAA Reform Act, making each form of the HCTC available for December 2002 and by August 2003, respectively.[52] While IRS's HCTC program office had primary responsibility for implementing the HCTC, officials from this and other

[52]HCTC program officials reported that some states were not ready to submit the names of potentially eligible individuals by August 1, 2003, but all states were able to transmit names of potentially eligible TAA recipients by the end of August 2003.

federal agencies involved in its implementation—HHS, Labor, and PBGC—reported that instituting the advance HCTC in particular was a cooperative effort that went well. Officials from workforce agencies and health plans in the states we reviewed largely concurred, stating that the HCTC program office was helpful in implementing the HCTC and addressing issues that have arisen. Meeting the 1-year implementation time frame for the advance HCTC was challenging for state workforce agencies, however. According to our survey of state workforce agencies conducted in March 2004, 71 percent reported that implementing the advance HCTC had been somewhat or very difficult.[53] For example, as figure 7 shows, state workforce agency officials were less satisfied with the timeliness of the information they received from the HCTC program and Labor to implement the advance HCTC than they were with the assistance itself.

[53]Puerto Rico's workforce agency was included in this survey; the District of Columbia's workforce agency was not included.

Figure 7: State Workforce Agencies' Perspectives on Timeliness and Adequacy of HCTC Program Office's and Labor's Assistance with Implementing the Advance HCTC, March 2004



Source: GAO survey of state workforce agencies.

Note: Puerto Rico's workforce agency was included in this survey; the District of Columbia's workforce agency was not included.

Ineligible Individuals Received End-of-Year HCTC for 2002, but New Procedures to Reduce Errors Were Instituted for 2003 Filing

HCTC program officials stated that, while individuals were able to claim the end-of-year HCTC for premiums paid in December 2002, IRS was unprepared to verify these claims and some credits were paid or denied in error—that is, some individuals received the HCTC who should not have and other individuals who were eligible for it did not. These errors were the result of mistakes individuals made on their tax returns—partly because of limited information in IRS's tax publications and communications for 2002 about how to claim the HCTC—and errors IRS staff made in processing each claim manually. Claims for the end-of-year HCTC in 2002 were still undergoing review as of June 2004, and the HCTC program reported that of the $2.9 million disbursed, about $465,000 had been improperly paid to ineligible individuals. More than half of this amount (about $243,000) had been recovered, and IRS continues to seek

recovery of the rest. HCTC program officials stated that for those who do not pay back the credit, future tax refunds would be offset by the outstanding amount. Additionally, IRS is in the process of auditing 577 claims (about 2 percent of the total) for 2002 that were for greater amounts than were expected. As of June 8, 2004, about half of the audits had been completed, and about 85 percent of the HCTC amounts claimed were disallowed.

To reduce the number of ineligible individuals receiving the end-of-year HCTC for 2003, HCTC program officials instituted new procedures and reporting requirements. For example, all tax records were prescreened against state workforce agency and PBGC eligibility lists to identify who was potentially eligible to receive the end-of-year HCTC. As of May 2004, HCTC program officials reported that this screening had prevented about 8,000 ineligible individuals from improperly claiming the end-of-year HCTC on their 2003 tax returns. However, this prescreening only identified whether an individual was potentially eligible for the HCTC at any time during the year, not the specific month or months in which he or she might have been eligible. IRS provided tax professionals with information about the HCTC and mailed each individual who was identified as potentially eligible for the credit in 2003 information about how to claim the end-of-year HCTC. Additionally, the IRS tax form used to claim the end-of-year HCTC was revised to include clearer instructions to help filers determine whether they were eligible for the credit, and individuals were required to attach copies of invoices and payments for each month in 2003 for which they claimed the end-of-year HCTC. This procedure does not, however, ensure that the individual purchased qualified health coverage. Therefore, potentially eligible individuals could have claimed the end-of-year HCTC in 2003 for more months than they should have or for coverage that did not qualify for the credit.

HCTC Program Office Adapted Policies and Procedures to Resolve Some but Not All Advance HCTC Implementation Issues

Advance HCTC payment and implementation issues prompted the HCTC program to change some of its procedures, but not all issues have been resolved. One such payment issue for which the HCTC program adapted its procedures was the refusal of some automatically qualified health plans to accept the advance HCTC from IRS. HCTC program officials reported that certain health plans refused to accept payments from IRS, primarily because they found the process to register to receive advance payments burdensome or they did not want to receive electronic payments. According to these officials, health plans had to register in the primary vendor database for the federal government—the Central Contractor Registration (CCR)—and accept electronic payments in order to receive

advance HCTC payments. The CCR requirement was reported to cause delays, and some plans, especially smaller ones, refused to accept electronic payments or did not have the necessary systems to process them. To encourage health plans to participate, the HCTC program office changed its registration process for health plans—it no longer requires plans to register with the CCR—and now issues paper checks if a health plan will not accept electronic payments. HCTC program officials reported that these changes have prompted some plans to agree to participate. However, as of June 2004, 211 health plans still refused to participate. Most of these were COBRA plans that covered few HCTC-eligible individuals. Because these 211 plans refused to accept payments, about 447 individuals who had tried to enroll for the advance HCTC had to wait until the end of the year to claim the HCTC. Officials from two COBRA plans told us why their plans did not accept advance payments: an official from one plan stated that too few individuals qualify for the HCTC for the plan to consider participating, while an official from another plan was concerned that the advance HCTC would encourage less healthy individuals to retain coverage and that this would result in financial losses for the plan. Nevertheless, a total of more than 600 health plans covering more than 13,000 individuals have agreed to receive the advance HCTC as of June 2004.

An unresolved payment issue identified by 3 of the 10 state-qualified plans we contacted in the states we reviewed was the receipt of incorrect advance HCTC payments from IRS when premiums change. While officials from most of the state-qualified plans we interviewed (6 of 10) reported that either they did not experience any problems with advance HCTC payments or that any problems they experienced had been resolved, the most common unresolved issue, reported by officials from three of the plans that identified ongoing issues, dealt with the receipt of incorrect payments when premiums changed. This problem was attributed largely to the time it takes for HCTC enrollees to notify the HCTC program of the new premium and for the HCTC program to adjust the allowable premium amount. For example, one plan reported that payments from IRS are incorrect—usually less than the required amount—for a couple of months after a premium change. To mitigate this problem, two officials from state-qualified plans suggested that the health plan, rather than the HCTC enrollee, notify the HCTC program of premium changes. Officials from two COBRA plan administrators that had a large number of advance HCTC enrollees stated that they did report premium changes directly to the HCTC program. However, HCTC program officials reported that some plans prefer not to report the changes to HCTC because it is outside their

normal procedures or they have few members receiving the advance HCTC.

An implementation issue affecting enrollees, for which the HCTC program revised its procedures, concerned how the program office responded to enrollees' payments that were less than the requested amount or late. According to HCTC program officials, between August 2003 and February 2004, more than 1,700 individuals who had enrolled for the advance HCTC were terminated temporarily from the advance HCTC because their payments to IRS were less than their 35 percent share or they were late. Approximately 55 percent of the individuals who were terminated subsequently reenrolled for the advance HCTC. HCTC program officials noted that the initial billing and payment procedures generated numerous calls to the customer service center because individuals received multiple invoices for their 35 percent premium amount, some of which they received late because of mail delivery problems. To mitigate this confusion and the burden of reenrolling individuals who had been dropped, the HCTC program office changed its billing and payment procedures in March 2004. Under the revised procedures, only one invoice would be sent each month and, instead of terminating individuals whose payments were less than the required amount, the HCTC program office would add a 65 percent HCTC proportional to the payment they receive and forward this amount to the health plan. The HCTC enrollee would be responsible for paying any outstanding difference to the health plan directly. HCTC program officials told us that since making these changes, no advance HCTC enrollee has been terminated as a result of payments that were less than the required amount or late. Additionally, officials we interviewed from five of the health plans in the states we reviewed reported that they were lenient in applying their payment rules to ensure that plan members did not lose coverage as a result of problems with the advance HCTC. For example, an official from one health plan reported that the plan had extended from 30 to 90 days the grace period for advance HCTC members to pay their monthly premiums.

The HCTC program office has also changed its procedures to address the receipt of incomplete lists of potentially eligible individuals from state workforce agencies. HCTC program officials reported that the lists state workforce agencies provide on which the HCTC program office relies to determine eligibility for the advance HCTC were incomplete for many states and that verifying that individuals remained eligible for the advance HCTC was time consuming. Some states also reported problems with transmitting these data to IRS. Ohio, for example, reported that the HCTC program office does not always receive all of the names of potentially

eligible individuals that it sends. HCTC program officials reported that from October 2003 through March 2004, the lists of TAA recipients potentially eligible to receive the HCTC submitted by about one-third to more than one-half of states (16 states to 28 states) failed to include the names of all eligible TAA recipients. Since October 2003, the HCTC program office has audited these states' lists and asked the workforce agencies to confirm that their transmissions were correct if any of the individuals enrolled to receive the advance HCTC from the previous month failed to reappear as eligible. During the first 6 months in which the HCTC program office performed these audits, it identified 2,984 individuals who were enrolled to receive the advance HCTC in a previous month but whose names dropped from the state lists in the current month. The state workforce agencies determined that approximately 55 percent (or 1,648) of these individuals were still eligible for the advance HCTC and that their names should not have been dropped from the list. Thus, without this audit process these individuals would have erroneously lost eligibility for the advance HCTC. However, HCTC program and Labor officials reported that this verification process is a burden on HCTC program staff and the states.

HCTC program officials reported that they did not track advance payment errors that occurred as a result of mistakes made by IRS. While these officials acknowledged that some mistakes did occur, such as late payments or accounting errors, they said that the majority of payments were timely and accurate and that problems were resolved at the time they occurred. Likewise, most officials from health plans we spoke with reported few problems with IRS's payments; problems identified included payments containing incorrect identification numbers or payments for incorrect amounts.

HCTC Program Office Used Contractors to Implement and Perform Most Program Functions

IRS established the HCTC program office with primary responsibility for overseeing and coordinating efforts for the HCTC. The HCTC program office is responsible for resolving operational and legal issues and monitoring the overall progress of the HCTC on a day-to-day basis. An executive steering committee, composed of affected federal agencies and contractors, also was established to provide guidance to the HCTC program office. The majority of officials on the HCTC program's executive steering committee are IRS or Treasury officials. High-level officials from each of the other federal agencies involved with the HCTC—Labor, HHS, and PBGC—as well as the IRS and Treasury officials are voting members. Officials from IRS's primary private contractor and a subcontractor—Accenture and The Lewin Group, respectively—are nonvoting members of

the committee.[54] This committee meets monthly to provide guidance on policy, legal, and programmatic issues.

