Health Coverage Tax Credit Authorized by the Trade Act of 2002

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Summary

The Trade Act of 2002 (P.L. 107-210) authorized the health coverage tax credit (HCTC): a federal income tax credit to cover 65% of the cost of "qualified health insurance" for eligible taxpayers and their family members. The credit is refundable, so taxpayers may claim the full credit amount 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.

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

The HCTC can be claimed for only 10 types of qualified health insurance specified in the statute, 7 of which require state action to become effective. For tax year 2007, 43 states and the District of Columbia made at least one of these seven types of state-qualified health plans available. In the remaining eight states, only the three types of qualified health insurance *not* dependent on state action (automatically qualified health plans) were available, though not necessarily all who were eligible for the credit could avail themselves of these options.

The HCTC is not used widely. In 2005, nearly 28,000 persons claimed the tax credit, out of 350,000 *potentially* eligible individuals. Possible reasons explaining the relatively low participation rate include barriers to finding qualified insurance and difficulties paying the part of the premium not covered by the tax credit (the remaining 35%).

The 110th Congress is likely to consider legislation affecting the HCTC program. The federal program that provides grants to states to cover operational losses has exhausted all appropriated amounts. Also, the TAA program was set to expire on September 30, 2007. A number of bills have been introduced to reauthorize the TAA program that also propose changes to the HCTC directly. On October 31, 2007, the House passed H.R. 3920, which would reauthorize and expand TAA. It has been referred to the Senate Finance Committee. Meanwhile, Congress passed legislation to temporarily extend TAA. H.R. 3375/P.L. 110-89 extended the TAA program through December 31, 2007. H.R. 2764/ P.L. 110-161 includes provisions to fully fund the TAA program through September 30, 2008.

This report will be updated as legislative activity warrants

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The Trade Act of 2002 (P.L. 107-210) authorized a federal income tax credit—Health Coverage Tax Credit (HCTC)—for certain workers displaced by international trade, and retirees whose private pension plans were taken over by the Pension Benefit Guaranty Corporation. This report outlines the rules regarding eligibility for the HCTC and the types of insurance that may be provided. In addition, it discusses both federal and state implementation of the credit. The report then explores the effectiveness of the credit in reaching targeted populations and discusses related equity and efficiency issues. It concludes with a brief discussion of recent legislative proposals regarding the HCTC.[1]

Introduction

The Health Coverage Tax Credit[2] covers 65% of the premium for qualified health insurance purchased by an eligible taxpayer. (The taxpayer is responsible for covering the remaining 35% of the premium.) The HCTC is refundable, so taxpayers may claim the full credit even if they have little or no federal income tax liability. The credit also may be advanced, so taxpayers have the option of using the credit on a monthly basis when premiums are due.

The HCTC is not used widely. In tax year 2005, nearly 28,000 persons claimed the tax credit, out of 350,000 *potentially* eligible individuals.[3] ("Potentially eligible" individuals are persons who receive assistance through specific programs that make them potentially eligible for the health coverage tax credit, provided they meet other eligibility criteria. So, while a person may be potentially eligible for the HCTC, it does not necessarily mean that person is, in fact, eligible.) Possible reasons explaining such low participation include barriers to finding qualified insurance and difficulties paying the part of the premium not covered by the tax credit (the remaining 35%).

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 enactment of the program reflect a broader discussion over the use of tax incentives to finance health coverage, in contrast to expanding public programs (e.g., Medicaid) or implementing market reforms.

The 110th Congress is likely to consider legislation affecting the HCTC program. The federal program that provides grants to states to cover operational losses has exhausted all appropriated amounts. Also, the TAA program was set to expire on September 30, 2007. A number of bills have been introduced to reauthorize the TAA program that also propose changes to the HCTC directly (discussed under the "Federal Proposals" section).

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[1] The Internal Revenue Service's website, http://www.irs.gov, includes information on the HCTC program and administration of the credit. A search for "HCTC"on the IRS homepage will list the overview document first. This document not only provides an overview of the program, but also includes links for eligible individuals, state agency officials, and health plan officials, as well as a glossary and a list of frequently asked questions.

