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PRIVATE HEALTH INSURANCE

Expiration of the Health Coverage Tax Credit Will Affect Participants' Costs and Coverage Choices as Health Reform Provisions Are Implemented



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Why GAO Did This Study

The HCTC pays 72.5 percent of health plan premiums for certain workers who lost their jobs due to foreign import competition and for certain retirees whose pensions from their former employers were terminated and are now paid by the Pension Benefit Guaranty Corporation. A small share of individuals who are potentially eligible for the HCTC participate. In 2010 there were 43,864 participants and 469,168 nonparticipants. The HCTC program will expire at the end of 2013 when premium tax credits and cost-sharing subsidies become available to eligible individuals who purchase health plans through health insurance exchanges under PPACA. PPACA also expands Medicaid eligibility to nonelderly individuals who meet specific income requirements to the extent that states choose to implement this provision. Therefore, the costs for health plans and coverage available to individuals potentially eligible for the HCTC will change when the HCTC expires.

This report examines (1) how the HCTC's expiration and the implementation of the PPACA premium tax credit, cost-sharing subsidies, and Medicaid expansion will affect HCTC participants and nonparticipants, and (2) how the coverage that will be available through the PPACA exchanges compares to HCTC participants' health plan coverage. GAO analyzed 2010 HCTC program data and individual tax filer data. GAO also compared the services and actuarial values of the plans that will be available through the exchanges to HCTC plans.

View [GAO-13-147](#). For more information, contact John Dicken at (202) 512-7114 or dickenj@gao.gov.

PRIVATE HEALTH INSURANCE

Expiration of the Health Coverage Tax Credit Will Affect Participants' Costs and Coverage Choices as Health Reform Provisions Are Implemented

What GAO Found

Expiration of the Health Coverage Tax Credit (HCTC) and implementation of Patient Protection and Affordable Care Act (PPACA) premium tax credits, cost-sharing subsidies, and Medicaid expansion will affect HCTC participants' costs for health plans in multiple ways. Projections from GAO's analysis of 2010 Internal Revenue Service (IRS) data show that most HCTC participants in 2014 will likely be eligible for less generous tax credits under PPACA than the HCTC. Specifically, about 69 percent of HCTC participants will likely be ineligible for either a PPACA premium tax credit or Medicaid, or they will likely receive a PPACA premium tax credit less generous than the HCTC. On the other hand, GAO's analysis also found that at least 23 percent will likely be eligible for PPACA premium tax credits more generous than the HCTC. In addition to the PPACA premium tax credit, up to 28 percent of all HCTC participants will likely be eligible for PPACA cost-sharing subsidies—subsidies that will help them pay for deductibles and copays—depending in part on whether or not their state expands Medicaid under PPACA. For HCTC nonparticipants, the projections from GAO's analysis of 2010 IRS data show that as many as 30 percent may be eligible for either Medicaid or a PPACA premium tax credit more generous than the HCTC in 2014, depending in part on whether or not their state expands Medicaid and whether they meet all other eligibility criteria for the PPACA premium tax credits.

In general, the health plan coverage that will be available through the PPACA exchanges will be comparable to coverage in HCTC participants' current plans; however, HCTC participants may have an incentive to choose plans through the exchanges that have different levels of coverage than their HCTC plans. Plans purchased through the PPACA exchanges will be required to provide essential health benefits—including coverage for specific service categories, such as ambulatory care, prescription drugs, and hospitalization—and most HCTC plans cover these categories of services. In addition, the vast majority of HCTC plans in 2012 likely had actuarial values—the expected percentage of costs that a plan will incur for services provided to a standard population—above the minimum actuarial value of 60 percent that health plans sold through the PPACA exchanges will be required to meet. However, because the PPACA premium tax credit amount will be based on a plan with an actuarial value of 70 percent, HCTC participants who currently have plans with either higher or lower actuarial values and are eligible for PPACA premium tax credits may have an incentive to choose plans that will have different levels of coverage than their HCTC plans. For example, those who have HCTC plans with actuarial values that are higher than 70 percent may have an incentive to shift to health plans with an actuarial value of 70 percent to avoid paying any difference in premiums that could result from choosing plans with higher actuarial values. Similarly, those who now have plans with actuarial values below 70 percent could have the opposite incentive and may purchase plans that offer a higher level of coverage than their current HCTC plans.

We provided draft copies of this report to the Department of Health and Human Services and IRS for review, and both provided technical comments, which we incorporated as appropriate.

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Abbreviations

CCIIO	Center for Consumer Information and Insurance Oversight
COBRA	Consolidated Omnibus Budget Reconciliation Act
EHB	essential health benefits
FPL	federal poverty level
HCTC	Health Coverage Tax Credit
HHS	Department of Health and Human Services
IRS	Internal Revenue Service
PBGC	Pension Benefit Guaranty Corporation
PPACA	Patient Protection and Affordable Care Act
RTAA	Reemployment Trade Adjustment Assistance
TAA	Trade Adjustment Assistance
VEBA	Voluntary Employees' Beneficiary Association

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Accountability * Integrity * Reliability

United States Government Accountability Office
Washington, DC 20548

December 28, 2012

The Honorable Max Baucus
Chairman
Committee on Finance
United States Senate

The Honorable John D. Rockefeller, IV
Chairman
Subcommittee on Health Care
Committee on Finance
United States Senate

The health coverage tax credit (HCTC) pays a share of health plan premiums for certain workers who lost their jobs because of foreign import competition and who are eligible for benefits in the Trade Adjustment Assistance (TAA) program and for certain retirees age 55 and over whose pensions from a former employer were terminated and are now paid by the Pension Benefit Guaranty Corporation (PBGC). The Trade Adjustment Assistance Reform Act of 2002 established the HCTC, which is administered by the Internal Revenue Service (IRS).¹ The Trade Adjustment Assistance Extension Act of 2011 increased the HCTC from 65 percent to 72.5 percent of health plan premiums and also specified that the HCTC program will expire at the end of 2013.² Beginning January 1, 2014, premium tax credits and cost-sharing subsidies—subsidies that will help individuals pay for out-of-pocket expenses such as deductibles and copays—will become available under the Patient Protection and Affordable Care Act (PPACA).³ These tax credits and subsidies will help eligible individuals pay for the premiums and cost-sharing for health plans purchased through health insurance exchanges

¹Pub. L. No. 107-210, div. A, § 201, 116 Stat. 935, 954. The HCTC was applicable to tax years beginning in 2002.

²Pub. L. No. 112-40, title II, § 241, 125 Stat. 402, 418. The increased credit rate was applicable to coverage months beginning after February 12, 2011.

³See Pub. L. No. 111-148, title I, subtitles D and E, title X, subtitle A, §§ 10104, and 10105, 124 Stat. 119, 162, 213, 896, 906 (2010), as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, title I, subtitle A, 124 Stat. 1029, 1030. For purposes of this report, references to PPACA include the amendments made by the Health Care and Education Reconciliation Act of 2010.

created under PPACA.⁴ Effective January 1, 2014, PPACA also expands eligibility for Medicaid to nonelderly individuals who meet specific income requirements to the extent that states choose to implement this provision.⁵ As a result, individuals who participate in or were potentially eligible for the HCTC may be eligible for Medicaid when the HCTC expires. The IRS will administer the PPACA premium tax credits and the Department of Health and Human Services' (HHS) Center for Consumer Information and Insurance Oversight (CCIIO) will oversee the PPACA exchanges and cost-sharing subsidies.