To meet the implementation date for the advance HCTC, IRS relied on contractors. According to HCTC program officials, IRS staff work closely with contractor staff and oversee their work on an ongoing basis. For example, within the HCTC program office are six project teams, each of which is managed by a senior-level IRS staff person. Paired with each senior-level IRS staff person is a senior contractor staff person, and most of the staff performing specific operational tasks for the HCTC are from the contractor. While the senior IRS and contractor staff share responsibility for their project team's work, the IRS staff person establishes the direction of the work on the basis of the HCTC program's strategic plan, sets priorities, and brings knowledge about IRS's processes to the team. IRS and contractor staff responsibilities are also clarified in the contract documents. For example, IRS contract documents state that the government responsibilities include defining the rules under which the program will function and that the primary contractor's responsibilities include designing and administering the HCTC program according to these rules. IRS officials in the HCTC program reported that close collaboration between government and contractor staff helped them implement the advance HCTC in a timely manner.

Officials from IRS's contracting office reported that oversight of the primary HCTC contractor responsible for developing and maintaining much of the HCTC program office's infrastructure is conducted in several ways. IRS contracting officers include direction on how work is to be completed in work requests, as well as reporting requirements and deliverables. For example, one work request required the contractor to report daily on the handling of calls received by the call center for a few months in 2003. IRS staff in the specific area where the work is to be done review and approve each work request under the contract, monitor the contractor's work, and make recommendations to the contracting official regarding whether the completed work is acceptable. Additionally, IRS contracting officials reported that they review monthly status reports, cost documents, and deliverables submitted by the primary contractor. However, the HCTC program office has not instituted performance

[54]In addition to its primary contractor, Accenture, IRS also contracted with MITRE for program management support and MITRE's subcontractor, The Lewin Group, for health industry expertise.

measures and is currently working on draft measures and preliminary goals for fiscal year 2005.

To implement and administer the advance HCTC, Congress appropriated $70 million to IRS for fiscal year 2003, which will remain available through fiscal year 2004, and $35 million for fiscal year 2004, available through fiscal year 2005.[55] HCTC program officials expected that costs to administer the HCTC program—from the time that work by the primary contractor began in February 2003 through June 2005—would be about $116 million.[56] These costs, broken down by major activities, included about $33 million for design and development work during February 2003 through April 2004. Implementation costs to establish the systems that would be used on an ongoing basis and costs to administer the advance HCTC for the first 9 months it was available were reported to be about $36 million for May 2003 through April 2004. In May and June 2004, the HCTC program office engaged in a planning process during which it restructured its operations and determined how it would transition from implementation activities to operating activities. Costs to reorganize and administer the HCTC during this 2-month transition period were expected to be about $6 million. After transitioning to operating activity levels, officials expected that costs for the HCTC would be about $40 million for the year July 2004 through June 2005, and IRS officials reported that they are identifying ways to further lower operating costs. Included in this $40 million are about $32 million for operating costs and about $8 million for program enhancements such as software updates. In total, the majority (at least $97 million) of the approximately $116 million to administer the HCTC—from its early 2003 start-up through mid-2005 operations—was expected to be paid to IRS's contractors. (See table 8.)

[55]IRS has requested about $35 million for implementation of the HCTC for fiscal year 2005 and receives separate funding for HCTC payments made to health plans and individuals. As of July 2004, payments to health plans for the advance HCTC were about $32 million, and, as of May 2004, payments to individuals for the end-of-year HCTC were $30 million.

[56]IRS's contract with Accenture, its primary contractor and the entity responsible for establishing and maintaining the HCTC program office, began February 1, 2003. These operating costs do not include costs incurred by IRS or other federal agencies or contractors prior to the establishment of the HCTC program office in February 2003. These costs also do not include those incurred by IRS outside of the HCTC program office, such as costs to process end-of-year HCTC claims or costs to states and other federal agencies to implement the HCTC.

Table 8: Summary of IRS's Incurred and Expected HCTC Administration Costs, February 2003 through June 2005

Dollars in millions				
	IRS	Primary contractor	Secondary contractors	Total
Design and development of the HCTC (February 1, 2003, to April 30, 2004)	$3.8	$28.7	$0.8	$33.3
Implementation of the HCTC (May 1, 2003, to April 30, 2004)	2.9	32.1	1.2	36.1
Transition to operational level of service (May 1, 2004, to June 30, 2004)	0.4	5.8	0.3	6.5
Expected operating and enhancement costs (July 1, 2004, to June 30, 2005)	3.6	26.3	1.9	40.0[a]
Total[b]	**$10.6**	**$92.8**	**$4.2**	**$115.9**

Source: IRS's HCTC program office.

[a]Included in the $40.0 million is $8.2 million for potential program enhancement costs. IRS could not estimate how program enhancements expenditures would be allocated between IRS and the contractors.

[b]Totals may not add because of rounding and are subject to change for IRS and the contractors according to how program enhancement costs are allocated.

From start-up through June 2004, IRS's primary contractor was responsible for most of the work for the HCTC.[57] The contractor's responsibilities during this time included assisting in the development of eligibility and payment processing policies and procedures, maintaining and operating the program office, and establishing a call center. While IRS had an average of 9 full-time-equivalent staff assigned during this time to design, develop, implement, and transition the HCTC program to ongoing

[57]The HCTC task order was awarded through IRS's Treasury Information Processing Support Services multiple-award contract. Eighteen multiple-award contractors, including Accenture, are eligible to receive individual task order awards in some or all of the service areas encompassed by the contract. IRS awarded Accenture the HCTC task order at the end of January 2003, with work beginning February 1, 2003.

operational service levels, the primary contractor had an average of 243 full-time-equivalent staff working on these activities.[58]

Starting July 1, 2004, HCTC program officials expected that operating and enhancement costs for the next 12 months would be about $40 million. This figure also reflects a decrease in contractor staff. These costs reflect a reduction in service levels and IRS's assumption of more of the administrative responsibilities for the HCTC. HCTC program officials stated that reduced service levels means that, for example, the HCTC program will focus on responding to issues raised by health plans rather than providing as much individual-level outreach to health plans as they had in the past. IRS's primary contractor is expected to continue to perform the majority of work for the HCTC, and officials reported that there would be a decrease in the amount of work done by the contractor, with contractor staffing to decrease to 167 full-time-equivalents. There would be a slight increase in the amount of work done by IRS, with no increase in the number of IRS staff positions designated but with hiring done to fill vacant positions to reach a total of 17 full-time equivalents.

45 States Received National Emergency Infrastructure Grants; Fewer States Received National Emergency Bridge or High-Risk Pool Grants

As of August 2004, 45 states received national emergency infrastructure grants from Labor to help them set up mechanisms to administer the HCTC, and 11 states received national emergency bridge grants to help pay a portion of the premiums. In total, $45 million, or half of the $90 million in available national emergency grant funds, was awarded. In response to our survey of state workforce agencies, two-thirds of the states that did not apply for the bridge grants said they did not have systems in place to implement the grant. A total of 21 states received high-risk pool grants from CMS as of August 2004. Sixteen states received high-risk pool operating grants to offset losses in state high-risk pools, and 6 states were awarded a seed grant for establishing a new high-risk pool (1 state received both a seed and an operating grant). As of August 2004, less than half of the $80 million in funds available for high-risk pool operating grants had been awarded, as well as less than one-fifth of available high-risk pool seed grants. CMS officials reported that one reason seed grants were not more popular is that states were reluctant to take on the ongoing financial

[58]According to the HCTC program office, Accenture subcontracted with 15 other companies for work on the HCTC. An official from Accenture stated that while most of these subcontracts were small and made for specific technological skills, there was one major subcontract for call center activities and two other minor subcontracts for network and backup program support.

obligation of a high-risk pool. (App. V lists the states awarded national emergency grants and high-risk pool grants and the amounts awarded.)

Half of Available National Emergency Grant Funds Have Been Awarded

As of August 2004, half ($45 million) of the $90 million available for national emergency grants had been awarded—about $7 million for infrastructure grants and about $38 million for bridge grants. Most states received national emergency grants, with 45 states receiving infrastructure grants and 11 receiving bridge grants. For fiscal year 2002, $60 million was appropriated for national emergency grants, including $50 million for bridge grants and $10 million for infrastructure grants. An additional $30 million was appropriated for fiscal year 2003 for both bridge and infrastructure grants.

While bridge grants were originally awarded to provide individuals with a 65 percent subsidy prior to the implementation of the advance HCTC in August 2003, Labor has expanded the use of bridge grants to cover the 1- to 3-month gap period during the HCTC enrollment process when individuals must pay 100 percent of their premiums out of pocket.[59] Five states—Maine, Maryland, North Carolina, Ohio, and Virginia—are using bridge grant funds to cover this gap period, and more states are in the process of seeking funds for this purpose. State officials reported that these grants are important to help individuals cover premiums during the advance HCTC enrollment process and that the availability of these funds during this period could increase eligible individuals' interest in and receipt of the HCTC.

In March and April 2004, the HCTC program piloted an initiative called "HCTC National Emergency Grant Bridge Support Activities" to support states that received bridge grant funds. The pilot was tested in Maryland and Virginia and involved three activities. First, the HCTC program began asking individuals in these states when they applied for the credit to consent to the HCTC program sharing certain private enrollment information with state officials, such as names, addresses, and enrollment

[59]Labor issued guidance to states for requesting national emergency grant funds in its Training and Employment Guidance Letter No. 20-02 in March 2003. In May 2004, Labor issued additional guidance on the use of NEG bridge grants for premium assistance during this gap period and provided procedures for states to access these funds. In addition to funds for premium assistance, states may use a portion of the grant for administration, outreach, and informational activities needed for the HCTC, an amount generally limited to 10 percent.

status. According to the HCTC program, most individuals (80 percent) in these states consented to this at the time of enrollment. The HCTC program office then sent a report to states weekly showing HCTC enrollment status, contact information, Social Security number, and eligibility type for all TAA recipients and PBGC beneficiaries who had consented to disclosure of this information. Pilot states were encouraged to use this information as a tool for outreach and for determining an individual's eligibility for bridge grant payments. Second, the HCTC program office offered support to states in promoting their bridge grant program to potentially eligible individuals. Third, the HCTC program office provided ad hoc support to bridge grant states on questions regarding HCTC eligibility and enrollment. Virginia reported that it used the consent reports to conduct outreach such as mailing application forms to potential eligibles, as well as to monitor enrollment status to avoid potential overpayments. Maryland used the consent reports to contact prescreened PBGC beneficiaries and offered them bridge services, including mailing out application packages, and Maryland officials said that the pilot experience helped improve federal and state coordination. The HCTC program and Labor have agreed to expand the bridge grant pilot to other states.

In response to our survey of state workforce agencies in March 2004, officials cited a variety of reasons to explain why they did not apply for bridge or infrastructure national emergency grants.[60] For example, officials in two-thirds of the states that did not apply for the bridge grants said that they did not have systems in place to implement the grant. The rest of the states cited a variety of reasons for not applying, including difficulty with the grant application process, insufficient TAA workers or activity, no need for the funding, and prohibitive administrative costs. One state indicated that it was hesitant to assist individuals with obtaining health coverage because it was unable to make decisions about health insurance coverage. Of the five states that Labor reported had not received infrastructure grants, two said that they did not require funding from the grant and another said that it had to complete some system changes before applying for a grant. One state said it would be applying for the grant in the future, and another was not sure whether an application had been submitted. (See table 9.)

[60]Since the time our survey was completed in March 2004, Labor has approved bridge grant applications for Utah and Ohio, and infrastructure grants for five states (Colorado, Louisiana, Pennsylvania, Utah, and Wisconsin).