[2] The Internal Revenue Service (IRS) refers to the credit as the "health coverage tax credit." However, the credit is sometimes known as the "trade adjustment assistance credit" (or TAA credit) and the "Trade Act credit." It appears in budget documents as the "tax credit for health insurance purchased by certain displaced and retired individuals." A similar phrase is used by the Joint Committee on Taxation. This report uses the term "health coverage tax credit" to conform to IRS practice.

[3] D. Williams, Electronic Tax Administration and Refundable Credits, Internal Revenue Service, testimony provided to the House Committee on Ways and Means at a hearing entitled "Promoting U.S. Worker Competitiveness in a Globalized Economy" on June 14, 2007, at http://waysandmeans.house.gov/hearings.asp?formmode=view&id=6131. (Hereafter cited as "IRS testimony.")

Eligibility

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.

Eligible Taxpayer Groups

Three groups of taxpayers are eligible to claim the HCTC:

- individuals receiving income support in the form of *Trade Readjustment Allowances (TRA)* under the Trade Adjustment Assistance (TAA) program, including persons eligible for, but not yet receiving, the allowance because they have not yet exhausted their state unemployment benefits;
- individuals aged 50 and over receiving wage subsidies in the form of *Alternative Trade Adjustment Assistance (ATAA)* allowances under the TAA program; and
- individuals between the ages of 55 and 64 who are receiving payments from the *Pension Benefit Guaranty Corporation (PBGC).*

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.[4] TAA benefits include counseling and other employment services, job search and relocation allowances, training, and a TRA or ATAA allowance.[5]

Trade Readjustment Allowance

To be eligible for a TRA (the first eligibility 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. Eligible individuals must participate in TAA-approved training or receive a training waiver. The allowance is paid after state unemployment benefits are exhausted; these benefits generally last several months for workers in certain states to a half year for workers in other states. (In most states, the maximum time period for unemployment benefits is 26 weeks, though workers with some employment histories qualify for less. Benefits are sometimes extended beyond the 26-week period due to

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[4] 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.

[5] 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 Christine Scott.

federal legislation or triggers based on higher unemployment rates.) The basic TRA provides 26 weeks of support, though it can be followed by 52 weeks of additional allowances to assist completion of training. Another 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.[6]

Alternative Trade Adjustment Assistance

To be eligible for an ATAA allowance (the second group identified above), individuals must obtain re-employment on a full-time basis (other than at the affected firm) within 26 weeks of separation from employment, be at least 50 years of age, and earn less in wages at the new firm than at the previous firm. 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.[7] The ATAA allowance is an option to other TAA benefits. Individuals who elect this allowance receive payments equal to 50% of the difference between their wages at the affected firm and their re-employment wages. Payments cannot exceed $10,000 in total, and may not be provided for more than two years. Eligibility for the ATAA allowance, and thus for the HCTC, is limited to two years.[8]

Pension Benefit Guaranty Corporation

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 federal agency.[9] 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).

Limitations on Eligibility

The HCTC program places several limitations on eligibility, even for those individuals in the three groups just described. Persons *enrolled* in the following health plans are not eligible for the tax credit:

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[6] Section 35(c) of the Internal Revenue Code extends eligibility for the HCTC for one month following the end of TAA eligibility. This would apply to individuals receiving a trade readjustment allowance.

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

[8] Section 35(c) of the Internal Revenue 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.

[9] 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 John J. Topoleski.

- 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 total premium;[10]
- Medicare Part B;
- the Federal Employees Health Benefits Program (FEHBP);
- Medicaid; or
- the State Children's Health Insurance Program (SCHIP).

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

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

In addition, individuals are not eligible for the tax credit if they are incarcerated, 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. 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 Health Insurance

An eligible individual can claim the HCTC only to help cover the premium for "qualified health insurance." The statute limits qualified health insurance to 10 different categories of coverage, identified as options (A) through (J). The tax credit cannot be claimed for any other insurance.

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:

[10] 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.

