Health Coverage Tax Credit

Bernadette Fernandez
Specialist in Health Care Financing

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Summary

The health coverage tax credit (HCTC) expired on January 1, 2014. This federal income tax credit subsidized most of the cost of qualified health insurance for eligible taxpayers and their family members. The Trade Act of 2002 (P.L. 107-210) first authorized the HCTC. Potential eligibility for the HCTC was limited to three groups of taxpayers, two of whom were individuals eligible for Trade Adjustment Assistance (TAA) allowances because they experienced job loss. The third group consisted of individuals whose defined benefit pension plans were taken over by the Pension Benefit Guaranty Corporation because of financial difficulties. Moreover, these potential HCTC-eligible individuals were allowed to claim the tax credit only if they either could not enroll in certain other health coverage (e.g., Medicaid) or were not eligible for other specified coverage (e.g., Medicare Part A).

To claim the HCTC, eligible taxpayers had to have *qualified health insurance* (specific categories of coverage, as specified in statute). Several of those categories required state action (*state-qualified health plans*) to become available. As of December 2010, 44 states and the District of Columbia made available at least one of the state-qualified health plans. In the remaining six states, the categories of qualified health insurance that were potentially available were ones that were *not* dependent on state action (*automatically qualified health plans*), though not necessarily all persons who were eligible for the HCTC could avail themselves of these options.

The HCTC was refundable, so taxpayers could claim the full credit amount even if they had little or no federal income tax liability. The credit also could be advanced, so taxpayers did not need to wait until they filed their tax returns to benefit from it. Despite these features, the HCTC was not widely used. For each year the HCTC was available, fewer than 30,000 individuals participated, out of hundreds of thousands of individuals who potentially were eligible for the tax credit. Possible reasons explaining such low participation included not knowing the tax credit was available, barriers to finding qualified insurance, complexity of the application and enrollment process, and difficulties paying the part of the premium not covered by the tax credit. Concerns were raised about whether the HCTC was equitable, since it provided a large tax subsidy to some unemployed workers but not others, and whether it was efficient, since it had what some analysts considered large administrative costs.

Coinciding with expiration of the HCTC, a new health insurance tax credit was authorized under the Patient Protection and Affordable Care Act (ACA; P.L. 111-148, as amended). Eligibility and other rules applicable to the new tax credit differ from those applicable to the HCTC.

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Introduction

The Trade Act of 2002 (P.L. 107-210) authorized a federal income tax credit—the Health Coverage Tax Credit[1] (HCTC)—for certain workers who had experienced job loss and for retirees whose private pension plans were taken over by the Pension Benefit Guaranty Corporation.[2] The purpose of the tax credit was to make the purchase of health insurance more affordable for such individuals. The HCTC is no longer available; the tax credit program terminated on January 1, 2014.

As part of congressional discussions related to expanding international trade authority, there has been discussion of reauthorizing Trade Adjustment Assistance (TAA), a program that provides various benefits to workers who have lost their jobs due to foreign trade. Prior to its expiration, the HCTC was available to TAA-eligible workers. Some TAA reauthorization bills have proposed renewing the HCTC as part of a broader extension of TAA. To provide context for such discussions, this report includes background information about the rules applicable to the HCTC at the time of its expiration.

Moreover, although the HCTC is no longer available, many programs associated with the HCTC still exist. For example, the three employment-related programs through which individuals potentially became eligible for the HCTC are still in operation. However, for the purposes of this report, those programs and other issues are described in the past tense, to be consistent with the description of the HCTC.

The report describes the expired eligibility criteria, as well as the types of health insurance to which the tax credit may have been applied. It discusses past federal and state roles in administering the HCTC program, and it summarizes analyses on the credit's effectiveness in reaching targeted populations and related equity and efficiency issues. In addition, the report includes a short discussion of relevant current law and summarizes statutory history of the HCTC program.