Although the HCTC pays a significant share of health plan premiums for eligible individuals who participate in the program, participation in the HCTC has been lower than expected. For example, in 2010 less than 10 percent of over 500,000 potentially eligible individuals were participating in the HCTC. In our prior work, we analyzed data from IRS surveys conducted in 2009 of individuals who were potentially eligible for the HCTC.⁶ We found that survey respondents most commonly reported improved affordability of health plans as a reason for participation in the HCTC and most commonly reported ineligibility as a reason for not

⁴An exchange is a mechanism for organizing the health insurance marketplace to help consumers and small businesses shop for health insurance plans and compare available plan options based on price, benefits, and quality. Throughout this report we refer to these as PPACA exchanges.

⁵Pub. L. No. 111-148, §§ 2001, 10201(c), 124 Stat. 271, 1051, as amended by Pub. L. No. 111-152 § 1201, 124 Stat. 1051. Eligibility for Medicaid varies by state. However, in most states, nondisabled childless adults are not currently eligible for Medicaid regardless of age or level of income. Under the Medicaid program, failure by a state to comply with federal requirements may result in a termination of federal Medicaid matching funds. However, the U.S. Supreme Court has ruled that states choosing not to expand Medicaid coverage to this group of individuals will forgo only the federal matching funds associated with such expanded coverage. See *National Federation of Independent Business, et al., vs. Sebelius, Sec. of Health and Human Services, et al.*, 567 U.S. ___, 2012 WL 2427810 (U.S. June 28, 2012).

⁶See GAO, *Health Coverage Tax Credit: Participation and Administrative Costs*, [GAO-10-521R](#) (Washington, D.C.: Apr. 30, 2010).

participating.⁷ The second most commonly reported reason for not participating was lack of affordability—such as being unable to afford to pay for health plan premiums even with the credit. While HCTC nonparticipants do not currently benefit from the HCTC, some may benefit from PPACA. That is, some may have new incentives to obtain health coverage under PPACA rules, for example if they are eligible for the PPACA premium tax credit, and particularly if they are eligible for a credit that is more generous than the HCTC. In addition, some nonparticipants may be eligible for PPACA cost-sharing subsidies or become newly eligible for Medicaid.

To receive the HCTC, recipients must be enrolled in HCTC-qualified health plans.⁸ These include certain group health plans, such as plans that are a continuation of employer-sponsored health plans through the Consolidated Omnibus Budget Reconciliation Act (COBRA)—referred to as COBRA plans throughout this report—and Voluntary Employees' Beneficiary Association (VEBA) plans.⁹ The HCTC-qualified health plans also include individual (nongroup) market plans and HCTC state-qualified plans, which can vary in design, but which must ensure certain consumer protections. Similarly, to receive PPACA premium tax credits and cost-sharing subsidies when they become available in 2014, recipients must be enrolled in health plans that are purchased through the PPACA exchanges. These plans will need to meet certain coverage requirements. Specifically, they will be required to provide essential health benefits (EHB) which include coverage for specific service categories, such as

⁷There are several reasons why individuals who are identified as potentially eligible may ultimately be ineligible for the HCTC. One reason is that HCTC eligibility is conditioned on the individual not having "other specified coverage," which is defined to include coverage under Medicare, Medicaid, or the state Children's Health Insurance Program. 26 U.S.C. § 35 (b)(1)(A)(iii), (f). Medicare is the federally financed health care program for persons 65 years of age or over as well as for certain individuals with disabilities and individuals with end-stage renal disease. Medicaid and the state Children's Health Insurance Program are joint federal-state programs that finance health care for certain categories of low-income individuals.

⁸26 U.S.C. § 35(a), (e).

⁹VEBAs may be established through bankruptcy court to provide certain specified benefits, including group health benefits, and are generally similar to employer-sponsored health plans. Group coverage obtained through a spouse's current or former employer may also be HCTC-qualified, with certain restrictions.

hospitalization, prescription drugs, and emergency services.¹⁰ A plan will be identified in each state that specifies what the EHB are for that state—this plan will be referred to as that state’s benchmark plan. In addition, plans sold through the PPACA exchanges will be offered at four different levels of coverage corresponding to a percentage of the full actuarial value of plan benefits for EHB and designated by a different metal tier: 60 percent (bronze), 70 percent (silver), 80 percent (gold), and 90 percent (platinum).¹¹ For the purposes of this report, the term “coverage” includes two elements: (1) the categories of services a plan covers; and (2) a plan’s actuarial value, which we refer to as a plan’s level of coverage.

Because the HCTC will expire when the PPACA premium tax credit and cost-sharing subsidies become available for health plans purchased through the PPACA exchanges and the PPACA Medicaid expansion takes effect, the costs for health coverage and the health plan options at that time will change for individuals who are currently participating in or who were potentially eligible for the HCTC. You asked us to examine issues related to the expiration of the HCTC and its interaction with the PPACA premium tax credit, cost-sharing subsidies, and expansion of Medicaid. Specifically, this report addresses (1) How the expiration of the HCTC and the implementation of the PPACA premium tax credit, cost-sharing subsidies, and Medicaid expansion will affect HCTC participants and nonparticipants, and (2) how the coverage that will be available for plans purchased through the PPACA exchanges compares to HCTC participants’ HCTC-qualified health plans’ coverage.

¹⁰Pub. L. No. 111-148, §§ 1301, 1302, 1311, 1321, 10104, 124 Stat. 162, 163, 173, 186, 896.

¹¹Pub. L. No. 111-148, §§ 1302 (d)(2), 10104(b)(1), 124 Stat. 167, 896. Accordingly, the actuarial value of a plan represents the expected percentage of costs the plan will incur for the EHB services provided to a standard population. For example, a gold plan with an 80 percent actuarial value would be expected to pay, on average, 80 percent of a standard population’s expected medical expenses for the EHB. The individuals covered by the plan would be expected to pay, on average, the remaining 20 percent of the expected cost-sharing expenses in the form of deductibles, copayments, and coinsurance.

To determine how the expiration of the HCTC and implementation of the PPACA premium tax credit, cost-sharing subsidies, and Medicaid expansion will affect HCTC participants and nonparticipants,¹² we analyzed 2010 IRS HCTC program data and individual tax filer data for HCTC participants, which were the most current data available. For the PPACA premium tax credit and the cost-sharing subsidies, we made projections assuming that HCTC participants would meet many of the key eligibility criteria—namely that they would not be eligible for Medicare or Medicaid and would not be enrolled in health plans in which employers paid for the majority of the premium amounts. Using these data, we determined whether each HCTC participant would be eligible for a PPACA premium tax credit on the basis of their household income¹³ and, if eligible, estimated the amount of that PPACA premium tax credit. We compared the estimated PPACA premium tax credit amounts to the estimated HCTC amounts for each participant.¹⁴ We also calculated the percentage of income in 2010 that HCTC participants paid for their share of premiums after the HCTC was applied, and compared these amounts to the estimated percentage of their income they will likely pay for premiums with the PPACA premium tax credit assuming their incomes would remain constant. We also used these data to estimate the

¹²For the purposes of our analysis we assumed that individuals in all states could potentially be eligible for PPACA premium tax credits, consistent with the final rule issued by IRS. See Health Insurance Premium Tax Credit, preamble 1.f and regulations to be codified at 26 C.F.R. §§ 1.36B-0 et seq., 77 Fed. Reg. 30377, 30378, 30385 (May 23, 2012). In addition, we limited our analysis of participants who will likely be eligible for cost-sharing subsidies to those earning up to 250 percent of the federal poverty level (FPL), consistent with CCIO guidance. See Center for Consumer Information and Insurance Oversight, *Actuarial Value and Cost-Sharing Reductions Bulletin* (Feb. 24, 2012).