A. Coverage under COBRA;[11]

I. Coverage under a group health plan available through a spouse's employer; 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.[12]

The other seven categories of coverage are known as *state-qualified health plans*. Individuals may choose these options only if their state has established these plans. These options (identified by their statutory letter designation) are as follows:[13]

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

C. Coverage offered through a state high risk pool;[14]

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;

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 four consumer protections, specified in statute, to all *qualifying* individuals.[15] 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 health plans are open

[11] 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 already offer health insurance to provide the option of continuing coverage to certain employees and their families under specified circumstances (such as termination, reduction in work hours, death, divorce or legal separation, and other circumstances) for a limited time. Employers may charge the beneficiary up to 100% of the premium (counting both the employer and employee share) plus 2% to cover 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.

[12] 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.

[13] For a list and contact information of state-qualified plans in each state for tax year 2007, see the IRS website at http://www.irs.gov/individuals/article/0,,id=119335,00.html.

[14] State high risk pools are health insurance programs designed for individuals with pre-existing health conditions who experience difficulty in obtaining coverage in the private market. For additional information about these pools, see CRS Report RL31745, *Health Insurance: State High Risk Pools*, by Bernadette Fernandez. (Hereafter cited as *State High Risk Pools*.)

[15] The consumer protections apply to "qualifying" individuals, defined in the statute as eligible individuals (as described above) who also have had three months of "creditable coverage" under 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 allows for preexisting condition exclusions to be imposed if the individual has less than three months of creditable coverage.

to all qualifying applicants and do not charge more or provide fewer benefits to people who are receiving the tax 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. Such coverage includes 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

Implementation of the HCTC relies on the participation of several federal and state agencies. The Department of the Treasury is primarily responsible for administering the advance payment system (provides the HCTC on a monthly basis to coincide with payment of insurance premiums) 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 coordinates the One-Stop Career Center system; these centers provide a full range of services to assist job seekers. Lastly, DOL administers two grant programs that provide assistance to states to establish the infrastructure to administer the program and provide temporary subsidies to individuals waiting for their first tax credit payment.

State-level entities include state workforce agencies (SWAs)—various agencies, funded by DOL, that administer unemployment benefits and TAA programs. Other relevant state entities include the departments of insurance (specifically regarding state-qualified health plans) and health agencies.

Notifying Eligibles

Beginning in 2002, DOL's Employment and Training Administration requested that 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.[16] SWAs are also required to submit to the HCTC office a daily listing of persons eligible for TAA and ATAA.[17]

Similarly, the PBGC 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.[18] Starting in February 2003, the IRS sent information packets, including forms and instructions for claiming the credit, to those persons in the PBGC list.

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

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

[18] 67 *Federal Register* 66674, November 2, 2002.

The HCTC office continues to mail packets to persons whose names are included on the lists provided to them by the SWAs and PBGC. 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 1 of the 10 types of qualified health insurance described above. The three automatically qualified plans are available in all states, but only for certain individuals. COBRA continuation coverage (option A in the list under the "Qualified Health Insurance" section) is available only if an individual's previous employer continues to offer health benefits 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 (option I) is available only if one is married and the spouse has coverage. 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 under employer-sponsored health care. Finally, coverage under an individual health insurance plan (option J) generally is not available due to the requirement that the worker had such coverage before loss of employment.[19]

The remaining seven qualified health plans (options B through H) are available only if states designate them as qualified insurance. In tax year 2007, 43 states and the District of Columbia made at least one of these seven state-qualified plan types available.[20] In the remaining eight states, individuals who are eligible for the HCTC can only select from the three automatically qualified plan options, but only if it is available to them.

Claiming the Tax 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, on a monthly basis, 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 (option I).

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

[20] Those states are: AL, AK, AZ, AK, CA, CO, CT, DC, FL, GA, ID, IL, IN, IA, KS, KY, LA, ME, MD, MA, MI, MN, MO, MT, NE, NH, NJ, NY, NC, ND, OH, OK, OR, PA, RI, SC, TN, TX, UT, VT, VA, WA, WV, and WI. For contact information for these state-qualified health plans, at http://www.irs.gov/individuals/article/0,,id=119335,00.html.

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. 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.

