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Health Coverage Tax Credit Authorized by the Trade Act

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Summary

The Trade Act of 2002 (P.L. 107-210) authorized a federal income tax credit of 65% of what eligible taxpayers pay for qualified health insurance for themselves and their family members. The credit is refundable, so taxpayers may claim the full credit even if they have little or no federal income tax liability. The credit can also be advanced, so taxpayers need not wait until they file their tax returns in order to benefit from it. The credit is called the health coverage tax credit (HCTC) by the Internal Revenue Service, the principal federal oversight agency, though other names are used as well.

Eligibility for the HCTC is limited to three groups of taxpayers. The first two consist of individuals who are eligible for Trade Adjustment Assistance allowances because they have lost manufacturing jobs due to increased foreign imports or shifts in production outside the United States. The third consists of individuals whose defined benefit pension plans were taken over by the Pension Benefit Guaranty Corporation due to financial difficulties. Eligible individuals cannot be enrolled in certain other health insurance (e.g., Medicaid) or entitled to certain other coverage (e.g., Medicare Part A).

The HCTC can be claimed only for 10 types of insurance coverage specified in the statute, seven of which require state action to become effective. As of November, 2004, 39 states and the District of Columbia made at least one of these seven forms of coverage available; in the remaining 11 states, only the three automatically qualified forms not requiring state action were available, though not to all who were eligible for the credit.

The HCTC is of interest to policy makers searching for ways to help people acquire and maintain health insurance coverage. Debates both before and after its enactment reflect a larger controversy over the use of tax incentives in financing healthcare, in contrast to expanding public programs such as Medicare and Medicaid.

The HCTC is not widely used. As of November 2004, 13,369 of the estimated 223,307 taxpayers who were potentially eligible for the credit were receiving advance payments, or about 6%. Others might be claiming the credit without an advance payment, but their number is not likely to be large. Reasons why eligible people do not use the credit include difficulties finding qualified insurance and difficulties paying the part of the premium not covered by the credit (the remaining 35%).

A number of bills were introduced in the 108th Congress to expand eligibility for the HCTC and exempt state qualified plans from its consumer protection provisions. As these measures were not enacted, they might be reintroduced in the 109th Congress. There may also be proposals for expanded tax credits that are generally available to lower and modest income families. This report will be updated as legislative activity occurs and more information about the credit and insurance options becomes available.

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The Trade Act of 2002 (P.L. 107-210) authorized a federal income tax credit of 65% of what eligible taxpayers pay for qualified health insurance for themselves and their family members. The credit is refundable, so taxpayers may claim the full credit even if they have little or no federal income tax liability. The credit can also be advanced, so taxpayers need not wait until they file their tax returns in order to benefit from it.

The credit is called the "health coverage tax credit" (HCTC) by the Internal Revenue Service on its website and in its forms and publications.[1] However, the credit is sometimes known as the "trade adjustment assistance credit" (or TAA credit) and the "Trade Act credit," and it appears in budget documents as the "tax credit for health insurance purchased by certain displaced and retired individuals."[2] This report uses the term HCTC to conform to IRS practice.

The HCTC is of interest to policy makers searching for ways to help people acquire and maintain health insurance coverage. Debates both before and after its enactment reflect a larger controversy over the use of tax incentives in financing healthcare, in contrast to expanding public programs such as Medicare and Medicaid.

This report begins by summarizing the detailed, complex rules regarding eligibility and qualified insurance for the HCTC. It then discusses steps the federal government and the states have taken to implement the credit. Next, the report discusses issues related to why the credit is not widely used — about 6% of the eligible population is claiming it — and whether it is equitable from a tax perspective. The report concludes with a brief discussion of legislation in the 108th Congress regarding the credit.

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[1] On the IRS website [http://www.irs.gov], search for "HCTC"in the box in the upper-left corner of the screen and then click on the overview document, which has links for individuals, state agency officials, and health plan officials as well as a glossary and a list of frequently-asked questions.

[2] *Analytical Perspectives, Budget of the United States Government, Fiscal Year 2005*, p. 312 and the accompanying tables. A similar phrase is used in Joint Committee on Taxation documents.

Eligibility for the HCTC

To claim the HCTC, taxpayers must be in one of three eligibility groups and not enrolled in (or sometimes even eligible for) certain types of health insurance. Some other statutory limitations also apply. In addition, eligible taxpayers must pay for qualified health insurance, the rules for which are discussed immediately after this section.

Eligibility Groups

Three groups of taxpayers are eligible to claim the HCTC:

- individuals receiving a *Trade Readjustment Assistance (TRA) allowance* under the Trade Adjustment Assistance (TAA) program, including those eligible for but not yet receiving the allowance because they have not yet exhausted their state unemployment benefits;
- individuals age 50 and over receiving an *Alternative Trade Adjustment Assistance (ATAA) allowance* under the TAA program; and
- individuals age 55 and over receiving a *Pension Benefit Guaranty Corporation (PBGC) pension payment*, including those who received a lump sum payment from the PBGC after August 5, 2002.

The first two groups consist of individuals who have lost manufacturing jobs due to increased foreign imports or shifts in production outside the United States. The U.S. Department of Labor (DOL) must certify that workers dislocated by these events are eligible for TAA assistance; this occurs upon petition from the workers, the affected company, a union, or others. After a petition is certified, workers are notified by a state workforce agency (SWA) and may apply for TAA benefits at One-Stop Career Centers.[3] TAA benefits include counseling and other employment services, job search and relocation allowances, training, and a TRA or ATAA allowance.[4]

TRA Allowance. To be eligible for a TRA allowance (the first group identified above), individuals must qualify for state unemployment compensation, have worked for the affected firm at least 26 of the 52 weeks preceding their layoff, and had weekly wages from the firm of at least $30. Usually they must be participating in TAA-approved training. The TRA allowance is paid after state

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[3] State workforce agencies are state offices, funded by the DOL, that are responsible for administering unemployment insurance, employment and training services, and labor market information programs in the 50 states and the District of Columbia. One-Stop Career Centers are part of a coordinated delivery system of employment and training services; they are organized by local workforce investment boards under the Workforce Investment Act of 1998. They can be located at [http://www.servicelocator.org].