¹³Household income was calculated by summing the income of each participant with the incomes of each participant's spouse and dependents.

¹⁴These estimates are from estimated annualized HCTC premiums for all HCTC participants. Participants can receive the HCTC in two ways: yearly as a tax credit when they file their federal income tax returns, or monthly as an advance payment directly to their health plans when their premiums are due each month. Data on HCTC monthly participants included monthly 2010 HCTC amounts, which we used to calculate annualized HCTC premiums. We calculated an estimated annualized HCTC premium for monthly participants who did not receive the HCTC for all 12 months in 2010. To calculate the estimated annualized HCTC premiums for yearly participants, we used available data on premium amounts from monthly HCTC participants and calculated a state average in the states in which these monthly participants lived in 2010. The state average estimate was applied to yearly participants according to the state in which they lived in 2010. We also used these estimated annualized HCTC premiums as the basis for our estimation of the PPACA premium tax credit amounts.

percentage of HCTC participants who will likely be eligible for PPACA cost-sharing subsidies and the number and percentage of participants who will likely be eligible for Medicaid, depending in part on whether or not their state expands Medicaid. We excluded from our analyses any participants and nonparticipants aged 65 or older at any point in 2010 because they would have likely been eligible for Medicare and therefore ineligible for either the HCTC, a PPACA premium tax credit, or PPACA cost-sharing subsidies. We conducted the same analyses for HCTC nonparticipants as we did for the HCTC participants using 2010 IRS data.¹⁵ However, we did not make the same assumption that most nonparticipants would meet many of the key eligibility criteria for the PPACA premium tax credit or cost-sharing subsidies because we could not determine why these individuals did not participate in the HCTC. For example, nonparticipants may have been enrolled in health plans paid for by an employer, which would make them ineligible for a PPACA premium tax credit or cost-sharing subsidy. In light of this, our ability to draw conclusions based on our analysis of the data on HCTC nonparticipants was more limited than it was for HCTC participants. We also reviewed regulations, guidance, and selected literature on the PPACA premium tax credit and cost-sharing subsidies. To determine the reliability of IRS's 2010 HCTC program data and individual tax filer data, we reviewed relevant documentation, conducted interviews with IRS officials knowledgeable about the data, and conducted electronic testing of the data to identify obvious errors or outliers. We determined that the data were sufficiently reliable for purposes of this report.

To determine how the coverage that will be available through the PPACA exchanges compares to the qualified health plans for HCTC participants for each HCTC plan type—COBRA, HCTC state-qualified, VEBA, and individual market—we compared the services that plans purchased through the PPACA exchanges will cover, and actuarial values that plans will be offered at through the exchanges, to the services and actuarial values of HCTC-qualified plans. Since COBRA plans are an extension of

¹⁵We also calculated an estimated annualized HCTC premium for HCTC nonparticipants using available data on premium amounts from monthly HCTC participants in the states in which these monthly participants lived in 2010. The state average estimate was applied to nonparticipants according to the state in which they lived in 2010. We used these estimated annualized HCTC premiums as the basis for our estimation of the PPACA premium tax credit amounts. In addition, we limited our analysis of nonparticipants who will likely be eligible for cost-sharing subsidies to those earning up to 250 percent of the FPL, consistent with the 2012 CCIIO bulletin on cost-sharing reductions.

employer-sponsored health plans, we based our comparison on existing data on the services covered by,¹⁶ and the actuarial values of, employer-sponsored health plans.¹⁷ For HCTC state-qualified plans, we used 2011 IRS HCTC program data to select a nongeneralizable sample of four states to compare the services covered by the plans that will likely be available through the PPACA exchanges in those states, and the actuarial values at which plans will be offered through the exchanges, to the services covered by and the actuarial values of, selected HCTC state-qualified plans.¹⁸ The four states selected—California, Michigan, North Carolina, and Ohio—were among the states with the largest number in 2011 of both individuals potentially eligible for the HCTC and HCTC monthly participants; were geographically varied; and offered different types of HCTC state-qualified plans.¹⁹ In each state we identified the state’s likely EHB benchmark plan and the HCTC state-qualified plan with the largest enrollment for our comparison.²⁰ In California and Michigan we used the benchmark plans that those states selected, and in the other two states we used the largest small group health plan in each state as the potential exchange benchmark plan because HHS has proposed this as the default exchange benchmark if the state does not choose a benchmark plan.²¹ In certain states, choosing an existing small group health plan as a benchmark may lead to lower costs for the state than if it

¹⁶Department of Labor, *Selected Medical Benefits: A Report From the Department of Labor to the Department of Health and Human Services* (Washington, D.C.: April 2011).

¹⁷Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, *Actuarial Value and Employer-Sponsored Insurance* (Washington, D.C.: November 2011).

¹⁸We used 2011 IRS HCTC program data to select the states because 2011 was the most recent year of data available regarding the types of HCTC-qualified plans that participants have.

¹⁹In 2011, the four selected states combined represented 28 percent of all individuals potentially eligible for the HCTC and 34 percent of all monthly participants. At the time of our analysis, data on yearly participants for 2011 were not yet available, so we selected states with the highest numbers of individuals potentially eligible for the HCTC and monthly participants in 2011.

²⁰Throughout this report we refer to these plans as potential exchange benchmark plans.

²¹Patient Protection and Affordable Care Act; Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation, 77 Fed. Reg. 70644, 70670 (proposed Nov. 26, 2011) (to be codified at 45 C.F.R. § 156.100(c)). The term “small group” is used to describe health plans offered by employers with 100 or fewer employees.

chose a different plan.²² In the four states, we reviewed health plan documents and interviewed health plan officials from the four potential exchange benchmark plans and the four selected HCTC state-qualified plans.²³ For VEBA plans, we analyzed the HCTC data from the selected states to identify the VEBA plan that had the largest number of HCTC participants. We reviewed health plan documents and interviewed health plan officials for the selected VEBA plan and compared the services covered by the potential exchange benchmark for the state that contained the majority of the VEBA plan's HCTC enrollees to the services covered by the VEBA plan. We also compared the actuarial values at which plans will be offered through the exchanges to the actuarial value of the VEBA plan. For individual market plans, we used available data on this type of plan to compare the services covered by,²⁴ and the actuarial value of, plans purchased through the PPACA exchanges to individual market plans.²⁵ We also reviewed regulations and guidance on EHB, actuarial value, and other insurance market reforms that may affect premiums and cost-sharing in 2014. To determine the reliability of IRS's 2011 HCTC program data, we reviewed relevant documentation, interviewed officials knowledgeable about the data, and conducted electronic testing of the data to identify obvious errors or outliers. To assess the reliability of the available data on employer-sponsored health plans and individual market health plans, we reviewed the methodologies used to collect and report these data. Using these methods, we determined that the data were sufficiently reliable for the purposes of this report.