Grants to States

Section 203 of the Trade Act of 2002 expanded the National Emergency Grant program to support implementation of the HCTC.[21] It authorized two new state grant programs to be administered by the Labor Department: Infrastructure Grants and Gap Filler Grants (previously referred to as Bridge Grants). In addition, Section 201 of the Trade Act authorized new funding to be made available through the Department of Health and Human Services to help states create new high risk pools and fund existing ones.

Infrastructure Grants

These grants assist states in developing infrastructure to conduct eligibility verification, notify eligible individuals, provide enrollment assistance, install data management systems, and support other administrative functions. Once the systems and procedures are in place and the state has begun supporting the operations of the HCTC program, the state may submit a request to modify the grant award to cover ongoing operational costs. Distributions are based on the states' anticipated costs.

For these grants, the Trade Act appropriated $10 million in FY2002. As of March 2007, almost $8 million had been distributed to 45 states.[22] **Table A-1** in the **Appendix** shows which states received grants and how much they received. States have five years to spend the funds.

[21] 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.

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

The Trade Act also authorized appropriations of $60 million for each fiscal year starting in 2003 through 2007. In FY2003, Congress appropriated $29.8 million to be used for Infrastructure and Gap Filler (see below) grant programs. None of the FY2003 appropriation was used for Infrastructure Grants, and in FY2006, $20 million was rescinded by Congress.

Gap Filler Grants (Formerly Bridge Grants)

These grants are awarded to states to provide eligible individuals with a subsidy during the HCTC enrollment process when individuals are responsible for 100% of the premium. Grant distributions are made during the months required for the IRS to enroll, process, and make the first HCTC payment. The IRS typically takes between one to three months to complete this process. These months are referred to as the "gap period." These gap filler payments cover 65% of the qualified health insurance premium, that is, the proportion that will later be covered by advance payments.[23] (These grants, made available through the National Emergency Grant program under the Workforce Investment Act, were originally referred to as Bridge Grants. The purpose of the Bridge Grants was to provide individuals with a subsidy, up to 65% of the premium, prior to implementation of the HCTC advance payment system in August 2003.[24])

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 PBGC eligibles; (2) the percent of eligibles expected to enroll for 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.

For these grants, the act appropriated $50 million for FY2002. DOL distributed all of these funds to 13 states by the end of FY2004. **Table A-2** in the **Appendix** displays which states received then-Bridge Grants and how much they received. The act also authorized appropriations of $100 million for FY2003 and $50 million for FY2004. As discussed above, Congress appropriated $29.8 million in FY2003 to be used for both Gap Filler and Infrastructure grants, but later rescinded $20 million, which left $9.8 million to be distributed. By the end of FY2004, $3.8 million had been distributed for Gap Filler Grants to two states.[25] **Table A-3** in the **Appendix** shows the amounts awarded to those two states, and the funds yet to be distributed.[26]

State High Risk Pool Grants

In an effort to expand the options for health coverage, 34 states have established high risk health insurance pools. These programs target individuals who cannot obtain or afford health insurance in the private market, primarily because of pre-existing health conditions. [27] Although the state

[23] The Department of Labor issued guidance on using this grant funding for gap filler payments; at http://www.ows.doleta.gov/dmstree/tegl/tegl2k2/tegl_20-02c1.htm.

[24] The Department of Labor issued guidance on the original use of these grant funds; at http://www.doleta.gov/tradeact/directives/tegl20-02.cfm.

[25] A third state, Florida, received a little over $4 million of this grant funding. Florida later de-obligated the funds.

[26] State contacts for gap filler programs (as of June 5, 2007) are available at http://www.irs.gov/pub/irs-utl/neg_contact_list.pdf.

[27] While high risk pools are designed for individuals who face high premiums (provided they are given an insurance offer in the first place), these individuals still must pay a premium for coverage in these pools. Some persons who would otherwise be eligible for high risk pools may be unable to afford the premiums and, therefore, will remain (continued...)

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 Health Insurance"). The Centers for Medicare and Medicaid Services (CMS) administers the federal grant program.

The Trade Act appropriated $20 million in the form of seed grants to be awarded to states that did not already have a high risk pool but wanted to establish one. Each qualifying state could receive up to $1 million to support the creation and implementation of a high risk pool. In 2003, CMS gave seed grants to six states, totaling approximately $4.2 million.