[4] Information on TAA certification and benefits is available through the DOL website at [http://www.doleta.gov/tradeact/]. For an overview, see CRS Report 94-478, *Trade Adjustment Assistance for Workers: A Fact Sheet*, by Paul J. Graney.

unemployment benefits are exhausted; these benefits generally last several months for some workers in certain states to a half year for others. (In most states, the maximum time period for unemployment benefits is 26 weeks, though workers with some work histories qualify for less. Benefits are sometimes extended beyond the 26-week period due to federal legislation or triggers based on higher unemployment rates.) The basic TRA allowance then provides 26 weeks of support, though it can be followed by 52 weeks of an additional allowance to assist completion of training. A further 26 weeks is allowed for those receiving remedial education. Persons in all these TRA groups are eligible for the HCTC as long as they are receiving either unemployment benefits or the allowance, and for one month afterwards.[5]

ATAA Allowance. To be eligible for an ATAA allowance (the second group identified above), individuals must obtain re-employment full-time (other than at the affected firm) within 26 weeks of separation from employment, be at least 50 years of age, and not earn more than $50,000 a year. The DOL must determine that a significant number of workers at the affected firm were age 50 or older and had job skills not easily transferable to other employment; competitive conditions within the workers' industry are considered as well.[6] The ATAA allowance is an option to other TAA benefits; individuals who elect it receive an allowance equal to 50% of the difference between their wage at the affected firm and their re-employment wage. Payments cannot exceed $10,000 over the course of two years. Eligibility for the ATAA allowance and thus for the HCTC is limited to two years.[7]

PBGC Pension Benefit. To receive a PBGC pension benefit (the third group identified above), individuals must have worked for a firm whose defined benefit pension plan was insured and then taken over by the agency.[8] The PBGC assumes control of defined benefit plans (pension plans that promise to pay a specific monthly benefit at retirement) when it determines the plans must be terminated to protect the interests of participants (for example, if currently due benefits cannot be paid) or when employers demonstrate they cannot remain in business unless the plan is terminated. The PBGC uses plan assets and its own insurance reserves to pay the pensions (up to a guaranteed amount) to the former workers and their survivors. Individuals receiving PBGC-paid pensions are eligible for the HCTC provided they are at least 55 years of age but not yet entitled to Medicare (which usually occurs at age 65).

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[5] Section 35(c) of the Code extends eligibility for the HCTC for one month following the end of TAA eligibility; this would apply to individuals receiving a TRA allowance.

[6] The ATAA program is a demonstration program, limited to five years from implementation by a state.

[7] Section 35(c) of the Code extends eligibility for the HCTC for one month following the end of TAA eligibility; this apparently would apply to individuals receiving an ATAA allowance. However, Section 246(a)(2)(B) of the Trade Act of 1974 as amended by the Trade Act of 2002, expressly limits their eligibility to two years.

[8] Information on the PBGC is available through its website at [http://www.pbgc.gov]. For an overview, see CRS Report 95-118, *Pension Benefit Guaranty Corporation: A Fact Sheet*, by Paul J. Graney, and CRS Report RL32702, *Can the Pension Benefit Guaranty Corporation be Restored to Financial Health?*, by Neela Ranade.

Limitations on Eligibility

Individuals in the three groups just described are not eligible for the HCTC if they have other specified health insurance coverage; this includes being *enrolled* in the following health plans:

- a plan (including COBRA elections described below) maintained by the individual's employer or former employer (or the spouse's employer or former employer) that pays 50% or more of the cost;[9]
- Medicare Part B (primarily covers doctors' services and outpatient hospital care);
- the Federal Employees Health Benefits Program (FEHBP);
- Medicaid; or
- the State Children's Health Insurance Program (SCHIP).

Similarly, eligible individuals cannot be *entitled* to the following coverage:

- Medicare Part A (primarily for inpatient hospital care); or
- coverage provided through the U.S. military health system (e.g., Tricare or CHAMPUS)

In addition, individuals are not eligible for the HCTC if they are imprisoned or if they may be claimed as a dependent by another taxpayer.

Family Members

Eligible individuals may use the HCTC for health insurance that covers a spouse and dependents who can be claimed on their tax return. For this purpose, children of divorced or separated parents are treated as dependents of the custodial parent.

Qualifying family members cannot be enrolled in or entitled to the insurance described above (e.g., Medicaid). They also cannot claim the credit on their own — when the eligible individual loses eligibility, the credit no longer applies to the family members.

Qualified Insurance

Eligible individuals can claim the HCTC only if they make payments for qualified insurance. The statute limits qualified insurance to ten different categories of coverage, identified as options (A) through (J). The credit cannot be claimed for other insurance.

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[9] Premiums paid by employees through a cafeteria plan (i.e., premium conversion arrangements) are considered to be paid by the employer. Additional eligibility restrictions apply to ATAA individuals for certain types of insurance if their current or previous employer (or the current or previous employer of a spouse) pays part of the coverage, or the premium could be paid on a pre-tax basis.

Three of the coverage categories are known as *automatically qualified health plans*. Individuals may elect these options without involvement by their state. These options (identified by their statutory letter designation) are as follows:

A. Coverage under a COBRA continuation provision;[10]

I. Coverage under a group health plan available through the employment of a spouse; and

J. Coverage under individual health insurance *provided* the eligible individual was covered under this type of insurance for the entire 30-day period ending on the date the individual became separated from employment which qualified the individual as a TAA, ATAA, or PBGC pension recipient.[11]

The other seven categories of coverage are known as *state qualified plans*; individuals may choose these options only if their state has chosen or established these plans to be included as qualified coverage. These options (identified by their statutory letter designation) are as follows:[12]

B. State-based continuation coverage provided by a state under state law requiring such coverage;

C. Coverage offered through a state high-risk pool;

D. Coverage under a plan offered for state employees;

E. Coverage under a state-based plan that is comparable to the plan offered for state employees;

F. Coverage through an arrangement entered into by a state and a group health plan, an issuer of health insurance, an administrator, or an employer;

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[10] COBRA refers to the Consolidated Omnibus Budget Reconciliation Act of 1985 (P.L. 99-272). Title X of this legislation requires employers with 20 or more employees that offer health insurance to provide the option of continuing coverage to their employees and their families under certain circumstances (including termination or reduction in hours of employment, death, divorce or legal separation, enrollment in Medicare; or the end of a child's dependency under a parent's health plan) for a limited time. Employers may charge the beneficiary for this coverage up to 100% of the premium (counting both the employer and employee share) plus 2% for administrative expenses. Individuals generally have 60 days from formal notification by the employer in which to elect COBRA coverage, though Section 203(e) of the Trade Act of 2002 authorizes an extension of the election period for individuals who are eligible for TAA assistance. For additional information, see CRS Report RL30626, *Health Insurance Continuation Coverage under COBRA*, by Heidi G. Yacker.

[11] The requirement for prior coverage does not apply to individual insurance obtained through a state qualified plan. This exception is not explicit in the statute.