Table 9: Reasons States Did Not Apply for National Emergency Grants

Reason	Bridge grant	Infrastructure grant
Did not have systems in place	24	[a]
Did not have enough TAA workers	6	0
Application process was too difficult	5	0
Did not require funding from the grant	4	2
Other reasons	6	2
Total	**35 states[b]**	**5 states[c]**

Source: GAO survey of state workforce agencies.

Note: Puerto Rico's workforce agency was included in this survey; the District of Columbia's workforce agency was not included.

[a]Not applicable. This was not a response option for the survey question.

[b]Some states cited multiple reasons for not applying for bridge grants.

[c]One state was uncertain of the status of its grant at the time we conducted our survey.

Twenty-one States Received Grants to Start or Operate High-Risk Pools

Almost half of the states (21 states) received high-risk pool grants as of August 2004. Six states were awarded seed grants of between about $53,000 and $1 million for establishing a high-risk pool and 16 states received operating grants to offset losses incurred by their high-risk pools.[61] As of August 2004, $4 million of the $20 million available for seed grants had been awarded to establish new high-risk pools, and less than half (about $30 million) of the $80 million available for high-risk pool operating grants had been awarded. CMS was reviewing an application from the District of Columbia, as of August 2004, and Vermont's application will be withdrawn because legislation to create a high-risk pool in Vermont was not enacted by its state legislature. (See app. V for a list of high-risk pool awards to states.)

According to a CMS official, one reason more states did not apply for high-risk pool seed grants was that states' fiscal concerns made them reluctant to take on the ongoing financial obligations of a new high-risk pool, which typically enrolls individuals with a history of high medical costs, incurs costs potentially higher than the premiums received from enrollees, and requires subsidization from taxes on local insurers or other revenue sources. CMS officials also said that several states that had high-risk pools

[61]New Hampshire received both a seed grant and an operating grant.

were not eligible for the high-risk pool operating grant because they did not meet the eligibility criteria. The operating grant is available only to qualified high-risk pools that meet certain eligibility criteria, and the award amounts are based on the number of uninsured individuals in each state. In addition to meeting the criteria for a qualified high-risk pool contained in the Public Health Services Act,[62] eligibility criteria for receipt of the grant included restrictions on the premiums charged, the number of plan choices available to enrollees, and the availability of mechanisms to fund ongoing losses incurred by the pool. California and Texas, where the numbers of uninsured people are among the highest in the nation and therefore would have been eligible for proportionately larger shares of the grant funds, were among the states that did not meet these criteria. California did not qualify because its high-risk pool did not meet the qualified high-risk pool requirement that eligible individuals have immediate access to the pool, and Texas did not qualify because the premiums for its high-risk pool were set above the allowable limits. Three other states—New Jersey, Idaho, and Oregon—that applied for an operating grant were turned down because their arrangements did not meet the definition of a qualified high-risk pool.

Conclusions

The Trade Adjustment Assistance Reform Act of 2002 established the HCTC to help trade-displaced workers and retirees whose pension plans have been assumed by PBGC to purchase health coverage. The establishment of the HCTC within 1 year of enactment, including development of a new mechanism for paying the HCTC directly to hundreds of health plans on behalf of enrollees in advance of the premium due date, resulted from the collaborative efforts of multiple federal and state agencies and private health plans. As implementation issues arose—such as certain health plans' reluctance to participate, some initial payment problems, and ineligible individuals receiving the end-of-year credit in 2002—the IRS-based HCTC program office worked with other federal, state, and private stakeholders and adapted its policies and processes to address these and other issues.

Despite these efforts, the number of individuals receiving the HCTC to date continues to be a smaller portion of those potentially eligible than

[62]July 1, 1944, c. 373, §2744(c)(2), as added by Pub. L. No. 104-191, §111(a), 110 Stat. 1984 (1996) (codified at 42 U.S.C. §300gg-44(c)(2)). CMS interprets the act to require, among other things, that high-risk pools provide coverage to all individuals who are guaranteed coverage through HIPAA.

many stakeholders had expected and some implementation issues remain unresolved. A major factor cited by many state and health plan officials as a reason for lower than expected enrollment was the affordability of coverage, as some eligible individuals may find it difficult to pay the entire premium for 3 to 6 months to maintain coverage until they receive the advance HCTC, and even the 35 percent share of premiums, once the HCTC covers remaining premium costs can represent a high proportion of income, particularly for displaced workers or retirees. Further, while the advance payment option was intended to make the HCTC attractive for eligible individuals by minimizing their out-of-pocket payments, most HCTC recipients in 2003 did not use this option. Instead, the majority of recipients opted to receive the HCTC by claiming the credit on their year-end tax forms. State, health plan, and union officials told us that the complexity of the eligibility determination and enrollment process contributed to the lower than expected usage of the advance payment option. For example,

- The multitude of tax, labor, and health coverage requirements related to the HCTC are challenging for workers and retirees to navigate. Potentially eligible individuals must often contact multiple federal, state, and private entities to obtain the information they need to enroll. While the HCTC program office offers information to potentially eligible individuals through its call center, this resource begins after individuals have been identified by states or PBGC as potentially eligible and often after individuals have already made decisions about maintaining, changing, or dropping health coverage.
- Individuals who have more than a 63-day break in continuous health coverage may lose federal consumer protections guaranteed in the TAA Reform Act, such as guaranteed acceptance by a health plan and coverage for their preexisting medical conditions. Given that it takes 3 to 6 months to become eligible for and receive the advance HCTC, during which time the individual is responsible for the full premium amount, some individuals may lose these consumer protections if they do not maintain coverage during this time.
- To receive the HCTC, the TAA Reform Act requires that an individual must meet certain trade readjustment allowance eligibility requirements, including (1) waiting 60 days or more from the time that a petition to certify that workers were displaced due to trade is submitted to Labor, and (2) complying with the requirement to obtain reemployment training or obtain a waiver from training each month. State workforce agencies contend that granting these waivers to facilitate eligibility for the HCTC is an added administrative burden that further complicates enrollment in the HCTC.

- Lists from state workforce agencies used to verify individuals' eligibility were sometimes incomplete, causing individuals to lose access to the advance HCTC if their names were erroneously dropped. Although the HCTC program office began auditing the lists to ensure that they contained all eligible individuals, this time-consuming process had not led to the correction of the underlying problem with the accuracy of the state lists.
- Enrollees may face delays in having the correct amount of their advance HCTC payment adjusted and paid promptly to their health plans if they fail to notify the HCTC program office when the health plan changes their premiums.
- PBGC beneficiaries who enroll in Medicare lose eligibility for the HCTC for themselves and their spouse and other dependents, even though their spouse or dependent may not yet be eligible for Medicare and may not have access to other sources of coverage. State and union officials often noted that this was a concern of PBGC beneficiaries when discussing potential eligibility for the HCTC.

As the HCTC program begins its second full year and transitions from design and early implementation to more routine operations, it is reducing its contractor staffing and some service levels. As the program evolves, a less complex enrollment process and shorter time period before enrollees begin receiving advance payments could enhance the attractiveness of the HCTC and the advance payment option for eligible individuals.

Matters for Congressional Consideration

We suggest that Congress consider taking the following three actions:

- To simplify the advance HCTC eligibility process and enable some trade-displaced workers to qualify for the HCTC sooner after losing employment, Congress may wish to amend existing law to permit TAA recipients to enroll in the HCTC program (1) without waiting 60 days or more to establish eligibility for the trade readjustment allowance and (2) without first meeting trade readjustment allowance requirements pertaining to training.
- To more promptly reimburse eligible individuals for some of the health coverage premiums they paid during the 3 to 6 months that the advance HCTC eligibility and enrollment process typically takes, Congress may wish to allow the HCTC program to retroactively pay the 65 percent HCTC for the 1 to 3 months between enrollment for and receipt of the advance HCTC, rather than requiring individuals to wait for the end-of-year credit to receive that portion of the benefit.
- To help eligible individuals maintain their rights to guaranteed coverage and other consumer protections during the time it takes to become eligible

and enroll for the HCTC, Congress may wish to specify that for individuals who had health coverage for the 3 months immediately prior to becoming eligible for TAA benefits or PBGC pension payments, the 63-day break in coverage used to determine continuous coverage may begin with the HCTC program office's notification of potential eligibility.

Recommendations for Executive Action

We recommend that the Secretary of Labor, Commissioner of Internal Revenue, Administrator of CMS, and Executive Director of the PBGC take the following five actions.

- To help individuals understand and comply with the multiple labor, health coverage, and tax eligibility requirements for receipt of the HCTC, the Secretary of Labor, the Commissioner of Internal Revenue, the Administrator of CMS, and the Executive Director of the PBGC should, in coordination with state officials, provide for a centralized resource for individuals to receive information on and assistance with HCTC eligibility criteria, including individualized assistance in completing each step of the eligibility and enrollment process and information about qualified health coverage options available in their local area. This centralized resource should be available at the time individuals must make decisions about purchasing qualifying health coverage and meeting other qualifying criteria, which may occur before the HCTC call center and other existing resources have been notified about an individual's potential eligibility.
- To ensure that HCTC-eligible individuals and recipients receive timely and appropriate information, responses to inquiries, enrollment processing, and advance HCTC payments, the Commissioner of Internal Revenue should evaluate the effect that any reduced service levels will have on eligible individuals and health plans' ability to receive the HCTC on a timely basis and their satisfaction with the information and services provided.
- To improve the quality of eligibility information provided by the states, the Secretary of Labor and the Commissioner of Internal Revenue should coordinate to improve the accuracy of data received from state workforce agencies.
- To simplify payment processing for advance HCTC enrollees and avoid disruptions resulting from premium changes, the Commissioner of Internal Revenue should encourage participating health plans to provide notification of changes in premiums directly to the HCTC program office rather than relying primarily on individuals for providing this information.
- Given that PBGC beneficiaries who enroll in Medicare lose eligibility for the HCTC even though their spouses or other dependents may not yet be eligible for Medicare or have alternative sources for insurance coverage, the Commissioner of Internal Revenue and the Executive Director of the

PBGC should coordinate to report to Congress on how many PBGC beneficiaries previously receiving the HCTC have attained the age of 65 and potentially lost eligibility due to enrolling in Medicare, and how many of these former HCTC recipients have spouses or other dependents who are no longer able to receive coverage subsidized by the HCTC.

Agency and State Comments and Our Evaluation

We provided a draft of this report to Labor, IRS, CMS, and PBGC and officials in the eight states we reviewed, including each state's workforce agency and the department of insurance or high-risk pool in seven states. We received comments from all four federal agencies, five states' workforce agencies (California, Maryland, New York, Ohio, and Pennsylvania), five states' departments of insurance (California, New York, Ohio, Pennsylvania, and Texas), and two states' high-risk pools (Illinois and Maryland).[63] The four federal agencies either concurred with our recommendations or deferred to IRS as the lead agency in implementing the HCTC. The state agencies that commented on our draft generally concurred with our findings. Comments from the federal agencies are reprinted in appendixes VI through IX.