Background

The HCTC, before its expiration, covered 72.5%[3] of the premium for certain types of health insurance purchased by an eligible taxpayer. The taxpayer was responsible for covering the remaining 27.5% of the premium. Eligible taxpayers were only allowed to use the HCTC toward the purchase of *qualified health insurance* (categories of health coverage that were specified in

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[1] The Internal Revenue Service (IRS) referred to the credit as the "health coverage tax credit." However, the credit was sometimes known as the "trade adjustment assistance credit" (or TAA credit) and the "Trade Act credit." It appeared in budget documents as the "tax credit for health insurance purchased by certain displaced and retired individuals." A similar phrase was used by the Joint Committee on Taxation. This report uses the term *Health Coverage Tax Credit* (HCTC) to conform to past IRS practice.

[2] The IRS's website included information about the HCTC program and administration of the credit; see "The Health Coverage Tax Credit (HCTC) Program," at http://www.irs.gov/Individuals/The-Health-Coverage-Tax-Credit-%28HCTC%29-Program.

[3] When the HCTC was initially authorized in 2002, the subsidy rate was 65%. The American Recovery and Reinvestment Act of 2009 (ARRA; P.L. 111-5) temporarily increased the subsidy rate to 80%, with a sunset date of February 13, 2011. Under P.L. 112-40, the subsidy rate of 72.5% became retroactively effective on that date.

statute). The HCTC was refundable, so taxpayers could have claimed the full credit even if they had little or no federal income tax liability. The credit also could be advanced, so taxpayers did not need to wait until they filed their tax returns to benefit from the tax credit. The HCTC program terminated on January 1, 2014.

The HCTC was not used widely. For each year the HCTC was available, fewer than 30,000 individuals participated, out of hundreds of thousands of individuals who potentially were eligible for the credit.[4] Possible reasons explaining such low participation include lack of widespread knowledge that the tax credit was available, barriers to finding qualified insurance, complexity of the application and enrollment process, and difficulties paying the part of the premium not covered by the tax credit.

Eligible Taxpayer Groups

To claim the HCTC, taxpayers must have been 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 applied. In addition, eligible taxpayers were allowed to use the HCTC only toward the purchase of qualified health insurance, the rules for which are discussed immediately after this section.

The three groups of taxpayers who were eligible to claim the HCTC were

- individuals who received 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 had not yet exhausted their state unemployment benefits;
- individuals who received wage subsidies in the form of *Reemployment Trade Adjustment Assistance* (RTAA) benefits; and
- individuals between the ages of 55 and 64 who received payments from the *Pension Benefit Guaranty Corporation (PBGC)*.

The first two groups consisted of individuals who lost manufacturing, service, or public agency jobs due to international trade or shifts in production or supply of services outside the United States. The U.S. Department of Labor (DOL) had to certify that workers dislocated by these events were eligible for TAA assistance. Certification occurred upon petition from the workers, the affected company, a union, or others. After a petition was certified, workers were notified by a state workforce agency (SWA) and could apply for TAA benefits at One-Stop Career Centers.[5] TAA benefits included income support, counseling and other employment services, job search

[4] Government Accountability Office, "Health Coverage Tax Credit: Participation and Administrative Costs," April 30, 2010, at http://www.gao.gov/new.items/d10521r.pdf. (Hereinafter cited as "Participation and Administrative Costs.")

[5] State workforce agencies were state offices, funded by the DOL, that were 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 were part of a coordinated delivery system of employment and training services; they were organized by local workforce investment boards under the Workforce Investment Act of 1998. To search for locations of such centers, see Department of Labor, "America's Service Locator," http://www.servicelocator.org.

and relocation allowances, and training.[6] Individuals who received TAA assistance may have been eligible to claim the HCTC.

Group One: Trade Readjustment Allowances

To have been eligible for a TRA, individuals must have exhausted state unemployment compensation. Generally, such individuals also must have been enrolled in TAA-approved training within 26 weeks of either the date they were certified TAA eligible or the date of job separation (whichever was later), have completed such training, or have received a training waiver. However, HCTC eligibility also included individuals who were receiving TAA benefits but were not enrolled in training. TRA consisted of two components: basic TRA and additional TRA. The statutory maximum time period for receiving TRA was 130 weeks; for persons in remedial training, the maximum was 156 weeks. Persons who received benefits under TAA were eligible for the HCTC for as long as they received either unemployment benefits or the allowance, and for one month afterward.[7]

Group Two: Reemployment Trade Adjustment Assistance

To be eligible for reemployment TAA (RTAA), individuals must have been certified eligible for TAA, aged 50 or older, and have been reemployed but not at the firm from which the worker originally separated, not earning more than $55,000 per year in wages,[8] and either have obtained employment on a full-time basis or on a part-time basis and enrolled in approved training. Individuals who elected RTAA received wage supplements worth half the difference in salary between their old and new jobs for a maximum of $12,000 over two years. Similar to Group One, persons who received RTAA benefits were eligible for the HCTC for as long as they received such benefits and for one month afterward.