The Trade Act also appropriated $80 million to be split evenly over FY2003 and FY2004 to defray some of the operating losses experienced by states with existing high risk pools. CMS awarded operational grants to 19 states to help cover FY2003 expenses; for FY2004 expenses, CMS awarded grants to 22 states. Taken together, CMS awarded the full $80 million appropriated to fund operational grants.

Additional grant funding was authorized under H.R. 4519, the State High Risk Pool Funding Extension Act of 2006 (P.L. 109-172). It authorized the following amounts to help cover FY2005 expenses: $75 million for operational and bonus grants, as well as $15 million for seed grants. (Bonus grants are to be used to provide additional benefits or premium assistance.) The Deficit Reduction Act of 2005 (P.L. 109-171) fully appropriated the amounts authorized under H.R. 4519. CMS awarded grants to 31 states that experienced operational losses in 2005. Of those 31 states, 25 also received bonus grants. In addition, CMS awarded seed grants to five states in 2006, and to another five states in 2007. Funding for future operational and bonus grants have not been appropriated.

Analysis of Program 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.

Throughout implementation and operation of this program, observers have raised questions about the effectiveness of the HCTC in assisting taxpayers obtain or retain health insurance coverage. Others question the equity of the program design (particularly with respect to eligibility) and raise concerns about its overall efficiency. These issues are discussed in this section.

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.

(...continued)

uninsured. For additional information about these pools and grants to states, see *State High Risk Pools*.

Participation

For the 2005 tax year, 27,816 taxpayers claimed the HCTC, with 54% choosing the monthly credit option, 21% choosing the end-of-the-year option, and the remaining 25% using both options. [28] (As discussed earlier, the potentially eligible population was approximately 350,000.) By eligibility group, TRA/ATAA recipients currently represent over a third of HCTC enrollees, whereas PBGC recipients represent the remaining two-thirds.[29]

Knowledge of HCTC benefit

One possible reason for the low use of the tax credit among eligible persons is that many workers may be unaware of this benefit in the first place. According to one Government Accountability Office (GAO) study, at most of the work sites they surveyed, more than half of the workers who visited one-stop career centers were not aware of this benefit. This is despite efforts by federal and state programs, local officials, unions, and others to inform workers of this tax credit program. Some workers indicated that they would have applied for the tax credit had they known about it.[30]

Availability of Qualified Health Plans

In 2007, 43 states and the District of Columbia made at least one of the state-qualified plan types available; most states provided multiple plan options. These states include the vast majority of HCTC eligible individuals. In addition, eligibles may be able to access one of the three automatically qualified plan options. As a practical matter, however, some HCTC eligibles continue to face difficulty in finding a qualified plan.

For example, the COBRA continuation coverage option (letter A in the list under "Qualified Health Insurance" is available only if the former employer had at least 20 workers and continues to offer health benefits to its remaining workers. One study, citing federal officials, noted that roughly 40% to 60% of HCTC eligibles have access to COBRA coverage; which means COBRA is not available to the remaining HCTC eligibles.[31] Moreover, those with access must be able to pay the full premium cost plus a 2% administrative fee (see the discussion in the "Affordability" section below). The spousal coverage and individual health insurance 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; for the latter, one must have had individual insurance before termination of employment.

As discussed above, a majority of states offer at least one state-qualified plan option. However, eight states do not. Eligibles in those eight states must be eligible for the automatically qualified plans discussed above, or they will have no qualified plan options available to them.

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[28] Data provided to CRS by the IRS.

[29] See "IRS testimony."

[30] U.S. Government Accountability Office, *Trade Adjustment Assistance: Most Workers in Five Layoffs Received Services, but Better Outreach Needed on New Benefits*, GAO-06-43, January 2006.

[31] S. Dorn and T. Kutyla, "Health Coverage Tax Credits Under the Trade Act of 2002: A Preliminary Analysis of Program Operation," The Commonwealth Fund, April 2004, at http://www.commonwealthfund.org/usr_doc/721_Dorn_taxcredits_tradeact2002.pdf?section=4039. (Hereafter cited as "Health Coverage Tax Credits.")