[12] For a current list and contact information of state qualified plans in each state, see the link through the IRS website at [http://www.irs.gov/individuals/article/0,,id=110016,00.html].

G. Coverage through a state arrangement with a private sector health care purchasing pool; and

H. Coverage under a state-operated plan that does not receive any federal financing.

Coverage under state qualified plans must provide consumer protections to all *qualifying* individuals.[13] Plans must guarantee issue (offer coverage to all qualifying applicants) and not deny coverage based on preexisting conditions. Premiums (without regard to subsidies) must not be greater for qualifying individuals than for other similarly situated individuals, and benefits for qualifying individuals must be the same as or substantially similar to those for others. In short, the statute attempts to ensure that state qualified plans are open to all qualifying applicants and do not charge more or provide fewer benefits to people who are receiving the credit. The consumer protections do not preclude use of medical underwriting to set premiums.

Certain types of coverage are not considered qualified plans (even if they otherwise fall in one of the categories above); these include accident or disability income insurance, liability insurance, workers compensation insurance, automobile medical payment insurance, credit-only insurance, coverage for on-site medical clinics, limited scope dental or vision benefits, long-term care insurance, coverage for a specified disease or illness, hospital and other fixed indemnity insurance, and supplemental insurance.

Implementation

The HCTC involves a number of federal and state agencies. The Department of the Treasury is primarily responsible for administering the advance payment system and, through the Internal Revenue Service, reviewing tax returns on which the credit is claimed. The Department of Labor (DOL) and the Pension Benefit Guaranty Corporation (PBGC) are responsible for helping Treasury identify who might be eligible for the credit. DOL also administers two grant programs that provide assistance to states for helping individuals enroll and for covering 35% of the premium for certain individuals. State-level entities include state workforce agencies, state health agencies, and state insurance commissioners.

Treasury has contracted with Accenture, a for-profit consulting company, to help administer the advance payment system. Accenture operates the HCTC

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[13] The four consumer protections mentioned apply to "qualifying" individuals, defined in the statute as eligible individuals (as described above) who had three months of creditable coverage in another health plan prior to applying for a state qualified plan. The requirement that creditable coverage immediately precede the application appears in the IRS guidance; it is not explicit in the statute. Even so, a break in coverage of up to 62 days is allowed between having prior coverage and enrolling in the new plan. IRS guidance explicitly provides that preexisting condition exclusions may be imposed if the individual has less than three months of creditable coverage.

Customer Contact Center, which registers people for advance payments and sends them monthly invoices for premium payments.

Notifying Eligibles

Toward the end of 2002, DOL's Employment and Training Administration requested that state workforce agencies (SWAs) mail HCTC information packets to all eligible TAA recipients or persons who would be eligible for TAA allowances as soon as they exhaust their unemployment benefits.[14] SWAs are also required to submit to the HCTC office a daily listing of persons eligible for TAA and ATTA.[15]

Similarly, the PGBC identified beneficiaries who are potentially eligible for the HCTC and provided the IRS with their relevant personal records — including names, addresses, social security numbers, and dates of birth.[16] Starting in February 2003, the IRS sent information packets, including forms and instructions for claiming the credit, to those persons in the PGBC list.

The HCTC office continues to mail packets to persons whose names are included on the lists provided to them by the SWAs and PGBC. These packets are approximately 20 pages and are available in English and Spanish. Labor unions and advocacy groups also inform members of their potential eligibility.

The HCTC program has had difficulty notifying one group of eligibles: persons who are receiving unemployment compensation but have not yet applied for TAA benefits. Unless they petition the DOL directly, their names and contact information are not easily identified. Unemployment compensation can last up to 26 weeks in most states, and recipients often don't apply for TAA benefits until near the end of that period. These persons, probably the largest group of TAA eligibles, generally will not receive notification about their HCTC eligibility until their unemployment benefits end.

Availability of a Qualified Health Plan

The HCTC is available only to eligible taxpayers who enroll in one of the 10 categories of qualified health plans described above. The three automatically qualified plans are available in all states, but only for certain individuals. COBRA continuation of prior employment-based coverage (letter A in the list under the "Qualified Insurance" section) is available only if one's previous employer continues to offer health insurance coverage to its remaining workers or retirees; if the company drops coverage completely or goes out of business, a COBRA election is not possible. Coverage under a group health plan available through the employment of a spouse (letter I) is available only if one is married and the spouse has coverage, two

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[14] U.S. Department of Labor, Employment and Training Administration, Advisory System, *Training and Employment Guidance Letters No. 05-03 and No. 16-02.*

[15] For more information about SWA's reporting requirements, see the questions and answers about HCTC on [http://www.doleta.gov//tradeact/directives/UIPL33-03_AttachA.cfm].

[16] 67 *Federal Register* 66674, Nov. 2, 2002.

conditions that might not apply. Even if the spouse has coverage, the credit is not available if the spouse's employer pays 50% or more of the cost, which usually is the case, as mentioned in the "Limitations on Eligibility" section, above. Finally, coverage under an individual health insurance plan (letter J) generally is not available due to the requirement that the worker had such coverage before loss of employment.[17]

The remaining seven qualified health plans (letters B through H) are available only if states designate them as qualified insurance. As of early November, 2004, 39 states and the District of Columbia had made at least one of these seven forms of coverage available. In the other 11 states, individuals who are eligible for the HCTC can only select one of the three automatically qualified plans, but only if it is available to them.

Claiming the Credit

Eligible taxpayers with qualified insurance may choose to receive the HCTC after they file their tax returns for the year, generally in the period February 1 through April 15 of the following year. Alternatively, they may choose to receive advance payments for the credit throughout the year. Some might choose to receive a portion of the credit through advance payments and the remainder after they file their return. Advance payments are not available for coverage through a spouse's employment.

Next-Year Payments. Taxpayers claim the HCTC after the tax year is over by completing Form 8885 and attaching it to their standard Form 1040. The credit cannot be claimed with standard forms 1040A or 1040EZ. Taxpayers must attach invoices and proof of payment to qualified health plans.

As the HCTC is refundable, taxpayers may receive the full amount for which they are eligible even if they have little or no tax liability. Their other tax credits have no effect on their HCTC, nor does the HCTC affect their other credits.

Advance Payments. To receive advance payments of the credit, individuals register with the HCTC program through its Customer Contact Center (telephone number 1-866-626-4282). They must be enrolled in a qualified health plan when they register. The program confirms applicants' eligibility and sends them an invoice for 35% of the total monthly premium. Participants send payments for this share plus additional premium charges for non-qualified family members (if applicable) to the Department of the Treasury. Upon receipt of these funds, Treasury sends payment for 100% of the premium (35% from the participant and 65% from Treasury) to the participants' health insurance plans. The payment system continues in this way on a monthly basis. Advance payments became available in August 2003.