Group Three: Pension Benefit Guaranty Corporation

To receive a Pension Benefit Guaranty Corporation (PBGC) pension benefit, 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 assumed control of defined benefit plans (pension plans that promise to pay a specific monthly benefit at retirement) when the agency determined that the plans must be terminated to protect the interests of participants (for example, if benefits that were due could not be paid) or when employers demonstrated that they could not remain in business unless the plan was terminated. The PBGC used plan assets and its own insurance reserves to pay the pensions (up to a guaranteed amount) to the former workers and their survivors. Individuals who received PBGC-paid pensions were eligible for the HCTC provided they were at least 55 years of age but not yet entitled to Medicare (which usually occurred at the age of 65).

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[6] See CRS Report R43945, *Health Insurance Premium Credits in the Patient Protection and Affordable Care Act (ACA) in 2015*, by Bernadette Fernandez.

[7] 26 U.S.C. § 35(c)(2)(A).

[8] However, eligible workers could have had combined wages and RTAA payments that exceeded $55,000 per year.

[9] Information on the Pension Benefit Guaranty Corporation was available through its website at http://www.pbgc.gov. For an overview, see CRS Report 95-118, *Pension Benefit Guaranty Corporation (PBGC): A Primer*, by John J. Topoleski.

Limitations on Eligibility

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

- 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 paid 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 (CHIP).

Similarly, to be eligible for the HCTC, individuals *could not be eligible* for the following:

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

In addition, individuals were not eligible for the tax credit if they were incarcerated or if they may have been claimed as a dependent by another taxpayer.

Family Members

Eligible individuals could have used the HCTC for health insurance that covered a spouse and dependents who could have been claimed on their tax return. For this purpose, children of divorced or separated parents were treated as dependents of the custodial parent.

Qualifying family members faced the same enrollment limitations as eligible taxpayers (i.e., they could not be enrolled in or eligible for the insurance described above). Family members could have continued to receive the tax credit for up to two years after any of the following events: the qualified taxpayer became eligible for Medicare, the taxpayer and spouse divorced, or the taxpayer died.

Qualified Health Insurance

An eligible individual was only allowed to claim the HCTC to cover part of the premium for qualified health insurance. The statute limited qualified health insurance to 11 categories of coverage, identified as options (A) through (K). Individuals were not allowed to claim the tax credit for another type of coverage.

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[10] Premiums paid by employees under premium conversion plans (through a cafeteria plan) were considered to be paid by the employer. Additional eligibility restrictions apply to RTAA individuals for certain types of insurance if their current or previous employer (or the current or previous employer of a spouse) paid part of the coverage or the premium could be paid on a pretax basis.

Four of the coverage categories were referred to as *automatically qualified health plans*. Individuals could elect these options without involvement by their state. These options (identified by their statutory letter designation) were as follows:

A. Coverage under COBRA;[11]

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

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 that qualified the individual as a TAA, RTAA, or PBGC pension recipient;[12] and

K. Coverage funded by a voluntary employees' beneficiary association (VEBA).[13]

The other seven categories of coverage were known as *state-qualified health plans*.[14] Individuals could have chosen these options only if their state had established these plans. These options (identified by their statutory letter designation) were as follows:

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

C. Coverage offered through a state high-risk pool (HRP);[15]

D. Coverage under a plan offered for state employees;

E. Coverage under a state-based plan that was 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 did not receive any federal financing.

Coverage under state-qualified health plans was required to provide four consumer protections, specified in statute, to all qualifying individuals. *Qualifying individuals* were defined in the

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[11] COBRA referred to the Consolidated Omnibus Budget Reconciliation Act of 1985 (P.L. 99-272). Title X of this legislation required 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 could have charged the beneficiary up to 100% of the premium (counting both the employer and employee shares) plus 2% to cover administrative expenses. Individuals generally had 60 days from either formal notification by the employer or date of loss of coverage in which to elect COBRA coverage, though Section 203(e) of the Trade Act of 2002 authorized an extension of the election period for individuals who were eligible for TAA assistance.