Regarding our recommendation that Labor, IRS, CMS, and PBGC work together to develop a centralized resource to help individuals understand the eligibility requirements for the HCTC, IRS agreed with our recommendation and highlighted efforts it has made to date to provide a centralized resource, including developing informational documents for individuals and states, making information available on its Web site, and establishing a call center. Labor agreed on the importance of providing individuals with information about the HCTC and highlighted certain actions it had taken to provide information and training to state workforce agencies and other interested parties such as businesses and unions. Labor also suggested reviewing and evaluating the quality of the existing information before taking further actions. PBGC commented that it would coordinate with the other agencies to address this recommendation, and CMS deferred to IRS as the lead in HCTC outreach and education. While we recognize that agencies have made efforts to provide individuals with

[63]Specifically, we received responses from the California Department of Insurance and the California Employment Development Department, Illinois's Comprehensive Health Insurance Plan, the Maryland Health Insurance Plan and the Maryland Department of Labor, Licensing, and Regulation, the New York State Department of Labor and the New York State Insurance Department, the Ohio Department of Insurance and Ohio Department of Job and Family Services, the Pennsylvania Insurance Department and Pennsylvania Department of Labor and Industry, and the Texas Department of Insurance.

information about the HCTC, we noted in the draft report that individualized assistance is not available until after individuals may have already made decisions that affect their eligibility for the HCTC. Thus, while a review of existing resources may be helpful, we have added to our recommendation the need for a centralized resource that provides individualized information and assistance earlier than it is currently available.

Regarding our recommendation for IRS to evaluate whether any reduced service levels will affect individuals' and health plans' satisfaction, IRS stated that the agency cannot at this time systematically measure customer satisfaction. In response to our recommendation, however, IRS stated that it would include questions in future surveys or other research to elicit an indication of changes in satisfaction.

In response to our recommendation that IRS and Labor improve the quality of eligibility information provided by the states, IRS agreed that the information provided by states continues to present a challenge. IRS noted that, although it does not have authority over states to implement solutions to problems with the eligibility lists, it will work with Labor to develop a plan for improving the accuracy of these data. Labor agreed with our recommendation and highlighted the burden the audits placed on states and agreed to continue to work with IRS to improve the quality of the data.

In response to our recommendation that IRS encourage health plans to provide notifications of premium changes directly to the HCTC program office, IRS agreed to develop an action plan to make this change. IRS noted that it would likely phase in this change because of the number of plans and individuals affected.

IRS and PBGC agreed with our recommendation that PBGC work with IRS to report to Congress the number of PBGC beneficiaries who turn 65 and lose eligibility for the HCTC even though their spouse or dependent may still need HCTC coverage. Additionally, PBGC suggested that IRS, as the lead agency for the HCTC, submit the recommended information to Congress. IRS noted that some estimates may be necessary because not all data elements are readily available to IRS or PBGC.

In addition to its comments on our recommendations, IRS stated that the HCTC presented significant new responsibilities for IRS and that challenges remain. IRS reported it is continuing to identify ways to improve the operation of the HCTC program, decrease administrative

costs, and obtain data about those who receive the HCTC in order to make outreach activities more effective. IRS stated that it is working to shorten the period of time required before an individual receives the advance HCTC. It noted, however, that the first 3 months of the 3- to 6-month period we identified for this process relates to TAA certification requirements, and that amending these requirements may have broader implications than just for the HCTC program. Additionally, regarding our statement that the benefits offered by qualified health plans across states differ widely, IRS noted that the coverage available for the HCTC is dependent on decisions made by the states and the plans that volunteer to participate. IRS stated that it hopes to obtain data that will enable a better understanding of the health status and other characteristics of HCTC enrollees to help alleviate health plans' uncertainty about health care costs of HCTC individuals compared to others and to encourage more health plans to participate in the advance HCTC program.

IRS and Labor and officials from Maryland, New York, Ohio, Pennsylvania, and Texas also provided technical comments, which we incorporated as appropriate.

As agreed with your offices, unless you publicly announce its contents earlier, we plan no further distribution of this report until 30 days after its date. We will then send copies to the Secretary of Labor, Secretary of the Treasury, Administrator of CMS, Commissioner of Internal Revenue, Executive Director of PBGC, appropriate congressional committees, and other interested parties. We will also make copies available to others upon request. In addition, this report will be available at no charge on GAO's Web site at http://www.gao.gov.

Please call me at (202) 512-7118 if you have additional questions. Another contact and key contributors are listed in appendix X.

Kathryn G. Allen
Director, Health Care—Medicaid and
Private Health Insurance Issues

Appendix I: Advance Health Coverage Tax Credit Enrollees, by State, July 2004

State	Potentially eligible population[a]	Enrolled[b]
Alabama	4,594	142[c]
Alaska	86	0
Arizona	1,865	45[c]
Arkansas	1,604	39[c]
California	7,574	259
Colorado	1,608	56[c]
Connecticut	2,281	83[c]
Delaware	402	20
District of Columbia	86	0
Florida	11,565	473
Georgia	8,907	93[c]
Hawaii	552	[c]
Idaho	1,291	55[c]
Illinois	12,149	478[c]
Indiana	10,139	841
Iowa	1,747	39[c]
Kansas	1,260	37[c]
Kentucky	4,309	228[c]
Louisiana	1,036	14[c]
Maine	1,970	131[c]
Maryland	5,269	577
Massachusetts	4,662	44[c]
Michigan	8,733	651
Minnesota	2,778	252
Mississippi	1,786	42
Missouri	6,537	161[c]
Montana	230	20[c]
Nebraska	452	17
Nevada	755	17
New Hampshire	1,274	24[c]
New Jersey	5,619	102[c]
New Mexico	430	[c]
New York	10,317	399
North Carolina	17,875	1,636[c]
North Dakota	80	0[c]

State	Potentially eligible population[a]	Enrolled[b]
Ohio	15,285	1,090
Oklahoma	2,617	42
Oregon	1,555	66
Pennsylvania	22,101	2,265
Puerto Rico	988[c]	0
Rhode Island	588	23[c]
South Carolina	4,934	136[c]
South Dakota	166	0[c]
Tennessee	7,629	259[c]
Texas	8,719	131[c]
Utah	998	57
Vermont	551	16
Virginia	6,541	505
Washington	4,737	274[c]
West Virginia	4,203	947[c]
Wisconsin	5,523	286[c]
Wyoming	77[c]	0
Total[d]	**229,044**	**13,194**

Source: IRS's HCTC program office.

Notes: Comparable numbers for those receiving the end-of-year HCTC were not available.

Data for Puerto Rico are also included in this table.

[a]Not all of the individuals that PBGC and state workforce agencies reported as potentially eligible will meet all eligibility criteria for HCTC.

[b]The enrollment total for each state is the sum of individuals enrolled in a state-qualified plan, COBRA, and individual market plans.

[c]Total number of eligible or enrolled individuals is incomplete because IRS does not report data categories where the number of individuals is from 1 to 9, citing its disclosure and privacy rules. For this reason, the sum of enrollment for all states listed does not equal the total.

[d]Totals include values not reported in state totals cited above.

Appendix II: State-Qualified Coverage Options

As of July 2004, 36 states had designated state-qualified coverage options that could be purchased by individuals receiving either the advance or end-of-year health coverage tax credit (HCTC). Another 3 states—Arizona, Idaho, and Washington—had designated state-qualified plans, but these plans were not yet open to enrollment as of July 2004. Most of the 36 states that made state-qualified coverage available chose to provide this coverage through arrangements with insurers or through state high risk-pools, and 3 states designated both their high-risk pool and an arrangement with an insurer as state-qualified coverage. Thirteen states designated mini-COBRA coverage—state-based continuation coverage pertaining to insurers providing coverage to plans maintained by employers with fewer than 20 employees. Mini-COBRA coverage was the sole state-qualified coverage option available to HCTC recipients in 4 states (see table 10). According to federal officials, only a small percentage of Trade Adjustment Assistance (TAA) recipients and Pension Benefit Guaranty Corporation (PBGC) beneficiaries eligible to receive the HCTC likely had access to mini-COBRA coverage, as few of these individuals formerly worked for an employer with fewer than 20 employees.

Table 10: Types of State-Qualified HCTC Plans Available, by State, July 2004

State	High-risk pool	Arrangement with one or more insurer	Mini-COBRA
Alabama		√	
Alaska	√		
Arkansas	√		
Colorado	√		√
Connecticut	√		√
District of Columbia		√	
Florida		√	√
Illinois	√		
Indiana	√	√	
Iowa	√		
Kansas	√		
Kentucky			√
Maine		√	
Maryland	√	√	
Michigan		√	
Minnesota	√		
Missouri			√

State	High-risk pool	Arrangement with one or more insurer	Mini-COBRA
Montana	√		
Nebraska	√		√
New Hampshire	√		
New Jersey			√
New York		√	√
North Carolina		√	
North Dakota	√		
Ohio		√	√
Oklahoma	√		
Pennsylvania		√	
Rhode Island		√	√
South Carolina	√		
Tennessee		√	
Texas	√	√	
Utah		√	√
Vermont		√	√
Virginia		√	
Wisconsin			√
West Virginia		√	
Total	**17**	**18**	**13**

Source: IRS's HCTC program office.

Note: According to IRS's HCTC program office, Arizona, Idaho, and Washington had begun the process of electing state-qualified coverage, but the plans in these states were not yet open to HCTC recipients as of July 2004.

Appendix III: Variation in Benefits Across State-Qualified Health Plans in Seven States

The benefits offered to HCTC recipients varied across coverage types and from plan to plan. COBRA benefits, which were typically identical to the benefits provided to working individuals covered by the employer's group market health plan, generally included lower deductibles than high-risk pools and more comprehensive benefits and lower deductibles than state-qualified arrangements with insurers in the seven states we reviewed that had state-qualified plans.[1]

The majority of state-qualified plans in the states we reviewed were preferred provider organization (PPO) plans, although health maintenance organization (HMO), exclusive provider organizations (EPO), unrestricted fee for service (FFS), and point of service (POS) plans were available in some states.[2] According to a national employer benefits survey, PPO health plans offered by employers in 2003 generally included an average annual deductible for services provided within the health plan's preferred provider network of $275.[3] Table 11 shows that most of the state-qualified health plans in the states we reviewed offered a choice among deductible amounts, ranging from $0 to $5,000, and that HCTC recipients generally selected the lowest deductibles available, typically $1,000 or less.

[1]We selected eight states for review that had large potentially eligible populations for the HCTC, had designated different types of state-qualified plans, and were in geographically diverse areas. One of these states did not designate any state-qualified coverage for HCTC recipients.

[2]A PPO is a type of managed care plan that offers a choice of health care providers but offers financial incentives to use preferred health care providers. HMOs and EPOs are types of managed care plans that typically provide coverage only for services through health care providers within the managed care plan's network. POS plans are similar to HMOs, but allow use of nonnetwork providers at a higher cost to participants. Unrestricted FFS plans do not differentiate coverage or cost-sharing requirements for preferred or nonpreferred health care providers.

[3]See Henry J. Kaiser Family Foundation and Health Research and Educational Trust, *Employer Health Benefits 2003 Annual Survey* (Menlo Park, Calif., and Chicago: 2003).