Advance payments are available for individuals who make timely payments. Individuals who make late or partial payments generally have to pay their insurance plan directly to maintain coverage, though they can continue to claim the tax credit.

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[17] Prior individual coverage would not be required to obtain individual coverage under a state qualified plan.

Grants to States

Section 203 of the Trade Act of 2002 expanded the National Emergency Grant program to support implementation of the HCTC.[18] It authorized two new state grant programs to be administered by DOL, Infrastructure grants and Gap Filler grants (previously referred to as Bridge grants). In a related development, Section 201 of the act authorized new funds to be made available through the Department of Health and Human Services (DHHS) to help states create new high risk pools and operate existing ones.

Infrastructure Grants. These grants assist states in developing systems and infrastructure to conduct eligibility verification, notify eligible individuals, process insurance credit eligibility certificates, provide enrollment assistance, and develop and install data management systems. They are also intended to assist with processing Gap Filler grants. Once the systems and procedures are in place and the state is processing requests for healthcare coverage, the state may submit a request to modify the grant award to cover ongoing operational costs for these activities. Distributions are based on the states' anticipated costs.

For these grants, the act appropriated $10 million for fiscal year (FY)2002. As of November 2004, $6.9 million had been distributed to states and about $3 million had not yet been distributed.[19] **Table 1** in the Appendix shows which states received grants and how much they received. States have five years to spend the funds.

The act also authorized appropriations of $60 million for each of fiscal years 2003 through 2007. Actual appropriations for FY2003 were $29.8 million. These funds are intended for use by both the Infrastructure and Gap Filler grant programs. As of November 2004, these funds had not yet been distributed for Infrastructure Grants. For FY2004, funding for Infrastructure Grants is available through the Dislocated Worker National Reserve Account, authorized under the Workforce Investment Act. No funds were appropriated for FY2005.

Gap Filler Grants (formerly Bridge Grants). These grants assist states in helping eligible individuals with the cost of insurance until they can obtain advance payments. Distributions are made during the months required for the Department of the Treasury to enroll, process, and make the first HCTC payments. These months are referred to as the "gap period." Distributions can cover up to three months of gap filler payments for 65% of the qualified health insurance premium (i.e., the proportion that will later be covered by advance payments).

The amount distributed to each state is based on a formula that takes account of four factors: (1) estimates of the total HCTC population in the state, including TAA, ATAA and PGBC eligibles; (2) the percent of eligibles expected to enroll for

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[18] National Emergency Grants were first authorized by the Workforce Investment Act of 1998 (P.L. 105-220); in general they support employment and training assistance to workers who lost their jobs due to layoffs or plant closings, and temporary jobs for workers affected by natural disasters.

[19] There is no time limit as to when these funds must be distributed.

advance payments; (3) the amount needed to cover 65% of a qualified health insurance premium, and (4) the average number of months eligibles will be expected to need the gap-filler payments (generally two months).

For these grants, the act appropriated $50 million for FY2002. DOL distributed all of these funds in FY2004. **Table 2** in the Appendix shows which states received grants and how much they received. The act also authorized appropriations of $100 million for FY2003 and $50 million for FY2004. However, $28.9 million (referred to above) was allotted by Congress for both Gap Filler grants and Infrastructure grants for FY2003. As of January 2004, $6.3 million had been distributed for Gap Filler Grants to two states; **Table 3** in the Appendix shows the amounts awarded to them. For FY2004, funds for Gap Filler grants will be made available through the Dislocated Worker National Reserve Account 2004. These funds have not yet been distributed. No funds were appropriated for FY2005.

High Risk Pool Grants. States establish high risk pools for individuals who have been denied policies in the individual insurance market or who have received offers from insurers that are unaffordable or that permanently exclude coverage for their pre-existing conditions.[20] Although the high risk pool grants authorized by the Trade Act do not directly support administration of the HCTC, they were intended to help states provide a state qualified plan option to HCTC eligibles (see letter C in the list under "Qualified Insurance").

The act appropriated $20 million for FY2003 for grants to states for the creation and initial operation of high risk pools. No state was to receive more than $1 million (at the time, approximately 20 states had not yet established high risk pools). Funds may remain available for obligation until the end of FY2004.

The act also appropriated $40 million for each of FY2003 and FY2004 for states with existing high risk pools. Funds may remain available for obligation until the end of the following fiscal year. Funds are allotted to the states based on the number of uninsured individuals; they can be used for matching grants for up to 50% of the losses states incur in connection with operating their high risk pool. To be eligible, states must have risk pools that restrict premiums to no more than 150% of the premium for applicable standard risk rates, that offer a choice of two or more coverage options, and that have in effect a mechanism reasonably designed to ensure continued funding of losses incurred after the end of the FY2004.

On September 22, 2004, the Senate Committee on Health, Education, Labor, and Pensions approved legislation (S. 2283) to increase funding for high risk pools.

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[20] Individuals enrolled in pools must also pay a premium for coverage. Some persons who would otherwise be eligible for high-risk pools may be unable to afford the premiums and therefore, will not have coverage. To qualify, participants may not be eligible for coverage under the state's Medicaid program for low-income persons. For additional information, see CRS Report RL31745, *Health Insurance: State High-Risk Pools*, by Julie Lynn Stone.

Issues in Design and Implementation

The Trade Act of 2002 became law on August 6, 2002 and the HCTC became effective that December. Advance payments began August 1, 2003. During that first year, the Department of the Treasury and the DOL established supporting administrative arrangements, which they continued to refine after advance payments were implemented. Thus, 2004 will be the first full tax year for which one might assess the credit.

Nonetheless, questions have already been raised about whether the HCTC will be effective in helping taxpayers obtain or retain health insurance coverage; so far, not many are using it. Moreover, there are questions about how equitable the credit is, particularly with respect to eligibility. These two issues are discussed in this section.

Two comprehensive studies of the HCTC have been released, tracking developments through early 2004: *Health Coverage Tax Credits under the Trade Act of 2002: A Preliminary Analysis of Program Operation*, by Stan Dorn and Todd Kutyla, and a Government Accountability Office report, *Health Coverage Tax Credit: Simplified and More Timely Enrollment Process Could Increase Participation*.[21]

Effectiveness

Data for the HCTC indicate that it is not widely used, raising questions about its effectiveness. At this time, it is not clear whether more taxpayers might use the credit in the future or if participation will always be low.