[12] The requirement for prior coverage did not apply to individual insurance obtained through a state-qualified plan. This exception was not explicit in the statute.

[13] Voluntary Employees' Beneficiary Association (VEBA) plans provided life insurance, medical, disability, accident and other welfare benefits to employee members and their dependents. Most were organized as trusts to be legally separate from employers. Provided certain conditions were met, the investment earnings of VEBAs were exempt from taxation, as were the benefits paid out if the benefit would normally be exempt. VEBAs were allowed to be funded by employers or employees.

[14] For a list of state-qualified health plans that were offered in each state, see the IRS website at http://www.irs.gov/Individuals/HCTC:-List-of-State-Qualified-Health-Plans.

[15] State high-risk pools (HRPs) were health insurance programs designed for individuals with preexisting health conditions who experienced difficulties in obtaining coverage in the private market. For additional information about state HRPs, see National Association of State Comprehensive Health Insurance Plans, "State Risk Pool Status Report," http://naschip.org/portal/.

statute as HCTC eligible individuals (as described above) who have had three months of *creditable coverage* under another health plan prior to applying to a state-qualified plan,[16] and did not have a significant break in coverage (defined as 63 days or more without coverage). For such individuals, state-qualified health plans must have been guaranteed issue (coverage was offered to all qualifying applicants), and these individuals may not have denied coverage based on preexisting health conditions. Premiums (without regard to subsidies) must not have been greater for qualifying individuals than for other similarly situated individuals. Benefits for qualifying individuals must have been the same as or substantially similar to benefits for others. In short, the statute attempted to ensure that state-qualified health plans were open to all qualifying applicants, and did not charge more or provide fewer benefits to people who were receiving the tax credit. The consumer protections did not preclude use of medical underwriting to set premiums.

Certain types of coverage were not considered qualified health insurance, even if they otherwise met one of the categories listed above. Such coverage included 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 relied on the participation of several federal and state agencies. The Department of the Treasury was primarily responsible for administering the advance payment system (it provided the HCTC on a monthly basis to coincide with payment of insurance premiums) and, through the Internal Revenue Service (IRS), reviewed tax returns on which the credit was claimed. The Department of Labor (DOL) and the PBGC were responsible for helping Treasury identify who may have been eligible for the credit. DOL also coordinated the One-Stop Career Center system; these centers provided a full range of services to assist job seekers. Lastly, DOL administered two grant programs that provided assistance to states to establish the infrastructure to administer the program and provided temporary subsidies to individuals waiting for their first tax credit payment.

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

Notifying Eligible Individuals

Beginning in 2002, DOL's Employment and Training Administration requested that SWAs mail HCTC information packets to all eligible TAA recipients or persons who could have been eligible for TAA allowances as soon as they exhausted their unemployment benefits.[17] Included with the

[16] The requirement that creditable coverage immediately precede the application appears in IRS guidance; it was not explicit in the statute. Even so, IRS guidance explicitly allowed for preexisting condition exclusions to be imposed if the individual had less than three months of creditable coverage.

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

information packet was an HCTC eligibility certificate, a document that identified the individual as potentially eligible for the tax credit. SWAs also were required to submit to the HCTC program a daily listing of persons eligible for TRA and RTAA. Similarly, the PBGC identified beneficiaries who were potentially eligible for the HCTC and provided to the IRS the beneficiaries' relevant personal information, including names, addresses, social security numbers, and dates of birth.[18] The HCTC program, administered through the IRS, mailed program kits[19] to persons whose names were included on the lists provided to them by the SWAs and PBGC.

The HCTC program had difficulty notifying one group of eligible individuals—persons who received unemployment compensation but had not yet applied for TAA benefits. Unless they petitioned the DOL directly, their names and contact information were not easily identified. Unemployment compensation lasted up to 26 weeks in most states, and recipients often did not apply for TAA benefits until near the end of that period. These persons, probably the largest group of TAA-eligible individuals, generally did not receive notification about their HCTC eligibility until their unemployment benefits ended.