Table 11: Annual Deductibles across Selected State-Qualified Health Plans in Seven States

	Annual deductible[a]	
State-qualified HCTC plan	**Deductible options offered**	**Deductible most commonly selected by HCTC recipients**
High-risk pools		
Illinois—PPO	$500, $1,000, $1,500, $2,500, and $5,000	$500
Maryland—PPO option	$1,000	[b]
Maryland—EPO option	[c]	[c]
Texas—PPO	$500, $1,000, $2,500, and $5,000	$2,500
Arrangements with one or more insurers[d]		
Maryland—FFS	$800	[b]
New York—HMO, Healthy NY	[c]	[c]
New York—HMO, Healthy NY Plus[e]	[c]	[c]
New York—HMO or POS	[c]	[c]
North Carolina—PPO[f]	$250, $500, $1,000, and $2,500	$250
Ohio—PPO	$500, $1,000, $2,500, and $5,000	$500
Pennsylvania—FFS (central region)	$750 and $1,500	$750
Pennsylvania—FFS (western region)[f]	$750	[b]
Texas—PPO	$500, $1,000, $1,500, $2,500, and $5,000	$1,000

Sources: GAO interviews with health plan officials and reviews of health plan Web sites, brochures, and benefit summaries.

Notes: Mini-COBRA plans were also designated as state-qualified plans by New York and Ohio; however, information on the benefits offered by these plans was not readily available and is not included in the table. Federal officials estimated that few individuals eligible to receive the HCTC had access to mini-COBRA coverage.

The eighth state we reviewed, California, did not designate any state-qualified coverage for HCTC recipients.

[a]Deductible options are for one-person coverage and apply to services received within the health plan's network, if applicable.

[b]This state-qualified plan or plan option did not offer a choice in deductible amounts.

[c]This state-qualified plan or plan option did not have an annual deductible.

[d]Some states provided state-qualified HCTC coverage through arrangements with more than one insurer. In these instances, we selected the insurer with the highest HCTC enrollment. New York was unable to provide HCTC enrollment data for each of its state-qualified HCTC coverage options, so we were unable to determine which insurer had the highest number of HCTC enrollees: we reviewed plans offered by an insurer that served areas in which companies had closed and HCTC-eligible individuals would likely have resided. The insurer with the largest HCTC enrollment in Pennsylvania sold coverage in both the central and western regions of the state, and this coverage varied between regions.

[e]Healthy NY Plus is an unsubsidized state-based health insurance plan available to HCTC recipients who do not meet the income criteria for the subsidized Healthy NY plan.

[f]More than one benefits package was offered by the insurer. We selected the benefits package most commonly purchased by HCTC recipients.

We reviewed these state-qualified health plans for the extent of the benefits they offered with regard to maternity care, mental health care, and prescription drugs. The extent to which maternity benefits were covered by state-qualified plans in the states we reviewed is shown in table 12. Employer-sponsored plans typically provided coverage for maternity benefits because the federal Pregnancy Discrimination Act required employers with 15 or more employees to cover expenses for maternity services on the same basis as coverage for other medical conditions.[4] Only one state-qualified plan in the states we reviewed did not provide coverage for maternity benefits, and three state-qualified health plans offered maternity coverage that was available as an optional benefit with an additional premium charge.

[4]Pub. L. No. 95-555, 92 Stat. 2076 (1978).

Table 12: Maternity Benefits across State-Qualified Health Plans in Seven States

State-qualified HCTC plan	Maternity benefits
High-risk pools	
Illinois—PPO	Optional[a]
Maryland—PPO option	Covered
Maryland—EPO option	Covered
Texas—PPO	Covered
Arrangements with one or more insurers[b]	
Maryland—FFS	Covered
New York—HMO, Healthy NY	Covered
New York—HMO Healthy NY Plus[c]	Covered
New York—HMO or POS	Covered
North Carolina—PPO[d]	Optional[a]
Ohio—PPO	Optional[a]
Pennsylvania—FFS (central region)	Covered
Pennsylvania—FFS (western region)[d]	Covered
Texas—PPO	Not covered[e]

Sources: GAO interviews with health plan officials and reviews of health plan Web sites, brochures, and benefit summaries.

Notes: Mini-COBRA plans were also designated as state-qualified plans by New York and Ohio; however, information on the benefits offered by these plans was not readily available and is not included in the table. Federal officials estimated that few individuals eligible to receive the HCTC had access to mini-COBRA coverage.

The eighth state we reviewed, California, did not designate any state-qualified coverage for HCTC recipients.

[a]The benefit is offered as an option available for an additional monthly premium charge.

[b]Some states provided state-qualified HCTC coverage through arrangements with more than one insurer. In these instances, we selected the insurer with the highest HCTC enrollment. New York was unable to provide HCTC enrollment data for each of its state-qualified HCTC coverage options: we reviewed plans offered by an insurer that served areas in which companies had closed and HCTC-eligible individuals would likely have resided. The insurer with the largest HCTC enrollment in Pennsylvania sold coverage in both the central and western regions of the state, and this coverage varied between the regions.

[c]Healthy NY Plus is an unsubsidized state-based health insurance plan available to HCTC recipients who do not meet the income criteria for the subsidized Healthy NY plan.

[d]More than one benefits package was offered by the insurer. We selected the benefits package most commonly purchased by HCTC recipients.

[e]Benefits for maternity care were not available under this plan except for treatment of pregnancy-related complications.

The mental health benefits offered by state-qualified health plans in the states we reviewed are summarized in table 13. A national survey of health benefits offered by employers in 2003 reported that 99 percent of employer PPO plans provided coverage for both inpatient and outpatient mental health services, and the majority of these plans provided coverage for at least 21 days of inpatient care and 21 outpatient visits per year.[5] In comparison, two state-qualified health plans in a state we reviewed did not provide any coverage for mental health benefits, and one health plan in another state we reviewed limited coverage of mental health benefits to 10 inpatient days and 10 outpatient visits per year. State-qualified plans in three states required enrollees to pay 50 percent of the cost of outpatient mental health visits. Two state-qualified health plans in one state limited coverage to certain mental disorders.

[5]See Kaiser Family Foundation, *Employer Health Benefits 2003 Annual Survey.*

Table 13: Mental Health Benefits across State-Qualified Health Plans in Seven States

	Mental health benefits[a]		
State-qualified HCTC plan	**Inpatient care**	**Outpatient care**	**Separate annual or lifetime mental health maximum benefit (dollars)**
High-risk pools			
Illinois—PPO	Maximum 45 days per year[b] 20% coinsurance	Maximum 50 visits per year[b] 20% coinsurance	None
Maryland—PPO option	Maximum 60 days per year[b] 30% coinsurance	Maximum 30 visits per year[b] 30% coinsurance	None
Maryland—EPO option	Maximum 60 days per year $250 copayment	Maximum 30 visits per year 30% coinsurance	None
Texas—PPO	Serious mental illness only[c] Maximum 45 days per year 20% coinsurance	Serious mental illness only[c] Maximum 60 visits per year 20% coinsurance	None
Arrangements with one or more insurers[d]			
Maryland—FFS	25% coinsurance	20% coinsurance for visits 1-5[b] 35% coinsurance for visits 6-30[b] 50% coinsurance for 31+ visits[b]	None
New York—HMO, Healthy NY	Not covered	Not covered	Not applicable
New York—HMO, Healthy NY Plus[e]	Not covered	Not covered	Not applicable
New York—HMO or POS	Maximum 30 days per year[b] 10% coinsurance	Maximum 33 visits per year 10% coinsurance	None
North Carolina—PPO[f]	50% coinsurance	50% coinsurance	$2,000 annual benefit[b] $10,000 maximum lifetime benefit[b]
Ohio—PPO	Maximum 10 days per year[b] 20% coinsurance	Maximum 10 visits per year[b] 20% coinsurance	None
Pennsylvania—FFS (central region)	Maximum 30 days per year 20% coinsurance	Maximum 60 visits per year 50% coinsurance	$50,000 maximum lifetime benefit
Pennsylvania—FFS (western region)[f]	Maximum 30 days per year 0% coinsurance	50% coinsurance	$25,000 maximum lifetime benefit[b]
Texas—PPO	Organic brain disease only[g] 20% coinsurance	Organic brain disease only[g] 20% coinsurance	None

Sources: GAO interviews with health plan officials and reviews of health plan Web sites, brochures, and benefit summaries.

Notes: Mini-COBRA plans were also designated as state-qualified plans by New York and Ohio; however, information on the benefits offered by these plans was not readily available and is not included in the table. Federal officials estimated that few individuals eligible to receive the HCTC had access to mini-COBRA coverage.

The eighth state we reviewed, California, did not designate any state-qualified coverage for HCTC recipients.

[a]Benefits are for services received within the health plan's network, if applicable.

[b]Applies to mental health and substance abuse benefits combined.

[c]Serious mental illness includes only the following psychiatric illnesses: schizophrenia; paranoid and other psychotic disorders; bipolar disorders; major depressive disorders; schizo-affective disorders; pervasive developmental disorders; obsessive compulsive disorders; and depression in childhood and adolescence as defined in the American Psychiatric Association's current revision of Diagnostic and Statistical Manual of Mental Disorders.

[d]Some states provided state-qualified HCTC coverage through arrangements with more than one insurer. In these instances, we selected the insurer with the highest HCTC enrollment. New York was unable to provide HCTC enrollment data for each of its state-qualified HCTC coverage options: we reviewed plans offered by an insurer that served areas in which companies had closed and HCTC-eligible individuals would likely have resided. The insurer with the largest HCTC enrollment in Pennsylvania sold coverage in both the central and western regions of the state and this coverage varied between regions.

[e]Healthy NY Plus is an unsubsidized state-based health insurance plan available to HCTC recipients who do not meet the income criteria for the subsidized Healthy NY plan.

[f]The insurer offered more than one benefits package. We selected the benefits package most commonly purchased by HCTC recipients.

[g]Organic brain disease includes dementia, alcohol- or drug-induced psychoses, or other disorders listed in the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders III-R or the International Classification of Diseases, Ninth Revision (ICD-9) under diagnostic codes 290 to 294 and 310. Other mental and nervous disorders are not covered.

Prescription drug benefits offered by state-qualified health plans in the states we reviewed are summarized in table 14. According to a national survey of employer-sponsored health benefits, 99 percent of employer PPO plans provided coverage for prescription drugs in 2003, and 92 percent of all employer-sponsored plans did not require a separate prescription drug deductible.[6] The average copayments for prescription drugs reported in this survey were $9 for generic products, $19 for brand-name products that the plan designated as preferred, and $29 for brand-name products that the plan did not designate as preferred. All but one of the state-qualified plans in the states we reviewed included coverage for prescription drugs, and the one plan that did not include such coverage offered it as an optional benefit available for an additional premium charge. State-qualified plans in three states we reviewed required a separate annual deductible for prescription drugs, ranging from $100 to $250. State-qualified health plans in five states we reviewed had annual benefit maximums for prescription drugs, ranging from $500 to $3,000, and one plan did not provide any coverage for brand-name drugs.

[6]See Kaiser Family Foundation, *Employer Health Benefits 2003 Annual Survey*.