Consumer Protection Requirements

One issue related to state-qualified plan options is whether the consumer protection requirements (guaranteed issue, no coverage denial based on preexisting conditions, and substantially the same premiums and benefits for eligibles and noneligibles) reduce the availability and increase the cost of such plans. These requirements impose stricter standards on health plans than other federal and most state laws.[32] 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.

Patient advocates and others contend that consumer protections, in general, make access to insurance more equitable and should apply to everyone, regardless of insurance status or medical need.[33] Although such observers acknowledge the consumer protections under the HCTC program, some argue that those requirements are not comprehensive enough. They argue that without broad requirements, health plans may still charge a high premium to persons with greater health care needs, particularly older workers and early retirees, making it difficult for them to find affordable coverage.[34]

Complexity

In addition to finding an available health plan that qualifies for the HCTC, eligibles must navigate a complicated enrollment system in order to receive the tax credit. "Workers must apply to between two and five public and private entities and frequently must deliver to one or more of these entities hard-copy documents issued by the others."[35] This burden was highlighted in responses to a DOL survey asking state officials for their views on the primary reason for low participation. Complexity was second only to affordability as the factor mentioned the most.[36]

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[32] 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.

[33] For example, see the National Alliance on Mental Illness, "Public Policy Platform," November 2006, at http://www.nami.org/; and Families USA study on consumer protections in state managed care laws at http://www.familiesusa.org/assets/pdfs/hitmiss64e2.pdf.

[34] See, for example, the Statement of K. Pollitz in U.S. Congress, House Committee on Ways and Means, *Hearing on Promoting U.S. Worker Competitiveness in a Globalized Economy*, 110th Cong., 1st sess., June 14, 2007, at http://waysandmeans.house.gov.

[35] S. Dorn, et al., "Limited Take-up of Health Coverage Tax Credits and The Design of Future Tax Credits for the Uninsured," Economic and Social Research Institute, November 3, 2005, p. 6, at http://www.esresearch.org/documents_1-05/HCTC_TakeUp.pdf.

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

Affordability

Even if qualified insurance is available, and a person has access to the tax credit, 35% of the premium is not covered. This contribution level may be unaffordable, especially considering most HCTC eligibles are no longer working. In the DOL survey mentioned above, 80% of state officials surveyed mentioned affordability as the primary factor for low use of the tax credit.

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 (unless that person receives subsidies through the gap filler grant program). Some might calculate that the copayments, deductibles, and other cost-sharing requirements would require sizable out of pocket expenditures.

Other Factors Affecting Participation

Additional reasons why the HCTC participation is low may include the following:

- delays in identifying dislocated workers receiving unemployment benefits who have not yet applied for TAA benefits;
- delays in certifying that dislocated workers are eligible for TAA assistance;
- loss of eligibility by younger spouse of affected worker when that worker becomes eligible for Medicare;
- 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; so taxpayers in higher-income brackets receive greater tax savings than those in lower-income brackets. In addition, the health coverage tax credits are 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 is 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. For example, in the case of a $3,000 self-only policy, the HCTC would provide $1,950 in tax savings to taxpayers with incomes of $80,000, as well as 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.

Another equity issue relates to who is eligible for the tax credit. Unemployed workers who do not receive TAA allowances may question why they are denied the credit, particularly if they too have lost their jobs because of competition from foreign firms. 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.

Efficiency

Some observers of the HCTC have voiced concerns regarding the efficiency with which the program is run. Given the complexity involved in enrollment in the program and administration of the tax credits themselves, it is not surprising that operational costs would constitute a significant portion of overall program costs, especially during the start-up phase. However, administrative costs remain high even after a few years of operation. One study estimated that of the federal funding going towards advance payments in 2007, a full third will be spent on administration.[37] This leaves only 66 cents for every federal dollar spent on the advance payment component for purchasing health coverage.