Availability of Qualified Health Insurance

The HCTC was available only to eligible taxpayers who enrolled in qualified health insurance, as described above. The automatically qualified plans were potentially available in all states, but only for certain individuals. COBRA continuation coverage (option A in the list under the "Qualified Health Insurance" section) was available only if an individual's previous employer continued to offer health benefits to its remaining workers or retirees. If the company dropped coverage completely or went out of business, a COBRA election was not possible. Coverage under a group health plan available through the employment of a spouse (option I) was available only if the individual was married and his or her spouse had coverage. Even if the spouse had coverage, the credit was not available if the spouse's employer paid 50% or more of the cost, which usually was the case under employer-sponsored health insurance. Individual health insurance coverage (option J) generally was not available due to the requirement that the worker needed to be enrolled in such coverage *before* loss of employment.[20] Finally, coverage funded through a VEBA (option K) depended on a VEBA being established in the first place.

The remaining categories of qualified health insurance (options B through H) were available only if states designated them as qualified insurance. As of December 2010, 44 states and the District of Columbia made at least one of the seven state-qualified plan types available.[21] In the remaining six states (Delaware, Mississippi, Nevada, New Mexico, South Dakota, and Wyoming), individuals who were eligible for the HCTC could select only from the automatically qualified plan options, if an option was available to them.

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

[19] See http://www.irs.gov/pub/irs-utl/program_kit_rev_1-2007.pdf.

[20] The requirement for individual coverage prior to job loss did not apply to individual coverage under a state-qualified health plan.

[21] For updated links to state-qualified health plans, see http://www.irs.gov/Individuals/HCTC:-List-of-State-Qualified-Health-Plans.

Claiming the Tax Credit

Eligible taxpayers with qualified insurance could choose to receive the HCTC after they filed their tax returns for the year, generally in the period February 1 through April 15 of the following year. Alternatively, they could have chosen to receive advance payments for the credit, on a monthly basis, throughout the year. Some might have chosen to receive a portion of the credit through advance payments and the remainder after they filed their return. Advance payments were not available for coverage through a spouse's employment (option I).

Next-Year Payments

Taxpayers claimed the HCTC after the tax year was over by completing Form 8885 and attaching it to their standard Form 1040. The credit could not be claimed with standard forms 1040A or 1040EZ. Taxpayers had to attach invoices and proof of payment for qualified health insurance.

Because the HCTC was refundable, taxpayers could receive the full amount for which they were eligible even if they had little or no tax liability. Their other tax credits had no effect on their HCTC, nor did the HCTC affect their other credits.

Advance Payments

To receive advance payments of the credit, individuals registered with the HCTC program through its Customer Contact Center. They must have been enrolled in qualified health insurance when they registered. The program confirmed applicants' eligibility and sent them an invoice for the taxpayer's share of the total monthly premium (the taxpayer's share of the premium was 27.5% because the HCTC's subsidy rate was 72.5%). Participants sent 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 sent payment for 100% of the premium (comprised of 27.5% from the participant and 72.5% from Treasury) to the participants' health insurance plans. The payment system continued in this way on a monthly basis. Advance payments first became available in August 2003.

An eligible taxpayer could have received retroactive payments to cover health insurance costs incurred during the time the IRS took to certify HCTC eligibility and make the first advance payment. Any retroactive payment could have been reduced by any payments received by the taxpayer, for purchase of health insurance, through the National Emergency Grant program (see discussion in the following "Grants to States" section for additional details about this program).

Grants to States

Section 203 of the Trade Act of 2002 expanded the National Emergency Grant (NEG) program to support implementation of the HCTC.[22] DOL administered two grant programs through the NEG program: infrastructure grants and gap filler grants. In addition, Section 201 of the Trade Act authorized new funding to be made available through the Centers for Medicare & Medicaid

[22] National Emergency Grants were first authorized by the Workforce Investment Act of 1998 (P.L. 105-220). In general, they supported 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.

Services (CMS) in the Department of Health and Human Services that helped states create new high risk pools and fund existing ones.