Table 14: Prescription Drug Benefits across State-Qualified Health Plans in Seven States

	Prescription drug benefits[a]		
State-qualified HCTC plan	**Copayment for 1-month supply (preferred/nonpreferred brand-name drugs)**	**Separate annual deductible[b] (dollars)**	**Separate annual prescription drug maximum benefit (dollars)**
High-risk pools			
Illinois—PPO	20% coinsurance Minimum $5 copayment per drug Maximum $100 copayment per drug[c]	None	None
Maryland—PPO option	$15 generic drugs $20/$35 brand-name drugs[c]	$250	None
Maryland—EPO option	$15 generic drugs $20/$35 brand-name drugs[c]	$250	None
Texas—PPO	$10 generic drugs $25/$40 brand-name drugs[c]	None	None
Arrangements with one or more insurers[d]			
Maryland—FFS	25% coinsurance	None	$500
New York—HMO, Healthy NY	Optional benefit[e] $10 generic drugs $20 brand-name drugs[c]	Optional benefit[e] $100	Optional benefit[e] $3,000
New York—HMO, Healthy NY Plus[f]	$10 generic drugs $20 brand-name drugs[c]	$100	$3,000
New York—HMO or POS	$5 generic drugs $10 brand-name drugs	$100[g]	None
North Carolina—PPO[h]	$10 generic drugs $35/$50 brand-name drugs	None	$2,000 for brand-name drugs
Ohio—PPO	$15 generic drugs No coverage for brand-name drugs	None	None
Pennsylvania—FFS (central region)	50% coinsurance[c] $10 minimum coinsurance per drug $100 maximum coinsurance per drug	$250	$3,000
Pennsylvania—FFS (western region)[h]	20% coinsurance	None	None
Texas—PPO	$15 generic drugs $30/$45 brand-name drugs	None	$2,500

Sources: GAO interviews with health plan officials and reviews of health plan Web sites, brochures, and benefit summaries.

Notes: Mini-COBRA plans were also designated as state-qualified plans by New York and Ohio, however; information on the benefits offered by these plans was not readily available and is not included in the table. Federal officials estimated that few individuals eligible to receive the HCTC had access to mini-COBRA coverage.

The eighth state we reviewed, California, did not designate any state-qualified coverage for HCTC recipients.

[a]Benefits are for services received within the health plan's network, if applicable.

[b]Separate annual deductibles are for one-person coverage. Prescription drug benefits could still be subject to an overall deductible for all medical services.

[c]In addition to the copayment or coinsurance amount for brand-name prescription drugs, the enrollee must pay any cost difference between the brand-name and generic drugs if there is a generic version available.

[d]Some states provided state-qualified HCTC coverage through arrangements with more than one insurer. In these instances, we selected the insurer with the highest HCTC enrollment. New York was unable to provide HCTC enrollment data for each of its state-qualified HCTC coverage options: we reviewed plans offered by an insurer that served areas in which companies had closed and HCTC-eligible individuals would likely have resided. The insurer with the largest HCTC enrollment in Pennsylvania sold coverage in both the central and western regions of the state and this coverage varied between regions.

[e]Benefit is offered as an option available for an additional monthly premium charge.

[f]Healthy NY Plus is an unsubsidized state-based health insurance plan available to HCTC recipients who do not meet the income criteria for the subsidized Healthy NY plan.

[g]Applies to coverage sold through HMOs only.

[h]More than one benefits package was offered by the insurer. We selected the benefits package most commonly purchased by HCTC recipients.

Appendix IV: Premiums Paid by Advance HCTC Enrollees

The cost of qualified health coverage for advance HCTC enrollees varied considerably across states. Total monthly premiums—representing both the individual and federal shares—were affected by the number of people covered on each enrollee's health plan and whether the advance HCTC enrollee was a TAA recipient or a PBGC beneficiary (see table 15). According to the HCTC program office, most advance HCTC enrollees purchased coverage for a single individual or for an individual and one other family member. On average, PBGC beneficiaries paid more for qualified coverage than TAA recipients.

Table 15: Average Total Monthly Premiums for Advance HCTC Enrollees, by State, February 2004

	TAA recipients		PBGC beneficiaries	
State	**Premium for 1 person**	**Premium for 2 people**	**Premium for 1 person**	**Premium for 2 people**
Alabama	$226	$476	$226	$427
Alaska	[a]	[a]	[a]	[a]
Arizona	312	654	323	587
Arkansas	334	589	397	1,028
California	253	443	279	495
Colorado	322	577	383	566
Connecticut	371	788	372	1,031
Delaware	360	690	666	970
District of Columbia	[b]	[b]	[b]	[b]
Florida	277	632	550	982
Georgia	291	706	403	557
Hawaii	[a]	[a]	[a]	[a]
Idaho	235	534	227	648
Illinois	321	788	598	595
Indiana	347	755	487	927
Iowa	284	554	270	510
Kansas	330	628	280	383
Kentucky	309	513	349	724
Louisiana	[a]	[a]	[a]	[a]
Maine	396	879	370	853
Maryland	320	707	478	929
Massachusetts	286	659	333	830
Michigan	373	820	403	861
Minnesota	276	583	327	691
Mississippi	262	[b]	453	868

	TAA recipients		PBGC beneficiaries	
State	Premium for 1 person	Premium for 2 people	Premium for 1 person	Premium for 2 people
Missouri	315	716	264	523
Montana	562	626	[b]	[b]
Nebraska	329	613	327	591
Nevada	[b]	[b]	267	801
New Hampshire	329	529	395	581
New Jersey	350	769	386	586
New Mexico	[a]	[a]	[a]	[a]
New York	267	454	378	719
North Carolina	415	716	478	997
North Dakota	[a]	[a]	[a]	[a]
Ohio	274	674	461	842
Oklahoma	273	527	277	891
Oregon	305	614	325	617
Pennsylvania	323	696	509	938
Puerto Rico	[b]	[b]	[b]	[b]
Rhode Island	[a]	[a]	[a]	[a]
South Carolina	310	591	676	869
South Dakota	[a]	[a]	[a]	[a]
Tennessee	336	636	421	897
Texas	321	662	481	693
Utah	[a]	[a]	[a]	[a]
Vermont	[a]	[a]	[a]	[a]
Virginia	275	543	393	839
Washington	337	663	289	520
West Virginia	312	774	441	933
Wisconsin	387	749	329	841
Wyoming	[b]	[b]	[b]	[b]
Average across states	$346	$660	$460	$877

Source: IRS's HCTC program office.

Notes: The most current state data available from the HCTC program office on the average monthly premium costs of TAA recipients and PBGC beneficiaries receiving the advance HCTC were from February 2004.

Data for Puerto Rico are also included in this table.

[a]Because of IRS disclosure and privacy regulations, premium data are only reported for states in which 10 or more individuals were receiving the advance HCTC in February 2004.

[b]There were no PBGC beneficiaries or TAA recipients using the advance HCTC to purchase plans covering this number of people in this state.

Appendix V: Amount Awarded for National Emergency Grants and High-Risk Pool Grants, by State, August 2004

	National emergency grant		High risk pool	
State	Bridge grant	Infrastructure grant	Seed grant	Operating grant
Alaska		$100,000		$495,769
Alabama		55,206		
Arizona		74,717		
Arkansas		200,000		1,764,129
California		50,000		
Colorado		184,615		2,945,322
Connecticut		189,700		1,460,719
Delaware		50,500		
Florida		288,020		
Georgia		199,953		
Hawaii		23,400		
Idaho		150,000		
Illinois		127,266		7,451,658
Indiana				2,889,802
Iowa		200,000		1,018,945
Kansas		150,000		1,337,299
Kentucky		50,000		2,297,008
Louisiana		50,000		
Maine	$7,500,000	136,853		
Maryland	5,632,000	579,867	$1,000,000	
Massachusetts		150,000		
Michigan		128,384		
Minnesota	4,000,000	81,551		1,710,789
Mississippi				1,890,350
Missouri		98,456		
Montana	266,923	36,572		638,228
Nebraska		97,156		719,841
Nevada		92,738		
New Hampshire		150,000	1,000,000	224,559
New Jersey	1,930,000	200,000		
New Mexico		78,499		
New York		214,425		
North Carolina	7,614,684	141,971		
North Dakota				310,349

	National emergency grant		High risk pool	
State	**Bridge grant**	**Infrastructure grant**	**Seed grant**	**Operating grant**
Ohio	1,600,000	222,105	150,000	
Oklahoma				2,681,597
Oregon		144,369		
Pennsylvania		394,908		
Rhode Island		152,000		
South Carolina		200,000		
South Dakota		57,760	1,000,000	
Tennessee		244,779		
Texas		200,000		
Utah	2,173,097	362,256	52,618	
Vermont		50,000		
Virginia	3,176,800	12,702		
Washington	1,512,000	74,219		
West Virginia	2,852,374	117,053	500,000	
Wisconsin		256,245		
Total awards	**$38,257,878**	**$6,818,245**	**$3,702,618**	**$29,836,364**
Total number of states	**11**	**45**	**6**	**16**

Sources: Department of Labor for national emergency grants and CMS for high-risk pool grants.

Appendix VI: Comments from the Department of Labor

U.S. Department of Labor

Assistant Secretary for
Employment and Training
Washington, D.C. 20210

SEP 16 2004

Ms. Kathryn G. Allen
Director
Health Care-Medicaid and
Private Health Insurance Issues
U.S. Government Accountability Office
441 G Street, NW
Washington, D.C. 20548

Dear Ms. Allen:

The Employment and Training Administration is in receipt of the draft Government Accountability Office (GAO) report, "HEALTH COVERAGE TAX CREDIT: Simplified and More Timely Process Could Increase Participation," GAO-04-1029. The objectives of the study were to examine: (1) how many individuals are receiving the Health Coverage Tax Credit (HCTC); (2) the factors influencing participation; and (3) the type and cost of coverage they purchase.

The report includes five specific recommendations for executive action. These include: (1) provide a centralized resource for individuals to receive information and assistance with HCTC eligibility criteria; (2) evaluate the effect of reducing service levels by the Internal Revenue Service (IRS) on the provision of timely and appropriate information, responses to inquiries, enrollment processing, and advance HCTC payments; (3) improve the quality of eligibility information provided by the states; (4) simplify IRS processing for advance HCTC recipients and avoid disruptions resulting from premium changes; and (5) provide a report to Congress regarding how Pension Benefit Guaranty Corporation (PBCG) beneficiaries receiving HCTC are affected due to turning 65. It is the first and third of these recommendations for executive action which appear to relate to the responsibilities of the Employment and Training Administration.

We believe the enclosed comments can improve the final report. If you would like additional information, please don't hesitate to contact me at (202) 693-2700.

Sincerely,

Emily Stover DeRocco

Enclosure

Pages 1 to 4 of the enclosed comments were technical in nature and are not reproduced in this report.

Specific Comments on the GAO Recommendations for Executive Action

Recommendation 1: To help individuals understand and comply with the multiple health coverage, labor, and tax eligibility requirements for receipt of the HCTC, the Secretary of Labor, the Commissioner of Internal Revenue, the Administrator of CMS, and the Executive Director of the PBGC should, in coordination with state officials, provide for a centralized resource for individuals to receive information and assistance with HCTC eligibility criteria, including individualized assistance in completing each step of the eligibility and enrollment process and information about qualified health coverage options available in their local area.