Understanding the reasons for low participation can help inform Congress about proposals to modify the credit as well as proposals for a more generally available health insurance tax credit. Among the reasons discussed below are the limited availability of qualified plans (perhaps due in part to consumer protection requirements and restrictions on individual market insurance) and difficulties affording the coverage. Other possible reasons include delays in certifying and identifying dislocated workers and additional factors that might be explored.

Participation Data. As of November 30, 2004, 13,369 taxpayers were receiving advance payments for the HCTC. They represented about 6% of the 223,307 taxpayers the IRS estimated were then potentially eligible for the credit, including 76,201 TRA and ATAA potential eligibles (34.1% of the total) and 147,106 PGBC potential eligibles (65.9% of the total).[22] Other taxpayers might be

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[21] Stan Dorn and Todd Kutyla, *Health Coverage Tax Credits under the Trade Act of 2002: A Preliminary Analysis of Program Operation* (New York: The Commonwealth Fund, Apr. 2004). [Hereafter cited as Dorn and Kutyla, *Health Coverage Tax Credits*.]; U.S. Government Accountability Office, *Health Coverage Tax Credit: Simplified and More Timely Enrollment Process Could Increase Participation*, GAO-04-1029, Sept. 2004.

[22] Data provided to CRS by the IRS. They include persons who registered and enrolled in (continued...)

claiming the credit on their tax returns without taking advance payments; however, their number is not thought to be large.

Participation is growing. At the end of December 2003, there had been 8,380 taxpayers who had received advance payments, representing about 3.6% of the 235,000 taxpayers the IRS estimated were then eligible for the credit.[23]

Table 4 in the Appendix shows the population of potential eligibles as of November 2004, and the number of persons registered and enrolled for advance payments in each state. West Virginia stands out as having the highest enrollment rate, with 24% of the state's potentially eligible population enrolled. Although some other states had participation rates exceeding 10% of their potentially eligible population (Pennsylvania, Utah, and Maryland), most states had rates that were far lower and some had no enrollees.

Limited Availability of Qualified Plans. One reason for low HCTC use may be the limited availability of qualified plans. In contrast to proposals for a generally available tax credit, which typically do not restrict choice of insurance, the HCTC is available only for categories of qualified plans listed in the statute. As it turns out, as a practical matter many of these options are not accessible by HCTC eligibles.

Of the three types of plans that are automatically qualified, COBRA continuation coverage (letter A in the list under "Qualified Insurance") is an option only if the former employer offered health insurance and then continues coverage for its remaining workers. Dorn and Kutyla state that roughly 40% to 60% of HCTC eligibles have access to COBRA coverage, citing unnamed federal officials.[24] Those with access must be able to pay for it, which often is difficult for people separated from employment (see the discussion on "Affordability" below). Even so, Dorn and Kutyla estimate that 56% of people enrolled in coverage for the credit in December 2003 were in COBRA plans.[25] The spousal and individual coverage options (letters I and J) have requirements that rule out most eligibles; for the former, one must be married to someone with coverage not largely paid for by their employer;[26] for the latter, one must have had individual insurance before termination of employment.

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[22] (...continued)
HCTC advance payment arrangements through June 2004.

[23] Data provided to CRS by the IRS. Approximately 60% of those receiving advance payments on that date were PBGC eligibles. Final numbers for 2003 are not yet available, pending receipt and processing of additional 2003 tax returns.

[24] Dorn and Kutyla, *Health Coverage Tax Credits*, p. 20, available at [http://www.cmwf.org/usr_doc/dorn_725_trade_act.pdf].

[25] Ibid. If dependents were not included, 54% of the HCTC eligibles enrolled for the credit would have COBRA coverage.

[26] While this requirement prevents otherwise eligible individuals from using the credit, it might be noted that they do have access to what generally is good insurance.

Dorn and Kutyla estimate that 4% of people enrolled in coverage for the credit in December 2003 were in individual plans.[27]

The remaining seven categories of qualified plans (letters B though H) are available only if the enrollee's state of residence has chosen or established them. As discussed above, 39 states and the District of Columbia adopted at least one of the seven options by August 2004 while 11 states had not yet acted. Dorn and Kutyla estimate that about three-quarters of HCTC eligibles resided in one of the 26 states and the District of Columbia that had a state qualified plan by December 2003. They argue that generally states with larger numbers of eligibles were more likely to adopt a qualified plan.[28] Even so, some states with relatively large numbers of eligibles (such as California and Georgia) still do not have a state qualified plan, and some with qualified plans have low participation.

Debate over Consumer Protection. One issue regarding participation is whether the consumer protection requirements discussed above (guaranteed issue, no preexisting condition exclusion, nondiscriminatory premiums, and substantially the same benefits for eligibles and noneligibles) reduce the availability and attractiveness of state qualified plans. These requirements impose stricter standards on health plans than other federal and most state laws.[29] As a result, when the Trade Act was enacted, many health plans sponsored or arranged by states did not meet the consumer protection requirements specified in the statute. In order to qualify a plan for the HCTC, states have had either to modify existing plans or to establish new ones. Sometimes this could be done by administrative action, but often it required state legislation. For some states, approving new plans has been difficult because of budget crises. Even if approval is achieved, budget constraints limit the amount of financial risk states are willing to take.

Some argue that the consumer protection requirements make access to insurance more equitable and guarantee HCTC eligibles premiums and benefit packages like those offered to similar groups of persons in their state. They argue that without these requirements plans could more easily deny coverage to eligibles with higher health care needs, particularly older workers and early retirees, making it difficult for them to find affordable coverage.

Others criticize these requirements for limiting the availability of state qualified plans, particularly where changing state sponsored or arranged health plans does not seem warranted given the small number of people who might be eligible for the credit. The requirements also increase the cost of state qualified health plans, making their premiums less affordable (with resulting withdrawal of some who were previously enrolled) and raising the possibility that states will have to provide

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[27] Dorn and Kutyla, *Health Coverage Tax Credits*, p. 21. If dependents were not included, 8% of HCTC eligibles enrolled for the credit would have had individual coverage.

[28] Ibid., pp. 21-22.

[29] For example, the Health Insurance Portability and Accountability Act (HIPAA, P.L. 104-191) generally prohibits health plans from imposing preexisting condition exclusions for individuals who previously had 12 months of continuous creditable coverage; for the HCTC, the time period is reduced to three months.

supplementary funding to cover plan losses. In the 108th Congress, H.R. 1528 would have modified consumer protection requirements for state qualified plans. This bill, which passed the House on June 19, 2003, is summarized below.