²²States will be required to defray the costs of state-mandated benefits in addition to EHB. See Pub. L. No. 111-148, § 1311(d)(3)(B), 124 Stat. 176. However, HHS has proposed that a state not be required to defray the costs of state-mandated benefits enacted on or before December 31, 2011 as they would be considered EHB. See, 77 Fed. Reg. 70644, 70647, 70668 (to be codified at 45 C.F.R. § 155.170(a)(2)). Because small group plans are typically subject to many of a state's mandated benefits, states may be more likely to choose a small group plan as their benchmark plan.

²³We reviewed health plan documents for the 2012 plan year for the HCTC state-qualified plans and potential exchange benchmark plans which were the most current data available. We also used 2012 plan documents for the VEBA plan we reviewed.

²⁴Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, *Essential Health Benefits: Individual Market Coverage* (Washington, D.C.: December 2011).

²⁵Jon.R Gabel et al., "More Than Half of Individual Health Plans Offer Coverage That Falls Short Of What Can Be Sold Through Exchanges As of 2014," *Health Affairs*, vol. 31, no 6 (Bethesda, Md.: June 2012).

We conducted this performance audit from November 2011 to November 2012 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Background

The HCTC, which pays a portion of health plan premiums for certain eligible workers and retirees, is set to expire at the end of 2013 when certain PPACA provisions, including PPACA premium tax credits, cost-sharing subsidies, and expansion of Medicaid eligibility, are implemented.

HCTC

The HCTC program is administered by the IRS and currently pays for 72.5 percent of health plan premiums for HCTC participants. The amount of the credit is based solely on the participant's health plan premium amount and is not based on other factors, such as the participant's income. As an example of the credit, an HCTC participant with an annual premium of \$10,000 would receive a credit of \$7,250. Individuals potentially eligible for the HCTC include manufacturing and service workers who lost their jobs due to foreign import competition and were eligible for TAA benefits (representing about 51 percent of all potentially eligible individuals),²⁶ and certain retirees between the ages of 55 and 64 whose pensions from a former employer were terminated and are now paid by the PBGC (representing about 47 percent of all potentially eligible individuals).²⁷

²⁶Within the TAA program, there is a Reemployment Trade Adjustment Assistance (RTAA) program. The RTAA program provides a wage subsidy to workers aged 50 years or older who have lost their jobs because of foreign import competition and have accepted a job where they earn less money than they did at their prior job. Throughout this report, any reference to TAA eligible individuals includes both TAA and RTAA eligible individuals.

²⁷About 1 percent of individuals potentially eligible for the HCTC have multiple eligibility types—they are eligible both through receiving TAA benefits and because their pensions are now paid by PBGC—and for about less than 1 percent, HCTC eligibility type could not be identified.

We have previously reported that many potentially eligible individuals do not participate in the HCTC program. In 2010, less than 10 percent of those potentially eligible for the program participated in the HCTC (see table 1). Some of the potentially eligible individuals may in fact not be eligible for the HCTC, for example if they are eligible for Medicare or Medicaid, or if they are covered by their spouse's employer-sponsored health plan under certain conditions. Others may choose not to participate, for example if even with the HCTC they still cannot afford the cost of their share of health plan premiums.

Table 1: Total Number of 2010 HCTC Participants and Nonparticipants

Participation category	Number of individuals
Number of HCTC participants	43,864
Number of HCTC nonparticipants	469,168
Total number of potentially eligible individuals	513,032

Source: GAO analysis of IRS data.

HCTC participants obtain coverage from HCTC-qualified health plans, which include COBRA plans,²⁸ HCTC state-qualified plans,²⁹ VEBA

²⁸COBRA in general requires employers that offer group health plans (i.e., employer-sponsored health plans) and have 20 or more employees to make health insurance available for a limited period of time for employees and their dependents who have lost health insurance because of certain events, including the loss of employment. Former employees who opt to continue their coverage through COBRA are responsible for the full cost of the health plan premium and the administrative costs for the continuation of coverage (not to exceed 102 percent of the applicable premium for such period). See 29 U.S.C. §§ 1161-1168.

²⁹HCTC state-qualified plans are health plans designated by each state's department of insurance. A state-qualified plan may be a private health insurance plan offered by a company or a public health insurance plan offered by a state (e.g., state high-risk pool). These plans must offer certain statutorily defined consumer protections.

plans,³⁰ and individual market plans.³¹ In 2011, the majority of HCTC participants received coverage from COBRA plans (46 percent) or HCTC state-qualified plans (37 percent).³² A smaller proportion of HCTC participants received coverage from VEBA plans (10 percent) or individual market plans (1 percent).³³

Selected PPACA Provisions

Beginning on January 1, 2014, a premium tax credit will be available to help eligible tax filers and their dependents pay for qualified health plans purchased through the PPACA exchanges, to be administered by the IRS.³⁴ PPACA premium tax credits will be calculated using income reported on tax returns.³⁵ The credits will generally be available to eligible tax filers and their dependents who are (1) enrolled in one or more qualified health plans through a PPACA exchange, and (2) not eligible for minimum essential coverage other than coverage in the individual

³⁰VEBAs may be established for individuals who have an employment-related common bond (e.g., common employer, coverage under one or more collective bargaining agreements, etc.) through a bankruptcy court to provide certain specified benefits, including health benefits, to their members or their members' designated beneficiaries. VEBAs can provide health plan benefits in place of COBRA and retiree benefits. Coverage under a VEBA may receive consideration for HCTC purposes only for eligible coverage months beginning before February 13, 2012.

³¹Group coverage obtained through a spouse's current or former employer may also be HCTC-qualified, with certain restrictions. Certain types of health plans do not qualify for the HCTC, including the Federal Employees Health Benefits plans, stand-alone dental or vision plans, and long-term care benefits; or coverage for only a specified disease or illness. HCTC candidates enrolled in these plans would not be eligible for the HCTC.

³²Data on the HCTC plan types of the 2011 yearly participants were not available, so all of the percentages are based on the HCTC plan types of the 2011 monthly participants.

³³About 6 percent of monthly participants in 2011 had multiple types of HCTC plans, which means that they may have changed plans during the year, such as switching from a COBRA plan to a HCTC state-qualified plan.

³⁴See Pub. L. No. 111-148, title I, subtitles D and E, title X, subtitle A, §§ 10104 and 10105, 124 Stat. 162, 213, 896, 906, as amended by Pub. L. No. 111-152, title I, subtitle A, 124 Stat. 1030. See also 26 C.F.R. §§ 1.36B-0 et seq.