- ETA agrees that the provision of information to individuals regarding HCTC is essential because of the complexity of this program. However, we would recommend that there be a review of the existing system, including the quality of the information provided to individuals as well as the referrals made to other federal agencies and the state workforce agencies. This review would include the HCTC Contact Center, including the scripts and information trees that are currently used by the CSRs, and the ETA Help Line, including the scripts and information trees. Also of interest would be the role of the state workforce agencies in providing information. Once this review is completed, recommendations could be implemented to improve this system.

- In addition, we think it is important to summarize our accomplishments to date to implement the Trade Reform Act of 2002.

  - ✓ Upon enactment of the legislation in August 2002, 15 training sessions were conducted from November 2002 through January 2003 on the provisions of the Act in eight locations around the country. Theses sessions included representatives from state and local workforce investment entities, business groups, unions, intergovernmental organizations and other interested parties.

  - ✓ Numerous directives were developed and issued containing policy and guidelines on implementation of the Act's requirements. Directives provided guidance on how to apply for infrastructure grants to support building of the system to transmit the names of potentially eligible trade-certified individuals to the HCTC operations center, as well as how to apply for grants to support partial payment of health coverage premiums.

  - ✓ Outreach resources were developed to inform interested parties of the provisions of the new Act and how to access assistance for the HCTC. These resources include a new web site on the program and a brochure designed to provide businesses, unions, worker groups and interested individuals with information on the program.

5

- ✓ Six regional forums launched to emphasize the importance of an integrated approach among programs and funding streams serving dislocated workers, including situations where trade contributed importantly to the dislocation. These forums were used to clarify policy and guidance relative to the Act's provisions including the HCTC program.

Recommendation 3: To improve the quality of eligibility information provided by the states, the Secretary of Labor and the Commissioner of Internal Revenue should coordinate to improve the accuracy of data received from state workforce agencies.

- ETA agrees with this recommendation that the Department of Labor and the IRS need to continue to work together and assist the HCTC office and the state workforce agencies to improve the process and the data.

- On page 70, Appendix II, the GAO report states that "State-based continuation coverage pertaining to employers with fewer than 20 employees, also known as mini-COBRA coverage, was designated by 11 states, and was the sole state-qualified coverage option available to HCTC recipients in 3 states (see table 10)." ETA suggests that this sentence be revised as follows: "State-based continuation coverage pertaining to insurers providing coverage to plans maintained by employers with fewer than 20 employees, also known as mini-COBRA coverage.

Appendix VII: Comments from the Internal Revenue Service

COMMISSIONER

DEPARTMENT OF THE TREASURY
INTERNAL REVENUE SERVICE
WASHINGTON, D.C. 20224

September 8, 2004

Ms. Kathryn G. Allen
Director, Health Care–Medicaid and
Private Health Insurance Issues
United States Government Accountability Office
Washington, DC 20548

Dear Ms. Allen:

I have reviewed your proposed report entitled "Health Coverage Tax Credit: Simplified and More Timely Enrollment Process Could Increase Participation" (GAO-04-1029). Your report recognizes the challenges that the Internal Revenue Service (IRS) and other federal and state agencies, as well as private entities, faced in timely implementing the provisions of the Trade Adjustment Assistance Act of 2002 (Trade Act), which created the Health Coverage Tax Credit (HCTC).

The Trade Act provided important new benefits for eligible individuals but presented significant new responsibilities for the IRS. Responsibility for determining individuals' eligibility for the credit, and whether those eligible individuals had purchased qualified insurance, was spread among multiple state and federal agencies. In addition, as the nation's tax collector, IRS had to develop expertise in administering health insurance benefits, because we had neither systems nor processes in place to implement the advance payment option at the time of passage of the Trade Act. IRS' processes are based on receiving information and data from taxpayers and refunding payments to taxpayers. Because data for the advance payment is received from state agencies and health insurance providers, existing IRS tax systems could not be used to receive, retain, or verify that data and issue payments to third-parties.

As your report noted, IRS implemented the HCTC on time and addressed most early implementation issues. We designed and implemented an advance payment system for health coverage; learned to identify and enroll potentially eligible individuals from two other Government programs; established new relationships with states, health plans, and other partners; and accomplished this within a very short timeframe. Successful implementation of the HCTC within the timeframe set by Congress was the result of close collaboration between federal and state agencies and the use of contractors to administer the advance payment portion of the HCTC.

Since late 2002, the IRS established the HCTC program office, engaged the services of a contractor to aid in program design and implementation, developed new tax forms and outreach materials, established a customer contact center, published information on the IRS website for all partners and participants, and developed and enhanced processes

for processing HCTC claims made with the tax return. The IRS and the Department of the Treasury have been very aggressive in recruiting state-qualified plans. In February 2003 there were no state-qualified health plans and there are now 39 states with at least one designated qualified plan. Similarly, we have continuously worked with every state to help them understand the overall program, identify qualified health plans, and integrate federal-state efforts to maximize potentially eligible candidates' understanding and participation in the program.

As a result, more than 19,000 individuals were able to receive $37.3 million in HCTC benefits for the year 2003. The 19,000 includes individuals who enrolled in the advance payment program plus those who received the credit on their tax return, and a combination of both. In 2004, enrollment in the advance option is steadily growing. Over 12,000 are now enrolled in the advance program compared to 6,800 in 2003. Since the advance payment program's inception, a cumulative participation of 17,900 individuals has been achieved as of July 31, 2004. Most importantly, we have learned that an advance payment for health care coverage is a viable option for administering this program.

The Trade Act set out substantial requirements for qualification and enrollment, in a process requiring participants to interact with multiple federal and state agencies, as well as private insurers. The GAO report recognizes the complexities of the process and the agencies' efforts to minimize their effect on participants to the extent possible in light of legal requirements.

These successes are due in large part to new and important partnerships developed at the federal and state level. The IRS established working relationships with the Department of Labor (DOL) and the Pension Benefit Guaranty Corporation (PBGC) to coordinate our efforts, and also developed relationships with non-government organizations to obtain their assistance and support in establishing the HCTC program. We have relied on labor unions and health plan associations to inform their members about HCTC and its requirements, and both were instrumental in helping identify qualified plans and supplementing HCTC outreach to individuals in several states. These relationships and efforts were critical in launching the advance HCTC program and remain so as we work to improve the program. The HCTC program office also worked very hard to develop a system that was flexible and fulfilled a variety of health plans' needs and concerns. With considerable help from the health plan community, we believe we have addressed these issues and have an effective payment process in place.

However, as outlined in your report, some challenges remain. The IRS has and continues to use HCTC communication channels to emphasize the importance of state eligibility data quality, and has established the HCTC monthly eligibility review process as a tool for the states to use in their efforts to improve data quality. The IRS can only identify processing errors as they occur and recommend solutions, but the IRS does not

have the authority to require the states to implement them. Continued collaboration with DOL will be important as we work to consider and implement approaches that could improve overall data quality.

Participants who claim the HCTC in advance often must pay 100 percent of the cost of health coverage for possibly one or more months before they are enrolled in the advance payment program. How quickly an individual registers, provides the required documentation, and whether the individual's health plan is currently enrolled to receive advance payments from the HCTC program affect the number of months it takes to enroll in HCTC. As a result, to minimize burden on individuals, we are working very hard to shorten the HCTC enrollment period of 3–6 months. However, the first 3 months of the 3–6 month period is the result of the Trade Adjustment Assistance (TAA) certification requirements under the Trade Act.

To enable state workforce agencies to help individuals maintain their health coverage between job loss and advance payment of the HCTC, the Trade Act established National Emergency Grant (NEG) Bridge funds. The IRS does not directly administer the NEG Bridge program, but has integrated the availability of NEG funds into HCTC marketing and outreach efforts. Additionally, we continue to explore opportunities to streamline our processes to expedite individuals' receipt of the HCTC.

The IRS is transitioning the HCTC Program from development and implementation to an operational environment. Recent contract restructuring has resulted in a projected savings of close to 30 percent. The IRS is also identifying ways to use existing IRS resources to supplant contractor resources, and projects that annual operating costs will decrease as processes are enhanced. An analysis by IRS' Office of Program Evaluation and Risk Analysis, currently underway, will identify administrative process and efficiency improvements and gain insights to eligibility demographics that will help maximize the effectiveness of our outreach efforts.

We would like to clarify several observations in your report regarding qualified health plans. First, the report mentions the diversity in benefits offered in various state qualified plans. The Trade Act does not give the IRS the authority to regulate the benefits offered by state qualified plans. This is a decision made solely by the states and the plans that voluntarily agree to participate. The IRS' role is limited to (1) verifying through the states, typically the state Department of Insurance, that the plans meet the four consumer protections established in the Trade Act and (2) providing state-qualified plan contact information on the IRS web site and through the HCTC customer contact center. Potentially eligible individuals must contact the qualified plans directly to obtain information about benefits or premiums.

Second, some plans have expressed a reluctance to participate in the HCTC program because they are unsure of the HCTC population's health status. A number of participating plans and plan associations have agreed to help the IRS establish a better

understanding of the enrolling population when a full calendar year of data are available, some time in 2005. We hope that this data will help encourage more health plans to participate in the HCTC. Finally, the consumer protections in the Trade Act differ significantly from existing state and federal insurance laws. This creates substantial uncertainty for insurers trying to decide whether to participate in the HCTC program.

We agree with your recommendations to accept notification of premium changes from participating health plans rather than relying on participants to provide this information. We will also work with PBGC to estimate the number of PBGC beneficiaries previously receiving HCTC that have lost their eligibility at attaining age 65 and the number whose spouses and/or dependents also have become ineligible for the HCTC due to the beneficiaries ineligibility upon turning age 65. We recognize that changes, such as amending certain TAA program requirements and helping eligible individuals maintain their rights to guaranteed coverage, may have broader implications for labor and health policy.

Our specific response to your recommendation for Executive Action is attached.

We appreciate the opportunity to address your recommendation and look forward to working with DOL, PBGC, and the states in improving the enrollment process, expediting payments, and improving outreach to potential participants. If you have any questions, please call Floyd Williams, Director, Legislative Affairs, at (202) 622-3720.

Sincerely,

Mark W. Everson

Enclosure

Enclosure

The IRS' Response to Recommendations included in GAO-04-1029, "Health Coverage Tax Credit -- Simplified and More Timely Enrollment Process Could Increase Participation."

Recommendation
We recommend that the Secretary of Labor, Commissioner of Internal Revenue, Administrator of Centers for Medicare and Medicaid Services (CMS), and Executive Director of the PBGC work together to take the following five actions.

The IRS generally agrees, and our responses to each of the recommended actions are as follows:

A) To help individuals understand and comply with the multiple health coverage, labor, and tax requirements for receipt of the HCTC, the Secretary of Labor, the Commissioner of Internal Revenue, the Administrator of CMS, and the Executive Director of the PBGC should, in coordination with state officials, provide for a centralized resource for individuals to receive information and assistance with HCTC eligibility criteria, including individualized assistance in completing each step of the eligibility and enrollment process and information about qualified health coverage options available in their local area.