Debate over Individual Market Insurance. A second issue regarding participation is the applicability of the HCTC to individual market insurance. Shortly after the enactment of the Trade Act, a dispute arose over whether the credit could apply to individual market policies only as an automatically qualified plan, in which case the eligible individual must have been covered by an individual policy during the 30-day period prior to separation from employment (see category J under "Qualified Insurance"), or whether the credit could also apply to individual market policies under a state qualified plan (such as category F), in which case there is no requirement for prior coverage. The statute is unclear and the IRS has adopted the latter position (that is, that prior coverage is not required). While individual policies provided through a state qualified plan must meet the consumer protection requirements discussed above, they can be subject to medical underwriting, which allows younger, healthier applicants to have lower premiums. Proponents of these arrangements argue they allow eligible individuals to obtain coverage they can afford, increasing the likelihood they will use the credit. Opponents argue that expanded access to individual market insurance weakens the risk pooling of group insurance, raising the premiums for older, less healthy applicants.

Affordability. Even if qualified insurance is available, eligible people might not be able to afford it. Generally, participants must pay 35% of the premium,[30] which might or might not be easy. Dorn and Kutyla show that premiums for state qualified plans vary widely, depending on state of residence, benefits provided, deductible levels, coinsurance rates, age, health status (where medical underwriting occurs), and other factors.[31] For example, the annualized 35% payment required for the most generous self-only coverage available in 15 states that they examined ranged from $264 for a healthy, 25-year old male to nearly $6,000 for a healthy, 60-year old male.[32] Another comparison of 19 states showed that the annualized 35% payments for a self-only policy averaged $741 in one state and $2,715 in another.[33] The cost of family coverage would be considerably higher.

It is difficult to assess these figures without having data on the eligible population's income and assets. Obviously, some people can afford the insurance because they are enrolled for the advance payment. But considering that nearly all of those who are eligible for the HCTC are not working, even the 65% credit rate might not be enough to make coverage affordable.[34]

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[30] In some states, Bridge Grants might pay for some or all the 35% premium share.

[31] Dorn and Kutyla, *Health Coverage Tax Credits*, pp. 24-36.

[32] Ibid, p. 35. The figures are based on Nov. 2003 premiums; they would likely be higher in 2004.

[33] Ibid., p. 26. The figures are based on Nov. 2003 premiums.

[34] "Health Care Subsidy Helps Some Jobless," *Washington Post*, Dec. 31, 2003, p. E1; "Sluggish Start for Offer of Tax Credit for Insurance," *New York Times*, Jan. 25,2004, p. 11.

Other costs may also be important. Some people might not apply for coverage since applicants must pay 100% of the premium pending completion of the enrollment process. Some might calculate that the copayments and deductibles would require sizable additional out of pocket expenditures before they receive insurance reimbursements. Still others might note that the insurance does not cover dental costs and some other ordinary healthcare expenses.

Other Factors Affecting Participation. Additional reasons why the HCTC participation is low may include the following:

- delays in certifying that dislocated workers are eligible for TAA assistance;
- delays in identifying dislocated workers receiving unemployment benefits who have not yet applied for TAA benefits;
- complexity of explanatory material and the application process;
- concerns of some people about their tax returns and tax compliance; and
- decisions by some people that health insurance is relatively unimportant, even if affordable.

Equity

Tax credits often are seen as a way to improve tax equity since the savings they yield are not based on taxpayers' marginal tax rates. In contrast, tax savings from a deduction or the widely-used exclusion for employer-provided insurance vary with marginal rates; savings for taxpayers in the 35% bracket (applying to taxable incomes over $319,000) generally would be 3½ times higher than savings for taxpayers in the 10% bracket (applying to taxable incomes up to $14,300 in the case of a married couple filing jointly). In addition, tax credits can be refundable, so low-income taxpayers can receive the full value of the credit even if they have little or no tax liability.

The 65% HCTC rate is available to all eligible taxpayers with qualified insurance, regardless of income. From the standpoint of inclusiveness, this seems equitable. Considering ability to pay, however, the one rate appears inequitable. The 65% rate provides the same dollar subsidy to taxpayers with high incomes and taxpayers with low incomes even though the former can more readily pay for their insurance. In the case of a $3,000 self-only policy, the HCTC provides $1,950 in tax savings both to taxpayers with incomes of $80,000 and those with incomes of $20,000. Proposals for a more generally-available tax credit reflect these different perspectives; some would have one rate for all taxpayers while others would phase out the rate for higher income taxpayers.

The 65% HCTC rate might seem roughly comparable to the proportion of insurance cost that is paid by employers (actually, that proportion usually is somewhat higher); from this perspective, the HCTC simply continues what employers would be paying if the workers had not lost their jobs. This perspective, though, overlooks the fact that employers can claim a tax deduction for their insurance costs and likely shift most of the rest back to the workers in the form of reduced wages and other benefits. By an economic measure, employer subsidies for

health insurance probably are far less than 65%. But if a 65% tax credit provides a more generous subsidy than employers, it apparently is still not high enough to help many cash-constrained families purchase insurance. This conundrum has been noted about proposals for a more generally-available health insurance tax credit; it is not unique to the HCTC.

Taxpayers in one of the three HCTC eligibility groups likely consider it equitable to receive tax benefits for insurance since taxpayers with employment-based insurance receive some as well. However, unemployed workers who do not receive TAA allowances may question why they are denied the credit, particularly if they too have lost their jobs to foreign firms. One study estimated that more than one-third of unemployed workers in 2000 lacked health insurance.[35] In the 108th Congress, H.R. 3881 would have extended TAA eligibility, and thus HCTC eligibility, to service sector or public agency workers who lose their jobs due to shifts to foreign countries. Also in the 108th Congress, S. 1693 would have made the credit generally available to individuals who are eligible to receive state unemployment compensation. Both of these bills are summarized below.

Similarly, early retirees whose pensions are not paid in part by the PBGC may question not being eligible for the credit, as may those who receive no pension at all.[36] Early retirees often find individual health insurance prohibitively expensive, even if they are in good health, since people in their 50s and early 60s have substantially higher medical costs than younger workers. In the 108th Congress, several bills would have extended the credit to additional groups of early retirees: H.R. 1999, S. 1361, and S. 1018. They are summarized below.

Legislation in the 108th Congress

A number of bills were introduced in the 108th Congress that would have modified or expanded the HCTC. They are summarized here because similar measures may be introduced in the 109th Congress.

H.R. 1528 *Taxpayer Protection and IRS Accountability Act of 2003*, attempted to address some of the concerns around the consumer protection requirements, on a temporary basis. Among other things, this bill as amended would allow individuals living in states without certain state qualified plans (coverage C through H in the list under "Qualified Insurance") to waive requirements for guaranteed issue and no preexisting condition exclusions.[37]

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[35] Jeanne Lambrew, *How the Slowing U.S. Economy Threatens Employer-Based Health Insurance* (New York: The Commonwealth Fund, Nov. 2001).