³⁵Therefore, the PPACA premium tax credits can only be obtained by eligible individuals who file tax returns.

market.³⁶ For example, individuals would not be eligible if they had coverage in a government program, such as Medicare or Medicaid, or certain employer-sponsored coverage.³⁷

Tax filers eligible for PPACA premium tax credits will be those with household incomes from 100 percent to 400 percent of the federal poverty level (FPL) for the tax year in which they are receiving the PPACA premium tax credit.³⁸ The amount of the PPACA premium tax credit will vary by household income level, family size, and other factors. It will subsidize a portion of the tax filer's health insurance premiums.³⁹ The tax filer's contribution to premiums will be based on their household income relative to the FPL, and will range from 2 percent of their household income for those with household incomes from 100 percent to less than 133 percent of the FPL, to 9.5 percent of household income for those with household incomes from 300 percent up to 400 percent of the FPL (see table 2).

³⁶26 C.F.R. § 1.36B-2 (2012). "Minimum essential coverage" includes health plans such as individual market health plans, eligible employer-sponsored health plans (if they meet affordability and quality standards), or government-sponsored health coverage such as Medicare, Medicaid, and the Children's Health Insurance Program. See 26 U.S.C. § 5000A(f).

³⁷PPACA also requires that individuals, subject to certain exceptions, obtain minimum essential health insurance coverage or pay a tax penalty. Pub. L. No. 111-148, §§ 1501(b), 10106(b), 124 Stat. 244, 909, as amended by Pub. L. No. 111-152, § 1002, 124 Stat. 1032. Exceptions may be available for certain individuals, such as those who cannot afford coverage or have been determined to have suffered hardships, members of Indian tribes, and those who qualify for religious reasons.

³⁸Individuals who are eligible for Medicaid, Medicare, or other minimum essential coverage may purchase a policy through a PPACA exchange but will not be eligible for coverage subsidized by the PPACA premium tax credits, regardless of their household income.

³⁹Household income is defined as the sum of a tax filer's modified adjusted gross income (i.e., adjusted gross income increased by amounts from tax-exempt interest, foreign earned income, and untaxed social security benefits) and the aggregate modified adjusted gross income of all other individuals for whom the tax filer is allowed a deduction for a personal exemption and who are required to file their own income tax returns for that taxable year.

Table 2: For Individuals Eligible for PPACA Premium Tax Credits, the Percentage of Household Income That Will Be Spent on Health Care Premiums for Plans Purchased through PPACA Exchanges in 2014

Household income level based on FPL (percent of FPL)	Percentage of income spent on health care premiums (percent of household income)
100 percent to less than 133%	2.0%
At least 133 but less than 150	3.0–4.0
At least 150 but less than 200	4.0–6.3
At least 200 but less than 250	6.3–8.05
At least 250 but less than 300	8.05–9.5
At least 300 and up to 400	9.5

Source: IRS and 26 C.F.R. §§ 1.36B-2(b), 1.36B-3(g)(2) (2012).

Eligibility for PPACA premium tax credits by household income level based on the FPL may vary by state because states may choose not to expand eligibility for Medicaid to nonelderly individuals whose household income does not exceed 133 percent of the FPL.⁴⁰ Under the PPACA rule, tax filers with household incomes from 100 percent of the FPL and up to 400 percent of the FPL will be eligible for PPACA premium tax credits. However, also under the PPACA rule, in states that expand Medicaid, individuals with household incomes from 100 percent and up to 138 percent of the FPL will be eligible for Medicaid and therefore ineligible for PPACA premium tax credits. Further, in states that do not expand Medicaid, individuals with household incomes from 100 percent and up to 400 percent of the FPL will be eligible for PPACA premium tax credits, and individuals with household incomes less than 100 percent of the FPL will not be eligible for PPACA premium tax credits and may not

⁴⁰In determining Medicaid income eligibility, PPACA requires an income equivalent to 5 percent of the FPL to be disregarded from an individual's income. Therefore, the threshold for Medicaid eligibility will effectively increase from 133 percent of the FPL to 138 percent of the FPL in states that expand Medicaid. Accordingly, we refer to the Medicaid upper income threshold as up to 138 percent of the FPL. From 2014 through 2016, the federal government will pay 100 percent of the cost of providing coverage to individuals who are newly eligible for Medicaid in the states that opt to expand Medicaid. Starting in 2017, the federal government will gradually reduce its share each year until 2020 when it reaches 90 percent, which is the percentage it will pay thereafter.

be eligible for Medicaid, depending on their states' Medicaid eligibility criteria.⁴¹

The applicable household income level expressed as a percent of the FPL determines an individual's share of his or her annual premium. The amount of the premium for the second-lowest-cost silver plan in the PPACA exchange available in the state where the eligible individual resides will be the reference for calculating the amount of the PPACA premium tax credit.⁴² See table 3 for an example of a PPACA premium tax credit for two different people, both in a family of four, one with a household income at 150 percent of the FPL, and the other with a household income at 300 percent of the FPL, using a hypothetical annual premium of \$10,000 for the second-lowest-cost silver plan (reference plan) in the PPACA exchange available in the state where they reside.

Table 3: Example of a PPACA Premium Tax Credit in 2014 at Two Different Income Levels Based on a Hypothetical Reference Plan with a Premium of \$10,000

Household income (percentage of FPL)	Hypothetical annual premium amount	Annual PPACA premium tax credit	Tax filer's share for annual premium amount	
			Percentage of household income	Dollar amount
\$33,075 (150% FPL)	\$10,000	\$8,677	4%	\$1,323
66,150 (300)	10,000	3,716	9.5	6,284

Source: GAO.

Note: Example is based on 2010 FPLs for the contiguous 48 states and the District of Columbia for a family size of four.

⁴¹Individuals' eligibility for Medicaid depends on their states' current Medicaid eligibility standards. According to a recent report by the Kaiser Family Foundation, Medicaid eligibility for adults, including parents, is very limited in most states. The report found that in 17 states, the eligibility level for parents is below 50 percent of the FPL and nondisabled childless adults are typically not eligible for Medicaid regardless of their income level. See Kaiser Commission on Medicaid and the Uninsured. *How Will the Medicaid Expansion for Adults Impact Eligibility and Coverage* (Washington, D.C.: Kaiser Family Foundation, July 2012).

⁴²If an individual chooses a more expensive plan than the reference plan (the second-lowest-cost-silver plan), the PPACA premium tax credit will not change and the individual will be responsible for the additional premium amount. If he or she chooses a plan with a less expensive premium than the reference plan, the individual will still be eligible to receive a PPACA premium tax credit up to the amount calculated based on the premium for the reference plan, which would reduce the amount of premium expenses the individual would have to pay.

Enrollees may also be eligible for separate, PPACA cost-sharing subsidies to help reduce their out-of-pocket expenses such as deductibles and copays.⁴³ However, as with the PPACA premium tax credits, tax filers will not be eligible for PPACA cost-sharing subsidies if they are eligible for Medicaid in their state. PPACA cost-sharing subsidies will reduce the maximum out-of-pocket limit for eligible individuals (not including health plan premiums).⁴⁴ For example, had the limits been in place in 2010, an eligible individual with an income of 150 percent of the FPL would have had his or her maximum out-of-pocket limit reduced by two-thirds. Therefore, the individual's maximum out-of-pocket limit would have been about \$1,981 instead of \$5,950 for single coverage.

PPACA Exchanges

PPACA provides for the establishment and operation of exchanges in each state that will provide competitive marketplaces for qualified individuals⁴⁵ and small employers⁴⁶ to directly compare and purchase available private health insurance plans by January 1, 2014.⁴⁷

PPACA requires that health plans purchased through the PPACA exchanges offer services in each of the following EHB categories:

- ambulatory patient services;

⁴³See Pub. L. No. 111-148, § 1402, 124 Stat.220, as amended by Pub. L. No. 111-152, § 1001(b), 124 Stat. 1031.