Response
Early on the IRS recognized the benefits of centralizing information and assistance for HCTC candidates. We made significant efforts to lay the foundation for delivering consistent messages about HCTC and, to the greatest extent possible, provide a centralized source of HCTC information and assistance with input from our federal, state, and private partners. The results of our efforts include:

- The HCTC brochure, program kit and registration form for individuals,
- The State Toolkit, which outlined roles and responsibilities and provided training for Governors' offices, state departments of insurance, and the state workforce agencies,
- Extensive content on the IRS website (www.irs.gov), and
- Early establishment of the HCTC Customer Contact Center, offering individuals, our partners, and the public another significant resource to address questions about the program.

Additionally, together with representatives from multiple state agencies, local qualified health plans, and labor unions, we organized a series of on-site registration sessions in 11 states. These sessions provided individualized assistance in completing each step of the eligibility and enrollment process. While over 4,000 HCTC candidates attended the sessions and over half completed forms or registered to receive advance payments, none of the agencies or health plans

involved have the resources to support such an effort on a routine basis. The IRS has explored requirements for creating a virtual registration support capacity. However, the numbers of affected agencies and health plans, as well as privacy and disclosure issues, make such a solution a major challenge.

In the interim, we will explore further development of our web and call center capabilities as we work with the Department of Labor (DOL), PBGC, and CMS to identify any possible cost-effective ways to meet this need we have not already considered.

B) To ensure that HCTC-eligible individuals and recipients receive timely and appropriate information, responses to inquiries, enrollment processing, and advance HCTC payments, the Commissioner of Internal Revenue should evaluate the effect that any reduced service levels will have on eligible individuals and health plans' ability to receive the HCTC on a timely basis, and their satisfaction with the information and services provided.

Response
Your report highlights our service level for processing HCTC registrations. This service level has not changed. The service levels most recently defined are part of our transition from implementation to operations. We will continue to monitor service levels and their impact on delivering quality service to our partners and customers. We will adjust our capabilities to meet changing demand. At this time, we cannot systemically measure customer satisfaction. However, we will include appropriate questions in future HCTC customer and stakeholder research that will give us an indication of changes in satisfaction.

C) To improve the quality of eligibility information provided by the states, the Secretary of Labor and the Commissioner of Internal Revenue should coordinate to improve the accuracy of data received from state workforce agencies.

Response
Although the IRS and DOL have taken several steps to address this problem, we agree that the quality of eligibility information provided by the states continues to present a challenge. As your report notes, the lists of eligible individuals provided by state workforce agencies and the PBGC are accepted by the IRS as valid and form the basis for participation in the HCTC Program. We will work with them to develop an action plan for improving the accuracy of eligibility data.

D) To simplify payment processing for advance HCTC recipients and avoid disruptions resulting from premium changes, the Commissioner of Internal Revenue should encourage participating health plans to provide notification of changes in premiums directly to the HCTC program office rather than relying primarily on individuals for providing this information.

Response
The IRS agrees that accepting notification of premium changes from participating health plans would be an administrative improvement. However, because of the number of plans and individuals affected, there are a significant number of issues that must be addressed. As a result, we will develop an action plan to phase in this change so we can monitor results and make adjustments based on plan and participant feedback.

E) Given that as PBGC beneficiaries turn 65 they lose eligibility for the HCTC even though their spouses or other dependents may not yet be Medicare-eligible or have alternative sources for insurance coverage, the Executive Director of PBGC, in coordination with the Commissioner of Internal Revenue, should report to the Congress on how many PBGC beneficiaries previously receiving the HCTC have lost eligibility due to turning 65, and how many of these former HCTC recipients have spouses or other dependents who are no longer able to receive coverage subsidized by the HCTC.

Response
We will work with the PBGC to develop this information and make it available to the Congress. This information may require the inclusion of estimates for some data elements that are not readily available to either the IRS or the PBGC.

Appendix VIII: Comments from the Centers for Medicare & Medicaid Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

SEP 24 2004

DATE:

TO: Kathryn G. Allen
Director, Health Care --Medicaid
And Private Health Insurance Issues
Government Accountability Office

FROM: Mark B. McClellan, M.D., Ph.D.
Administrator

SUBJECT: Government Accountability Office (GAO) Draft Report: *HEALTH COVERAGE TAX CREDIT: Simplified and More Timely Enrollment Process Could Increase Participation* (GAO-04-1029)

Thank you for the opportunity to review and comment on the above-referenced GAO draft report. Although the Centers for Medicare & Medicaid Services (CMS) was only involved in the implementation of the high risk pool grant programs, we agree with the intent and goals of the Health Care Tax Credit (HCTC) Program and feel that GAO is providing an invaluable service in its review of the implementation of the HCTC program.

Because the draft report accurately states the status of the high-risk pool grant programs, we do not have any substantive comments on the report. Attached are CMS' comments on the specific recommendations, none of which addresses the high- risk pool grant programs.

Attachment

Centers for Medicare & Medicaid Services' (CMS) Comments to the Government Accountability Office (GAO) Draft Report: *HEALTH COVERAGE TAX CREDIT: Simplified and More Timely Enrollment Process Could Increase Participation* (GAO-04-1029)

We recommend that the Secretary of Labor, Commissioner of Internal Revenue, Administrator of CMS, and Executive Director of the PBGC take the following five actions:

GAO Recommendation

To help individuals understand and comply with the multiple health coverage, labor, and tax eligibility requirements for receipt of the HCTC, the Secretary of Labor, the Commissioner of Internal Revenue, the Administrator of CMS, and the Executive Director of the PBGC should, in coordination with state officials, provide for a centralized resource for individuals to receive information and assistance with HCTC eligibility criteria, including individualized assistance in completing each step of the eligibility and enrollment process and information about qualified health coverage options available in their local area.

CMS Response

The Internal Revenue Service has the lead in the HCTC outreach and education. We defer to the Commissioner of Internal Revenue.

GAO Recommendation

To ensure that HCTC-eligible individuals and recipients receive timely and appropriate information, responses to inquiries, enrollment processing, and advance HCTC payments, the Commissioner of Internal Revenue should evaluate the effect that any reduced service levels will have on eligible individuals and health plans' ability to receive the HCTC on a timely basis and their satisfaction with the information and services provided.

CMS Response

This recommendation does not impact CMS jurisdiction. We defer to the Secretary of Labor, Commissioner of Internal Revenue, and Executive Director of the PBGC.

GAO Recommendation

To improve the quality of eligibility information provided by the states, the Secretary of Labor and the Commissioner of Internal Revenue should coordinate to improve the accuracy of data received from state workforce agencies.

CMS Response

This recommendation does not impact CMS jurisdiction. We defer to the Secretary of Labor, Commissioner of Internal Revenue, and Executive Director of the PBGC.

GAO Recommendation

To simplify payment processing for advance HCTC recipients and avoid disruptions resulting from premium changes, the Commissioner of Internal Revenue should encourage participating health plans to provide notification of changes in premiums directly to the HCTC program office rather than relying primarily on individuals for providing this information.

CMS Response

This recommendation does not impact CMS jurisdiction. We defer to the Secretary of Labor, Commissioner of Internal Revenue, and Executive Director of the PBGC.

GAO Recommendation

Given that as PBGC beneficiaries turn 65 they lose eligibility for the HCTC even though their spouses or other dependents may not yet be Medicare-eligible or have alternative sources for insurance coverage, the Executive Director of the PBGC, in coordination with the Commissioner of Internal Revenue, should report to the Congress on how many PBGC beneficiaries previously receiving the HCTC have lost eligibility due to turning 65, and how many of these former HCTC recipients have spouses or other dependents who are no longer able to receive coverage subsidized by the HCTC.

CMS Response

This recommendation does not impact CMS jurisdiction. We defer to the Secretary of Labor, Commissioner of Internal Revenue, and Executive Director of the PBGC.

Appendix IX: Comments from the Pension Benefit Guaranty Corporation

Pension Benefit Guaranty Corporation
1200 K Street, N.W., Washington, D.C. 20005-4026

Office of the Executive Director

SEP 0 2 2004

Ms. Kathryn G. Allen, Director
Health Care - Medicaid and Private Health Insurance Issues
Government Accountability Office
441 G St., NW (Room 5A14)
Washington, DC 20548

Dear Ms. Allen:

Thank you for the opportunity to review and comment on your draft report entitled, *Health Coverage Credit: Simplified and More Timely Enrollment Process Could Increase Participation* (GAO-04-1029).

As discussed at the exit conference, the Internal Revenue Service (IRS) is primarily responsible for administration of the Health Coverage Tax Credit (HCTC) program. PBGC helps promote the program by highlighting it in *Your Guaranteed Pension* and various PBGC newsletters. PBGC also provides participant data to the IRS's HCTC program office so that it may follow up with beneficiaries regarding their potential eligibility under the program. Finally, PBGC refers participants and beneficiaries that contact our Customer Service Center regarding this program to the HCTC Program Customer Contact Center's 1-800 number.

Two of the report's five recommendations relate to PBGC, and we provide our specific responses, as follows:

GAO Recommendation:

To help individuals understand and comply with the multiple health coverage, labor, and tax requirements for receipt of the HCTC, the Secretary of Labor, the Commissioner of Internal Revenue, the Administrator of CMS, and the Executive Director of the PBGC should, in coordination with state officials, provide for a centralized resource for individuals to receive information and assistance with HCTC eligibility criteria, including individualized assistance in completing each step of the eligibility and enrollment process and information about qualified health coverage options available in their local area.

PBGC Response:

PBGC defers to the other agencies responsible for administration of the HCTC program on this recommendation to provide a centralized resource for HCTC information. PBGC will continue support the IRS and coordinate with other agencies, as needed, to help address this recommendation.

GAO Recommendation:

Given that as PBGC beneficiaries turn 65 they lose eligibility for the HCTC even though their spouses or other dependents may not yet be Medicare-eligible or have alternative sources for insurance coverage, the Executive Director of PBGC, in coordination with the Commissioner of Internal Revenue, should report to the Congress on how many PBGC beneficiaries previously receiving the HCTC have lost eligibility due to turning 65, and how many of these former HCTC recipients have spouses or other dependents who are no longer able to receive coverage subsidized by the HCTC.

PBGC Response:

PBGC suggests that IRS, as the lead agency responsible for administering the HCTC program, should submit the report to Congress called for in the recommendation. PBGC has and will continue to work closely with the IRS in support of their administration of the HCTC program, particularly by providing information on PBGC recipients who may be eligible for the HCTC. Also, we note that PBGC benefit administration does not require information on spouses of all PBGC participants, therefore, we do not have this information for many participants. We can provide the IRS with spousal information on some, but not all, PBGC recipients.

Again, we thank you for the opportunity to review and comment on this proposed report and appreciate your work in reviewing this important program.

Sincerely,

Bradley D. Belt
Executive Director

Appendix X: GAO Contact and Staff Acknowledgments

GAO Contact

John E. Dicken, (202) 512-7043

Acknowledgments

The following staff made important contributions to this report: N. Rotimi Adebonojo, JoAnne R. Bailey, Elizabeth T. Morrison, and Pamela N. Roberto.

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