[36] For data on pension plans and retirement accounts, including the shift from defined benefit plans to defined contribution plans, see CRS Report RL30922, *Retirement Savings and Household Wealth: A Summary of Recent Data*, by Patrick J. Purcell.

[37] The waiver would not supersede or otherwise affect consumer insurance protections under (continued...)

Individuals could use these waivers only through December 31, 2004. In addition, the bill would permanently exempt state based continuation coverage (coverage B in the list) from the requirements regarding guaranteed issue, preexisting condition exclusions, nondiscriminatory premiums, and similar benefits. The bill was introduced on April 1, 2003, by Representative Portman, reported by the Committee on Ways and Means on April 8, and passed by the House on June 19, 2003.

H.R. 1999 *Health Care Tax Credit Enhancement for Workers and Steel Security Act of 2003.* Among other things, this bill would lower the minimum age for eligibles receiving PBGC pensions from 55 to 50; eliminate the three-month requirement for previous coverage with respect to state qualified plans; and allow a spouse to be eligible even if the individual eligible for the HCTC were entitled to Medicare Part A. Introduced on May 7, 2003 by Representative Visclosky and referred to the Committee on Ways and Means. (An amendment to H.R. 1528 with these same provisions was rejected during House floor debate on June 19, 2003.)

H.R. 3601 *Steel Industry Retiree Benefits Protection Act of 2003.* This bill would add a fourth group of taxpayers eligible for the HCTC: individuals who are qualified steel industry retirees. In addition, it would allow the credit to be claimed by qualifying steel companies and certain suppliers, unions, and transporters; add steel retiree health benefits to the list of qualified health insurance; and include a number of special rules related to these changes. Introduced on November 21, 2003, by Representative English and referred to the Committee on Ways and Means.

H.R. 3881 *Trade Adjustment Assistance Equity for Service Workers Act of 2004*. Among other things, this bill would extend TAA eligibility to service sector and public agency workers who lose their jobs due to shifts in the provision of services to foreign countries. In addition, it would (a) provide presumptive eligibility for the HCTC when the TAA provision is filed, (b) allow a 100% credit the first month of eligibility, (c) require that premiums for individual market insurance (coverage J on the list on page 4) be restricted under a community rating or rate-band system, (d) modify the measurement period for creditable coverage regarding pre-existing condition exclusions, (e) allow other family members to remain eligible when the individual eligible for the HCTC becomes entitled to Medicare Part A, and (f) allow enrollment in FEHBP if their state has not adopted a state qualified plan. Introduced on March 3, 2004, by

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[37] (...continued)
state law.

Representative A. Smith and referred to the Committee on Ways and Means.

S. 1018 Same as H.R. 1999. Introduced on May 7, 2003 by Senator Bayh and referred to the Committee on Finance.

S. 1693 *Health Care Tax Credit Expansion Act of 2003.* This bill would add a fourth group of taxpayers eligible for the HCTC: individuals who are eligible to receive state unemployment compensation. The bill was introduced on October 1, 2003 by Senator Grassley and referred to the Committee on Finance.

Legislation in the 109th Congress

The President's FY2006 budget, released on February 7, 2005, includes a proposal that would allow state qualified plans to impose a pre-existing condition exclusion for a period of up to 12 months, provided the plan reduces the restriction period by the length of the eligible individual's creditable coverage as of the date of application for the state qualified plan.[38]

The FY2006 budget also proposes allowing the spouse of an HCTC-eligible individual to claim the credit when the HCTC-eligible individual becomes entitled to Medicare. The spouse would have to be at least 55 years of age and meet other HCTC eligibility requirements.

In addition, the budget proposes five clarifications to current law HCTC. Similar changes had been included in the FY2005 budget.

- clarify that individuals who receive one-time lump sum payments from the PBGC and certain alternative PBGC payees would be eligible for the credit;
- deem Puerto Rico, the Northern Mariana Islands, American Samoa, Guam, and the U.S. Virgin Islands to be states for purposes of state-based coverage rules;
- clarify that health insurance providers could include employers and administrators of health plans and allow disclosure of information necessary to carry out the advance payment program;
- clarify that state continuation coverage under state law would automatically be considered qualified health insurance as federally mandated COBRA coverage, without meeting the requirements for state qualified coverage; and
- make the definition of "other specified coverage" for ATAA allowance recipients conform to the definition applying to other eligible individuals.

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[38] U.S. Department of the Treasury, *General Explanations of the Administration's Fiscal Year 2006 Revenue Proposals*, p. 27.

The following bills have been introduced in the 109th Congress that would change or affect the HCTC:

S. 14 *Fair Wage, Competition, and Investment Act of 2005.* Among other things, this bill would extend TAA eligibility to service sector and public agency workers who lose their jobs due to shifts in the provision of services to foreign countries. In addition, it would lower the minimum age for a worker to be eligible for the ATAA allowance from 50 to 40. The HCTC would be changed by (a) setting the credit equal to what the taxpayer paid for qualified insurance minus the lesser of 20% of that amount or 5% of the taxpayer's income (as certified by the taxpayer's state); (b) allowing eligible taxpayers to enroll in health plans offered in the Federal Employees Health Benefits Program (FEHBP); and (c) allowing the spouse of an eligible taxpayer to be eligible if the eligible taxpayer becomes entitled to Medicare.

Appendix

Table 1. Infrastructure Grants from FY2002 Allocation of $10 million (as of January 1, 2005)

State	Amount Awarded
Alabama	$55,206
Alaska (two grants)	$135,000
Arizona	$74,717
Arkansas	$200,000
California	$50,000
Colorado	$184,615
Connecticut	$189,700
Delaware	$50,500
Florida (two grants)	$288,020
Georgia	$199,953
Hawaii	$23,400
Idaho	$150,000
Illinois	$127,266
Iowa	$200,000
Kansas	$150,000
Kentucky	$50,000
Louisiana	$50,000
Maine	$136,853
Maryland (two grants)	$579,867
Massachusetts	$150,000
Michigan	$128,384
Minnesota	$81,551
Missouri	$98,456
Montana (two grants)	$36,572
Nebraska	$97,156
Nevada	$92,738
New Hampshire	$150,000
New Jersey	$200,000
New Mexico	$78,499
New York	$214,425
North Carolina	$141,971
Ohio	$222,105
Oregon	$144,369
Pennsylvania (two grants)	$394,908
Rhode Island	$152,000
South Carolina	$200,000
South Dakota	$57,760
Tennessee	$244,779
Texas	$200,000
Utah (six grants)	$428,946
Vermont	$50,000
Virginia	$12,702
Washington	$74,219
West Virginia	$117,053
Wisconsin (two grants)	$256,245
Total awards to states	**$6,919,935**
Amount unspent of allocation	**$3,080,065**

Source: Provided to CRS by the Department of Labor in January 2005.