⁴⁴If these maximum out-of-pocket limits had been in place in 2010 they would have been \$5,950 for an individual and \$11,900 for a family. These out-of-pocket limits are updated annually, so when these limits become effective in 2014 they will likely be different than what they would have been in 2010.

⁴⁵Qualified individuals include U.S. citizens and lawful residents who are not incarcerated.

⁴⁶Small Business Health Options Program exchanges, which are separate from the exchanges offering qualified health plans to individuals, are designed to help small businesses with up to 100 employees obtain a plan offered in the small group market in the state for their employees. States may also elect to provide only one exchange for both qualified individuals and small employers if the exchange has adequate resources. Our study focuses on exchanges that will offer health insurance options in the individual market.

⁴⁷HHS will establish and operate exchanges within states not electing to establish an exchange or that will not have an exchange operational by January 1, 2014. Pub. L. No. 111-148, § 1321(c), 124 Stat. 186. HHS will consider an exchange fully operational if it is capable of beginning operations by October 1, 2013 to support the initial open enrollment period.

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- emergency services;
 - hospitalization;
 - maternity and newborn care;
 - mental health and substance use disorder services, including behavioral health treatment;
 - prescription drugs;
 - rehabilitative and habilitative services and devices;
 - laboratory services;
 - preventive and wellness services and chronic disease management; and
 - pediatric services, including oral and vision care.

CCIO will oversee the implementation and operation of the exchanges, including the provision of guidance on EHB categories and the actuarial value of plans purchased through the PPACA exchanges. Because each state will have its own benchmark plan, EHB services may vary by state.⁴⁸ Health plans will be offered at four levels of actuarial value through the exchanges and designated by different metal tiers. These levels of coverage will allow individuals purchasing a plan to compare what the potential differences in out-of-pocket expenses would be for each plan. The four metal tiers include the following:

- bronze: plans that have actuarial values of 60 percent,
- silver: plans that have actuarial values of 70 percent,
- gold: plans that have actuarial values of 80 percent, and

⁴⁸See 77 Fed. Reg. 70644, 70669 (to be codified at 45 C.F.R. Part 156, Subpart B).

-
- platinum: plans that have actuarial values of 90 percent.⁴⁹

When the HCTC Expires Most HCTC Participants Will Likely Be Ineligible for a PPACA Premium Tax Credit or Eligible for a Credit Less Generous Than the HCTC

The expiration of the HCTC and implementation of the PPACA premium tax credits and Medicaid expansion will affect HCTC participants' costs for health plans in multiple ways. Projections from our analysis of 2010 IRS data show that about 69 percent of HCTC participants will likely either be ineligible for a PPACA premium tax credit or Medicaid, or will be eligible for a PPACA premium tax credit that is less generous than the HCTC. These projections show that about 37 percent of HCTC participants will likely be ineligible for either a PPACA premium tax credit or Medicaid because their incomes are too high, and 32 percent will be eligible for a PPACA premium tax credit less generous than the HCTC. On the other hand, at least 27 percent of HCTC participants will be eligible for a PPACA premium tax credit more generous than the HCTC or be eligible for Medicaid. An additional 3 percent of all participants will likely be ineligible for a PPACA premium tax credit because their incomes are too low, and their eligibility for Medicaid will depend in part on their state's decision on Medicaid expansion (see table 4).

⁴⁹HHS has proposed a *de minimis variation* of +/-2 percentage points for the actuarial value associated with each metal tier (e.g., silver plans will be able to have actuarial values that range from 68 to 72 percent). See 77 Fed. Reg. 70644, 70671 (to be codified at 45 C.F.R. § 156.140). CCIIO officials told us, that in 2014, plans with actuarial values that do not fall within +/- 2 percentage points of one of the metal tiers will not be allowed to be sold either inside or outside of the PPACA exchanges.

Table 4: Percentage of HCTC Participants Who Will Likely Be Eligible and Ineligible for a PPACA Premium Tax Credit, and Possibly Eligible for Medicaid in 2014

HCTC participants	Number	Percentage (among all HCTC participants)
Eligible for PPACA premium tax credit (household income >138% FPL to 400% FPL)	21,748	55%
Credit more generous than HCTC	9,054 ^a	23
Credit less generous than HCTC	12,694 ^a	32
Either eligible for PPACA premium tax credit more generous than HCTC ^b or eligible for Medicaid (household income 100% FPL to 138% FPL)	1,678 ^a	4
Ineligible for PPACA premium tax credit but possibly eligible for Medicaid (household income <100% FPL)	1,312	3
Ineligible for PPACA premium tax credit (household income >400% FPL)	14,726	37
Total number of participants	39,464^c	100%

Source: GAO analysis of IRS data.

Notes: The percentages may not add to 100 percent because of rounding.

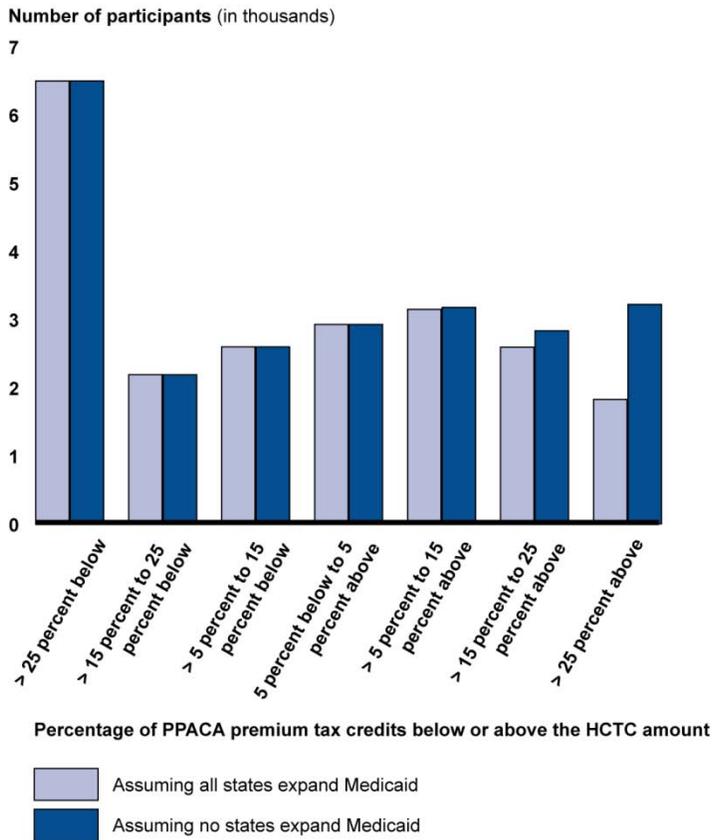
^aTo compare the PPACA premium tax credit amounts to the HCTC amounts, we calculated PPACA premium tax credits using the same premium amount each HCTC participant was estimated to have paid for his or her HCTC coverage.

^bFor participants who will likely be eligible for a PPACA premium tax credit because their state did not expand Medicaid, the tax credit will likely be more generous than the HCTC.