Infrastructure grants assisted states in developing administrative systems to conduct eligibility verification, notify eligible individuals, provide enrollment assistance, install data management systems, and support other administrative functions. Once the systems and procedures were in place and the state began supporting operations of the HCTC program, the state could request modifications to cover ongoing operational costs.

Gap filler grants (formerly known as bridge grants) were awarded to states to subsidize eligible individuals during the HCTC enrollment process when they were responsible for 100% of the premium. Distributions were made during the months required for the IRS to enroll, process, and make the first HCTC payment. The IRS typically took between one to three months (referred to as the *gap period*) to complete this process. Gap filler payments covered the portion of the premium that would later be covered by advance payments.

State high-risk pool grants were provided to states to help them establish and fund programs for individuals who could not obtain or afford private health insurance, primarily because of preexisting health conditions. Although the grants did not directly support administration of the HCTC, they were intended to help states provide a state-qualified plan option to individuals eligible for the HCTC (see letter C in the list under the section titled "Qualified Health Insurance"). As of December 2010, 35 state HRPs were operational.[23]

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 raised questions about the effectiveness of the HCTC in assisting taxpayers obtain or retain health insurance coverage. Others questioned the equity of the program design and raised concerns about its overall efficiency. These issues are discussed in this section.

Effectiveness

Data for the HCTC indicated that it was not widely used, raising questions about its effectiveness. It is not clear whether changes to the HCTC program would have led to more taxpayers using the credit, or if participation always would have been low.

[23] For updated information about state HRPs, see National Association of State Comprehensive Health Insurance Plans, "State Risk Pool Status Report," at http://naschip.org/portal/. These HRPs were different from the temporary high-risk pools that were established under the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended). For additional information about the temporary high-risk pools established under the ACA, see "Pre-Existing Condition Insurance Plan," at http://www.cms.gov/CCIIO/Programs-and-Initiatives/Insurance-Programs/Pre-Existing-Condition-Insurance-Plan.html.

Participation

As discussed earlier, for each year the HCTC was available, fewer than 30,000 individuals claimed the HCTC, out of hundreds of thousands of potentially eligible individuals. Key provisions under the American Recovery and Reinvestment Act of 2009 (ARRA, P.L. 111-5) expanded both eligibility for and benefits of the HCTC program, which affected HCTC participation once those provisions were implemented. Prior to ARRA, approximately 14,000 individuals per month received the tax credit as advance payments (of the fewer than 30,000 individuals who claimed the HCTC). After ARRA enactment, the monthly participation rate for advance payments increased 36%.[24]

Knowledge of HCTC Benefit

One possible reason for the low use of the tax credit among eligible persons was that many workers may have been unaware of the benefit in the first place. According to one Government Accountability Office (GAO) study, at most of the work sites surveyed, more than half of the workers who visited One-Stop Career Centers were not aware of the HCTC benefit. This was despite efforts by federal and state programs, local officials, unions, and others to inform workers of the program. Some workers indicated that they would have applied for the tax credit had they known about it.[25]

Availability of Qualified Health Insurance

As of December 2010, 44 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 included the vast majority of HCTC eligible individuals.[26] In addition, eligible individuals may have been able to access one of the automatically qualified plan options. As a practical matter, however, some who were eligible for the HCTC continued to face difficulty in finding a qualified plan.

For example, COBRA continuation coverage (option A in the list under the "Qualified Health Insurance" section) was available only if the former employer had at least 20 workers and continued to offer health benefits to its remaining workers. One study, citing federal officials, noted that roughly 40% to 60% of HCTC eligible individuals had access to COBRA coverage, which meant that COBRA was not available to the remainder.[27] The spousal coverage and individual health insurance options (letters I and J) had requirements that ruled out most eligible individuals—for the former, one must have been married to someone with coverage not largely paid for by his or her employer; for the latter, one must have had individual insurance before termination of employment.

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[24] See "Participation."

[25] 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.

[26] F. Pervez and S. Dorn, "Health Plan Options Under the Health Coverage Tax Credit Program," December 2006, http://www.urban.org/UploadedPDF/411389_Health_Plan_Options.pdf.

[27] 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.

As indicated above, a majority of states offered at least one state-qualified plan option in 2010. However, six states did not. Eligible individuals in those states would have been able to claim the HCTC only for automatically qualified plans that were available to them (as discussed in the "Qualified Health Insurance" section in this report).