Legislation in the 110th Congress

A number of bills have been introduced that would make substantive modifications to the HCTC program. Most of those bills have proposed HCTC changes within the broader context of reauthorizing the TAA program. Congress currently is in the midst of discussions regarding reauthorization. On October 31, 2007, the House passed H.R. 3920, which would reauthorize and expand the TAA program (a more detailed description of this bill is included below). It has been referred to the Senate Finance Committee.

Meanwhile, Congress passed legislation to temporarily extend TAA. H.R. 3375/P.L. 110-89 extended the TAA program through December 31, 2007. H.R. 2764/ P.L. 110-161 includes provisions to fund the TAA program through September 30, 2008. According to the Department of Labor, the department considers the appropriation amount sufficient to continue fully operating the TAA program, including issuing new certifications for eligibility, through the end of the current fiscal year.[38]

House

H.R. 910, the American Competitiveness and Adjustment Act, would amend the Trade Act of 1974 to increase the federal subsidy rate under the health coverage tax credit program from 65% to 75% of the premium. The bill would also establish presumptive eligibility, up to 90 days, for individuals who have filed petitions to receive trade adjustment assistance but have not yet received final determination of their eligibility for such assistance. It also would clarify that the three (or more) months of creditable coverage necessary to be considered qualified must be prior to the separation from employment. H.R. 910 was introduced on February 8, 2007, by Representative English, and referred to the House Ways and Means Committee, Income Security and Family Support Subcommittee, on February 20, 2007.

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[37] S. Dorn, "Administrative Costs for Advance Payment of Health Coverage Tax Credits: An Initial Analysis," The Urban Institute, March 2007, at http://www.cmwf.org/usr_doc/1017_Dorn_admin_costs_advance_payment_HCTC.pdf.

[38] See DOL letter to Senate Finance Committee Chairman Baucus and Ranking Member Grassley at http://www.senate.gov/~finance/press/Bpress/2007press/prb121907e.pdf.

H.R. 1729, the Trade Adjustment Assistance Reform Act, would amend the Trade Act of 1974 to increase the federal subsidy rate under the health coverage tax credit program to 80% of the premium. It would also delegate authority to the Secretaries of Treasury and Labor to simplify the enrollment process for receiving trade readjustment allowances, and the process for claiming and receiving the tax credit, including through the advance payment system. H.R. 1729 was introduced on March 28, 2007, by Representative Hayes, and referred to the House Ways and Means Committee on the same date.

H.R. 2764, Consolidated Appropriations Act, 2008 (P.L. 110-161), appropriated $888.7 million for the TAA for workers program for FY2008. The Act prohibits any of the funds made available from being used to finalize or implement any proposed regulation until TAA is reauthorized. President Bust signed H.R. 2764 into law on December 26, 2007.

H.R. 3589, a bill to amend the Trade Act of 1974, would extend trade adjustment assistance to certain service workers This bill would amend the Trade Act of 1974 to extend eligibility for TAA (and, therefore, HCTC) assistance to service workers who work in the information technology sector or provide "other high technology services." H.R. 3589 was introduced on September 19, 2007, by Representative King, and referred to the House Ways and Means Committee on the same date.

H.R. 3920, the Trade and Globalization Assistance Act of 2007, would amend the Trade Act of 1974 to (among other provisions) extend eligibility for TAA (and, therefore, HCTC) assistance to service workers and workers in public agencies, and broaden the basis on which the Labor Secretary may determine that workers in a firm, agency, or an entire occupational category are eligible for trade adjustment assistance. The bill also extends the time period that COBRA continuation coverage is available to a TAA-eligible worker to last at least as long as the time period that the worker is eligible for TAA. With respect to HCTC-specific provisions, the bill would increase the federal subsidy rate under the health coverage tax credit program from 65% to 85% of the premium, and make retroactive HCTC payments to eligible persons for the one or more months needed by the IRS to certify eligibility and make the first HCTC payment under the advance payment system. It also would allow qualified family members to continue to receive the HCTC even in the event that the qualified worker becomes eligible for Medicare, the worker and spouse are divorced, or the worker dies. H.R. 3920 was introduced on October 22, 2007, by Representative Rangel. It passed the House on October 31, 2007, on a vote of 264-157, and was referred to the Senate Finance Committee on November 5, 2007.