^cWe excluded all participants who were age 65 or older in 2010, and those for whom we were unable to obtain tax data. As a result, 39,464 of the 43,864 participants in 2010 were included in our analyses.

For the HCTC participants who will likely be eligible for a PPACA premium tax credit in 2014, projections from our analysis of 2010 IRS data show that there will be variation in the extent to which their credit differs from the HCTC. For example, of the total 39,464 HCTC participants in our analysis, 6,492 will likely receive a PPACA premium tax credit at least 25 percent less than the HCTC. However, up to 12,141 participants will likely receive a credit similar to or greater than the HCTC. For example, 2,922 participants will likely receive a PPACA premium tax credit of about the same value as the HCTC (within 5 percentage points above or below the HCTC). In addition, depending in part on whether or not their state expands Medicaid, between 1,823 and 3,217 participants will likely receive a credit more than 25 percent higher than the HCTC (see fig. 1).

Figure 1: Comparison of the PPACA Premium Tax Credit to the HCTC among HCTC Participants Who Will Likely Be Eligible for a PPACA Premium Tax Credit in 2014



Source: GAO analysis of IRS data.

Note: To compare the PPACA premium tax credit amounts to the HCTC amounts, we calculated PPACA premium tax credits using the same premium amount each HCTC participant was estimated to have paid for his or her HCTC coverage.

The PPACA premium tax credit was designed to provide a larger subsidy amount to lower-income tax filers than to higher-income tax filers. Thus, lower-income HCTC participants who will likely be eligible for a PPACA premium tax credit⁵⁰ will pay a smaller share of their incomes for premiums under PPACA in 2014 than they did under the HCTC.

⁵⁰This assumes that HCTC participants with household incomes from 100 percent of the FPL to 400 percent of the FPL will likely be eligible for a PPACA premium tax credit.

For example, projections from our analysis of 2010 IRS data show that while all 2,488 HCTC participants with incomes from 100 percent⁵¹ to 150 percent of the FPL will likely pay between 2 percent and 4 percent of their incomes for health plan premiums under the PPACA rule, 1,456 HCTC participants—close to 60 percent of participants in the same income range—paid 9.5 percent or more of their incomes for health plan premiums under the HCTC. In contrast, while all 7,658 HCTC participants with incomes from 300 percent to 400 percent of the FPL⁵² will likely pay 9.5 percent of their household income for premiums under the PPACA rule, 2,391—over 30 percent of participants in the same income range—paid less than 4 percent of their household income for premiums under the HCTC (see fig. 2). Unlike the HCTC that pays 72.5 percent of health plan premiums, individuals eligible for a PPACA premium tax credit will continue to pay that set percentage even if premiums increase because PPACA rules limit the amount individuals will pay for premiums to a set percentage of their incomes.⁵³

⁵¹Household incomes at 100 percent of the FPL in 2010 ranged from \$10,830 for an individual to \$22,050 for a family of four in the 48 contiguous states and the District of Columbia.

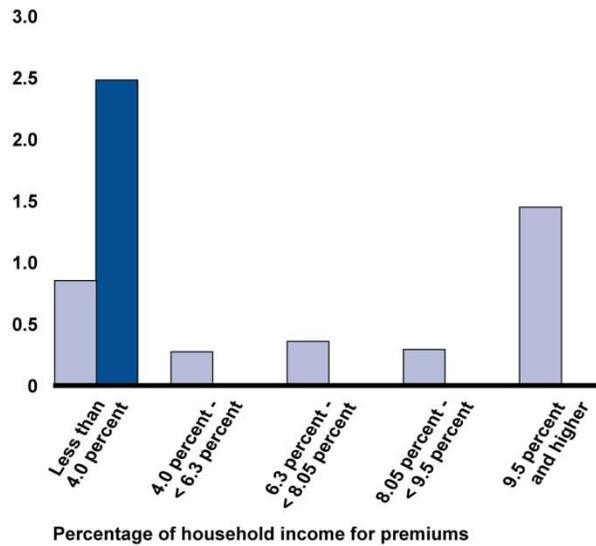
⁵²Household incomes at 400 percent of the FPL in 2010 ranged from \$43,320 for an individual to \$88,200 for a family of four in the 48 contiguous states and the District of Columbia.

⁵³In 2012, the Congressional Budget Office and staff from the Joint Committee on Taxation reported that there is uncertainty about the future growth rate of private insurance premiums as a result of the insurance coverage provisions in PPACA. See Congressional Budget Office, *Estimates of the Effects of the Affordable Care Act on the Number of People Obtaining Employment-Based Health Insurance* (Washington, D.C.: March 2012). However, according to Congressional Budget Office projections, premiums for private health insurance per enrollee will increase by 5.7 percent per year, on average, between 2012 and 2022. See Congressional Budget Office, *Updated Estimates for the Insurance Coverage Provisions of the Affordable Care Act* (Washington, D.C.: March 2012). Another study from the Commonwealth Fund said that the provisions in PPACA may help slow the rate of premium growth over time with a larger risk pool of younger, healthier people. See The Commonwealth Fund, *Help on the Horizon: How the Recession Has Left Millions of Workers Without Health Insurance, and How Health Reform Will Bring Relief* (Washington, D.C.: March 2011).

Figure 2: Comparison of the Percentage of Household Income Spent on Premiums with the HCTC to Premiums with a PPACA Premium Tax Credit among HCTC Participants Who Will Likely Be Eligible for a PPACA Premium Tax Credit in 2014

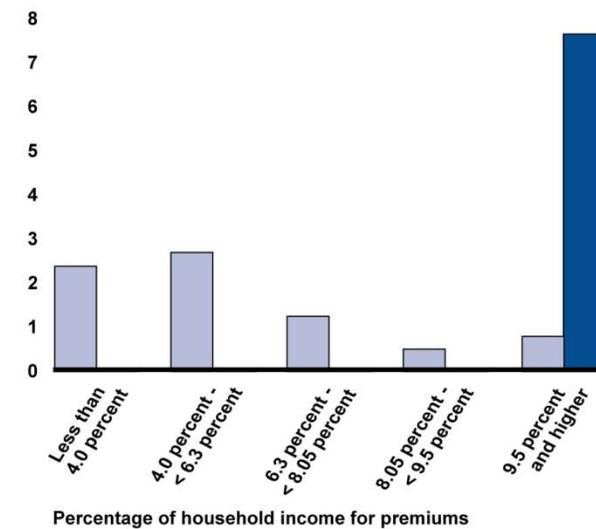
HCTC Participants with Household Incomes from 100% to Less than 150% FPL

Number of participants (in thousands)



HCTC Participants with Household Incomes from 300% to 400% FPL

Number of participants (in thousands)



Percentage of income for premiums with the HCTC
 Percentage of income for premiums with a PPACA premium tax credit*

Source: GAO analysis of IRS data.

^aThis analysis assumes that the second-lowest-cost silver plan was chosen. The percentage of household income for premiums with a PPACA premium tax credit may vary if a more or less generous plan is purchased through the exchanges.