Consumer Protection Requirements

One issue related to state-qualified plan options was whether the consumer protection requirements (guaranteed issue, no coverage denial based on preexisting conditions, and substantially the same premiums and benefits for people who were eligible and those who were ineligible) reduced the availability and increased the cost of such plans. At the time these requirements were put in place, they imposed stricter standards on health plans than other federal and most state laws.[28] As a result, when the Trade Act of 2002 was enacted, many health plans did not meet the consumer protection requirements specified in the statute. To qualify a plan for the HCTC, states either modified existing plans or established new ones. In some instances, this could have been done by administrative action, but it often required state legislation.

Some health care observers argued that the consumer protections under the HCTC program were not comprehensive enough. They stated that without broad requirements, health plans were allowed to charge higher premiums to persons with greater health care needs, making it difficult for them to find affordable coverage.[29]

Complexity

In addition to finding an available health plan that qualified for the HCTC, eligible individuals had to navigate a complicated enrollment system 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."[30] This burden was highlighted in responses to a DOL survey asking state officials for their views on the primary reason for low participation.[31] Complexity was second only to affordability as the factor mentioned the most often.

Affordability

Even if qualified insurance was available and a person had access to the tax credit, 27.5% of the premium was not covered. This contribution level may have been unaffordable, especially considering most HCTC-eligible individuals were no longer working. A majority of state officials

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

[29] For example, see 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*, June 14, 2007.

[30] 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.

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

surveyed about the HCTC program mentioned affordability as the primary factor for low use of the tax credit.[32]

Other costs also may have been important. Some individuals may not have applied for coverage because applicants must pay 100% of the premium pending completion of the enrollment process (unless that person received retroactive payments, or subsidies funded through gap filler grants). Some others may have realized that the co-payments, deductibles, and other cost-sharing requirements would require sizable out-of-pocket spending, based on anticipated use of health care services.

Other Factors Affecting Participation

Additional reasons why HCTC participation was low may have included the following:

- delays in identifying dislocated workers receiving unemployment benefits who had not yet applied for TAA benefits;
- delays in certifying that dislocated workers were eligible for TAA assistance; and
- decisions by some people that health insurance was relatively unimportant, even with a tax credit.

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 were refundable, so low-income taxpayers could receive the full value of the credit even if they had little or no tax liability.

The 72.5% HCTC subsidy rate was available to all eligible taxpayers with qualified insurance, regardless of income. From the standpoint of inclusiveness, this seemed equitable. Considering ability to pay, however, the flat rate was inequitable. The 72.5% rate provided the same level of assistance to taxpayers with higher incomes and taxpayers with lower incomes, even though the former may have been in a better financial position to pay for their insurance.

Another equity issue was related to who was eligible for the tax credit. Unemployed workers who did not receive TAA allowances may have questioned why they were denied the credit, particularly if they too had lost their jobs because of trade competition. Similarly, early retirees whose pensions were not paid in part by the PBGC may have questioned not being eligible for the credit, as may those who received no pension at all.

Efficiency

Some observers of the HCTC voiced concerns regarding the efficiency with which the program was run. Given the complexity involved with enrollment and administration of the tax credits

[32] Ibid.

themselves, it was not surprising that operational costs constituted a significant portion of overall program costs, especially during the start-up phase. However, administrative costs remained high even after a few years of operation. For instance, the GAO estimated that between 2003 and 2008, the federal government incurred $161 million in administrative costs. This constituted 17% of total HCTC-related costs ($953 million) for those years combined.[33]

Another study estimated that of the federal funding going toward advance payments in 2007, a full third would be spent on administration.[34] This would leave only 66 cents for every federal dollar spent on the advance-payment component for purchasing health coverage.