Table 2. Gap Filler Grants From FY2002 Allocation of $50 million (as of September 30, 2004)

State	Amount Awarded
Florida	$8,542,978
Illinois	$2,802,966
Maine	$7,500,000
Maryland	$5,632,000
Minnesota (2 grants)	$2,965,264
Montana	$114,548
New Jersey	$1,930,000
North Carolina	$7,614,684
Ohio	$1,569,493
Utah	$3,786,892
Virginia	$3,176,800
Washington	$1,512,000
West Virginia	$2,852,374
Total awards to states	**$49,999,999**
Amount unspent of allocation	**$1**

Source: Provided to CRS by the Department of Labor in January 2005.

Table 3. Gap Filler Grants From FY2002 Allocation of $29.8 million (as of January 1, 2004)

State	Amount awarded
Florida	$4,023,874
Kentucky	$2,317,865
Total awards to states	**$6,341,739**
Amount unspent of allocation	**$23,463,261**

Source: Provided to CRS by the Department of Labor in January 2005.

Table 4. Potentially Eligible Population for the HCTC and Cumulative Counts of Eligibles Registered and Enrolled for Advance Payments (November 30, 2004)

Potentially Eligible Population				Registered and Enrolled Population				Potentially Eligible Population Enrolled or Registered (Rounded)
State	PBGC	TAA/ATAA	Total	State Qualified Plan	Cobra Plan	Individual Plan	Total	
Alabama	2,554	1,626	4,180	75	84	*	159	3.8%
Alaska	73	21	94	0	0	0	0	0.0%
Arizona	1,447	484	1,931	0	42	*	42	2.2%
Arkansas	767	940	1,707	*	61	*	61+	3.6%
California	6,279	1,317	7,596	na	227	18	245	3.2%
Colorado	1,233	362	1,595	*	52	*	52+	3.3%
Connecticut	1,548	919	2,467	*	90	*	102	4.1%
Delaware	270	94	364	na	18	0	18	4.9%
District of Columbia	87	0	87	0	0	0	0	0.0%
Florida	10,963	599	11,562	264	232	11	507	4.4%
Georgia	6,368	2,599	8,967	na	103	12	115	1.3%
Hawaii	530	24	554	na	*	*	*	0.0%
Idaho	359	774	1,133	0	49	0	49	4.3%
Illinois	8,183	4,480	12,663	242	212	*	454+	3.6%
Indiana	7,358	2,921	10,279	462	402	14	878	8.5%
Iowa	1,169	574	1,743	*	45	*	45+	2.6%
Kansas	978	234	1,212	0	44	*	44+	3.6%
Kentucky	1,467	2,901	4,368	*	219	20	239+	5.5%

Potentially Eligible Population				Registered and Enrolled Population				Potentially Eligible Population Enrolled or Registered (Rounded)
State	PBGC	TAA/ATAA	Total	State Qualified Plan	Cobra Plan	Individual Plan	Total	
Louisiana	994	89	1,083	na	18	*	18+	1.7%
Maine	367	1,092	1,459	49	64	*	113+	7.7%
Maryland	4,293	521	4,814	278	269	*	547+	11.4%
Massachusetts	3,822	838	4,660	na	37	*	37+	0.8%
Minnesota	2,445	820	3,265	165	64	*	229+	7.0%
Michigan	5,406	3,756	9,162	427	264	10	701	7.7%
Mississippi	999	894	1,893	na	72	0	72	3.8%
Missouri	5,484	1,046	6,530	0	132	*	132+	2.0%
Montana	76	141	217	*	11	0	11+	5.1%
Nebraska	303	135	438	*	18	0	18+	4.1%
Nevada	745	30	775	na	16	0	16	2.1%
New Hampshire	926	348	1,274	*	25	*	25+	2.0%
New Jersey	3,474	1,592	5,066	*	90	*	101	2.0%
New Mexico	301	125	426	na	*	*	*	0.0%
NewYork	7,556	2,162	9,718	201	180	17	398	4.1%
North Carolina	6,293	10,904	17,197	996	638	*	1,634+	9.5%
North Dakota	26	28	54	*	*	*	0+	0.0%
Ohio	12,685	2,253	14,938	769	360	25	1,154	7.7%
Oklahoma	960	1,271	2,231	0	39	*	39+	1.7%
Oregon	471	914	1,385	na	57	*	57+	4.1%

Potentially Eligible Population				Registered and Enrolled Population				Potentially Eligible Population Enrolled or Registered (Rounded)
State	PBGC	TAA/ATAA	Total	State Qualified Plan	Cobra Plan	Individual Plan	Total	
Pennsylvania	16,770	4,759	21,529	703	1,505	51	2,259	10.5%
Puerto Rico	978	0	978+	na	0	0	0	0.0%
Rhode Island	271	424	695	*	19	*	19+	2.7%
South Carolina	2,333	3,063	5,396	14	131	*	145+	2.7%
South Dakota	57	117	174	na	*	0	0+	0.0%
Tennessee	2,997	3,952	6,949	11	258	*	269+	3.9%
Texas	4,165	3,497	7,662	37	121	*	158+	2.1%
Utah	701	393	1,094	121	*	0	121+	11.1%
Virginia	2,908	3,430	6,338	419	136	10	565	8.9%
Vermont	449	79	528	*	*	*	21	4.0%
Washington	1,125	2,333	3,458	*	175	*	175+	5.1%
Wisconsin	1,852	3,585	5,437	*	260	*	260+	4.8%
West Virginia	3,169	727	3,896	532	404	*	936+	24.0%
Wyoming	72	0	72+	na	0	0	0	0.0%
Total	**147,106**	**76,201**	**223,307**	**5,813**	**7,279**	**277**	**13,369**	**6.0%**

Source: Data provided to CRS by the IRS in January 2005.

Notes: Registered and enrolled numbers are for the advance payment option only. Totals include the count of persons represented by the asterisk. States shaded in gray do not have state qualified plans.

* Denotes a value less than 10. These data cannot be released due to IRS Disclosure and Privacy guidelines.
+ Denotes the total number of Registered and Enrolled persons plus the number of persons represented by *.
na = not applicable. Such states do not have state qualified plans.