H.R. 3943, the Trade Adjustment Assistance and Training Improvements Act of 2007, would amend the Trade Act of 1974 to reauthorize the TAA for workers program. It is similar to H.R. 3920 in approach. The bill includes provisions to expand TAA eligibility to workers that create intangible products such as computer programs, and allow participants to simultaneously work and receive job training. H.R. 3943 was introduced on October 23, 2007, by Representative Herger, and referred to the House Ways and Means Committee on the same date.

Senate

S. 1652, Trade Adjustment Assistance Reform Act, is identical to H.R. 1729. S. 1652 was introduced on June 19, 2007, by Senator Dole, and referred to the Finance Committee on the same date.

S. 1739, the TAA Health Coverage Improvement Act of 2007, would amend the Internal Revenue Code of 1986 to (among other provisions) increase the federal subsidy rate under the health coverage tax credit program from 65% to 95% of the premium, and provide a 100% subsidy to eligible individuals in the months prior to issuance of certificates stating their eligibility for the tax credit. It also would establish presumptive eligibility, up to 90 days, for individuals who have filed petitions to receive trade adjustment assistance but have not yet received final determination of their eligibility for such assistance. The bill would allow qualified family members to continue to receive the HCTC even in the event that the qualified worker becomes eligible for Medicare, the worker and spouse are divorced, or the worker dies. In addition, it would clarify that the three (or more) months of creditable coverage necessary to be considered qualified must be prior to the separation from employment, and the calculation of a lapse in coverage of 63 days (in relation to consumer protections for "qualifying" individuals) begins following TAA certification. Moreover, the bill would allow funds through the National Emergency Grants program to be used to provide health insurance coverage to PBGC pension recipients and their families for three months preceding the first month they must have qualified health insurance in order to be eligible to claim the tax credit. S. 1739 was introduced on June 28, 2007, by Senator Rockefeller, and referred to the Finance Committee on the same date.

S. 1848, the Trade and Globalization Adjustment Assistance Act of 2007, is similar to H.R. 3920, with respect to provisions affecting the HCTC program. All the provisions described above under H.R. 3920 also apply to S. 1848. In addition, the Senate bill allows funds through the National Emergency Grants program to be used to provide health insurance coverage to workers and their families for three months preceding the first month they must have qualified health insurance in order to be eligible to claim the tax credit. S. 1848 was introduced on July 23, 2007, by Senator Baucus, and referred to the Finance Committee on the same date.

Appendix. Infrastructure Grants, Bridge Grants, and Gap Filler Grants, by State, FY2002-FY2003

Table A-1. Infrastructure Grants from FY2002 Appropriation of $10 Million (as of March 2007)

State	Amount awarded
Alabama	$55,206
Alaska	$135,000
Arizona	$74,717
Arkansas	$200,000
California	$50,000
Colorado	$184,615
Connecticut	$189,700
Delaware	$50,500
Florida	$288,020
Georgia	$1,000,000
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	$657,867
Massachusetts	$150,000
Michigan	$128,384
Minnesota	$81,551
Missouri	$98,456
Montana	$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

State	Amount awarded
Ohio	$222,105
Oregon	$144,369
Pennsylvania	$394,908
Rhode Island	$152,000
South Carolina	$200,000
South Dakota	$57,760
Tennessee	$244,779
Texas	$200,000
Utah	$428,946
Vermont	$50,000
Virginia	$12,702
Washington	$74,219
West Virginia	$117,053
Wisconsin	$256,245
Total awards to states	**$7,997,935**
Amount of unspent allocation	**$2,002,065**

Source: Provided to CRS by the Department of Labor in March 2007.

Table A-2. Bridge Grants from FY2002 Appropriation 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	$2,965,264
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 A-3. Gap Filler Grants from FY2003 Appropriation of $29.8 Million (as of March 2007)

State	Amount awarded
Kentucky	$2,317,865
North Carolina	$1,500,000
Total awards to states	**$3,817,865**
Amount rescinded by Congress	**$20,000,000**
Amount unspent of allocation	**$5,987,135**

Source: Provided to CRS by the Department of Labor in March 2007.

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