Moreover, between 2009 and 2011, the IRS estimated that it would spend around $40 million to implement legislative changes and upgrade computer systems related to the HCTC program. Given these changes, the IRS assumed that the proportion of total HCTC costs attributable to administration was likely to increase during that time. However, the IRS assumed that such spending on systems operations would decrease after 2011, absent significant changes to the HCTC program.[35]

Current Law

Following termination of the HCTC on January 1, 2014, some recipients may have qualified for new tax credits authorized under the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended).[36] The new credits became available the same day the HCTC expired. Like the HCTC, these new tax credits are advanceable, refundable credits that may be used toward the purchase of health insurance. However, eligibility and other rules applicable to these new tax credits differ from those applicable to the HCTC. GAO projected from an analysis of 2010 IRS data that most HCTC participants in 2014 likely were either ineligible for the new credits or eligible for less generous credits under the ACA compared with the HCTC program.[37]

[33] From 2003 through 2008, total HCTC-related costs were comprised of the cumulative tax credit amounts provided by the government ($515 million), the share of premiums paid by the HCTC recipients ($277 million), and administrative costs. See "Efficiency."

[34] 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.

[35] See "Efficiency."

[36] For background on the ACA tax credits, see CRS Report R43945, *Health Insurance Premium Credits in the Patient Protection and Affordable Care Act (ACA) in 2015*, by Bernadette Fernandez.

[37] Government Accountability Office, "Private Health Insurance: Expiration of the Health Coverage Tax Credit Will Affect Participants ' Costs and Coverage Choices as Health Reform Provisions Are Implemented," December 2012, http://www.gao.gov/assets/660/651118.pdf.

Appendix. Legislative History

Table A-1.Health Coverage Tax Credit (HCTC) Legislative History

Name of Legislation (Public Law)	Date of Enactment	Summary of Relevant Provisions
Trade Act of 2002 (P.L. 107-210)	August 6, 2002	Amended the Internal Revenue Code (IRC) to authorize a new refundable, advanceable tax credit to cover 65% of the cost of "qualified health insurance" for eligible taxpayers and their family members.
Working Families Tax Relief Act of 2004 (P.L. 108-311)	October 4, 2004	Amended the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (P.L. 108-173), which amended the IRC to exclude distributions from health savings accounts from the calculation of the tax credit amount.
Tax Technical Corrections Act of 2007 (P.L. 110-172)	December 29, 2007	Amended the IRC to correct a citation to the IRC definition of a custodial parent.
American Recovery and Reinvestment Act of 2009 (P.L. 111-5): Part VI cited as the "TAA Health Coverage Improvement Act of 2009"	February 17, 2009	Amended the IRC to enact the following temporary changes that would have expired on January 1, 2011: • Increased the subsidy rate from 65% to 80%; • Allowed one or more retroactive payments to be made: • Modified the definition of an "eligible TAA recipient" to include: persons who receive unemployment compensation but are not enrolled in training, and individuals who would be eligible for a trade readjustment allowance except that they are in a break in training that exceeds a specified time period; • Allowed family members to continue to receive the HCTC for up to two years after any of the following events occur: the qualified taxpayer becomes eligible for Medicare, the taxpayer and spouse are divorced, or the taxpayer dies; and • Added a new option under "qualified health insurance": health plans funded by voluntary employees' beneficiary associations. Enacted the following permanent changes: • Broadened eligibility criteria to include service sector and public agency workers; and • Added a new study and reporting requirements for the Treasury Secretary and the Comptroller General.
Temporary Extension Act of 2010 (P.L. 111-144)	March 2, 2010	Amended the IRC to make a technical correction related to the definition of an individual who receives COBRA premium assistance.
Omnibus Trade Act of 2010 (P.L. 111-344): Title I – Extension of Trade Adjustment Assistance and Health Coverage Improvement	December 29, 2010	Amended the IRC to extend the HCTC-related expiring provisions with a new expiration date of February 13, 2011.
Trade Adjustment Assistance Extension Act of 2011 (P.L. 112-40)	October 21, 2011	Amended the IRC to enact a number of changes to the HCTC program, which affected the program's duration, subsidy rate, availability of payments, eligibility criteria, and definition of qualified insurance, among other program components. Key changes included a new subsidy rate of 72.5% and termination of the tax credit on January 1, 2014. The effective date for these changes was for coverage months beginning after February 12, 2011.

Source: CRS analysis of amendments to the Internal Revenue Code related to Section 35.

Author Contact Information

Bernadette Fernandez
Specialist in Health Care Financing
bfernandez@crs.loc.gov, 7-0322

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