The expiration of the HCTC and implementation of PPACA cost-sharing subsidies will also affect HCTC participants' out-of-pocket costs for health plans. Projections from our analysis of 2010 IRS data show that up to 28 percent of all HCTC participants who are eligible for the PPACA premium tax credit will likely also be eligible for a PPACA cost-sharing subsidy in 2014 to help pay for deductibles and copays, depending in part on whether or not their state expands Medicaid. Similar cost-sharing subsidies are not available for the HCTC, therefore, this would be an additional financial benefit for those who qualify.

The effect of the expiration of the HCTC and implementation of certain PPACA provisions will likely be different for nonparticipants⁵⁴—individuals who were potentially eligible for the HCTC in 2010 but did not participate in it—than it will be for participants. First, nonparticipants who may not be eligible for PPACA premium tax credits or who may be eligible for tax credits less generous than the HCTC will not be losing any benefits because they are not receiving the HCTC. Our projections show that 70 percent of nonparticipants fall into this category. Second, because some individuals do not participate in the HCTC since they cannot afford to do so, some nonparticipants who will be eligible for PPACA premium tax credits that are more generous than the HCTC or who are eligible for Medicaid coverage under PPACA may choose to use these options and receive benefits they do not receive under the HCTC. Our projections show that up to 30 percent of nonparticipants fall into this category, depending in part on whether or not their state expands Medicaid and whether they meet all other eligibility criteria for the PPACA premium tax credits.⁵⁵

⁵⁴We excluded all nonparticipants who were age 65 or older in 2010, and those for whom we were unable to obtain tax data. As a result, 390,203 of the 469,168 HCTC nonparticipants in 2010 were included in our analyses.

⁵⁵For example, individuals who have access to employer-sponsored health plans may not be eligible for the PPACA premium tax credits.

In addition to being eligible for the PPACA premium tax credit, based on projections from our analysis of 2010 IRS data, up to 30 percent of all HCTC nonparticipants may also be eligible for a PPACA cost-sharing subsidy in 2014 to help pay for deductibles and copays, depending in part on whether or not their state expands Medicaid and whether they meet all other eligibility criteria for the PPACA premium tax credits.

See appendix I for details on characteristics of 2010 HCTC participants and nonparticipants.

Health Plan Coverage under PPACA Will Be Comparable to HCTC Plans, but Participants May Have an Incentive to Change Their Level of Coverage

The health plan coverage available under PPACA will be comparable to coverage in current HCTC-qualified health plans. Specifically, the categories of services that plans purchased through the PPACA exchanges will be required to cover are comparable to those currently covered by most HCTC plans, and the actuarial values of HCTC plans are likely above the minimum level of coverage that will be required in PPACA exchange plans. However, under PPACA, HCTC participants may have an incentive to choose plans through the exchanges that have different levels of coverage than their HCTC plans.

The Categories of Services That Will Be Required for Plans Purchased through the PPACA Exchanges Are Comparable to the Categories of Services Currently Covered by HCTC Plans

The EHB categories that will be required for plans purchased through the PPACA exchanges are comparable to the categories of services covered in almost all of the health plans used now by HCTC participants. Specifically, the categories covered by COBRA plans as well as the four HCTC state-qualified plans and the VEBA plan that we reviewed are comparable to the EHB categories. Collectively, at least 93 percent of HCTC participants in 2011 were enrolled in these three types of HCTC plans. However, for two of the EHB categories—"rehabilitative and habilitative services and devices" and "pediatric services, including oral and vision care"—more services may be covered by the plans purchased through the PPACA exchanges than are covered by the COBRA, HCTC state-qualified, and VEBA plans. This is because many health plans, whether HCTC or other, do not currently cover habilitative services or pediatric dental and vision services. While not all of the EHB categories are covered by individual market plans, only about 1 percent of HCTC participants are covered by individual market plans.

COBRA plans (46 percent of HCTC participants). COBRA plans are an extension of employer-sponsored health plans, and our analysis of data reported in a 2011 Department of Labor report found that employer-sponsored health plans generally covered services in the EHB categories.⁵⁶ For example, in the EHB category of ambulatory care, 100 percent of employer-sponsored health plans cover physician office visits; 98 percent of plans cover outpatient surgery; and 73 percent of plans cover home health care services. In addition, the report indicated that the majority of employer-sponsored health plans cover services in the EHB categories of hospitalization, emergency services, maternity care, mental health and substance abuse disorders, and prescription drugs. Although COBRA plans generally cover services in the EHB categories, it is possible that coverage of habilitative services and pediatric dental and vision services will be more generous in plans purchased through the PPACA exchanges than in COBRA plans. According to CCIIO, the EHB categories that are commonly not covered among typical employer plans are habilitative services, pediatric oral services, and pediatric vision services.⁵⁷

HCTC state-qualified plans (37 percent of HCTC participants). Our analysis of four 2012 HCTC state-qualified plans found that they also generally covered services in all of the EHB categories. Specifically, all of the plans we reviewed—including both the four potential exchange benchmark plans and the four HCTC state-qualified plans—covered services in the same EHB categories, such as ambulatory care, preventive care, laboratory services, hospitalization, and emergency services. In addition, all of the plans covered prescription drugs to some extent; although one of the HCTC state-qualified plans that we reviewed covered generic prescriptions but did not cover brand-name prescriptions. Among some of the HCTC state-qualified plans and the potential benchmark plans there was an absence of coverage for subsets of

⁵⁶Department of Labor, *Selected Medical Benefits*. The report used data that the Department of Labor obtained from 2009 health plan documents as well as published survey data from the 2008 and 2009 Bureau of Labor Statistics National Compensation Survey (NCS), which were the most recently available NCS service-level data for health plans sponsored by private sector employers.

⁵⁷See 77 Fed. Reg. 70644, 70649 (preamble to proposed rules, II. C. 2. c.). It is unknown whether the specific COBRA plans that HCTC participants are enrolled in cover these services, as the data sources that we reviewed on employer-sponsored health plans did not address these services.

services in certain EHB categories, such as habilitative services and pediatric dental and vision services, which are services that will be required to be covered in plans sold through the PPACA exchanges. For example, habilitative services were not covered by two of the potential exchange benchmark plans or by three of the HCTC state-qualified plans.⁵⁸

VEBA plans (10 percent of HCTC participants). The potential exchange benchmark plans cover the same EHB categories that the 2012 VEBA plan that we reviewed does. Also, like some of the potential exchange benchmark plans, the VEBA plan does not cover certain services that are a subset of certain EHB categories, such as habilitative services.

Individual market plans (1 percent of HCTC participants). Plans purchased through the PPACA exchanges may provide coverage of EHB categories in which coverage may be more limited in individual market plans. In 2011, HHS reported that coverage of certain EHB categories is limited in individual market plans, specifically for maternity services, substance abuse services, mental health services, and prescription drugs.⁵⁹ However, only about 1 percent of HCTC participants are enrolled in individual market plans.

HCTC Plans' Actuarial Values Are Likely above PPACA's Minimum Level of Value

The vast majority of HCTC participants in 2012 were likely enrolled in plans with actuarial values that were above the minimum level of 60 percent (bronze) required for plans purchased through the PPACA exchanges, including many who were likely enrolled in plans that had actuarial values of 80 percent (gold) or higher.

⁵⁸For any EHB category where a potential exchange benchmark plan lacks coverage, the plan will be supplemented to ensure that the plan covers services in all 10 EHB categories. For example, to ensure that plans cover habilitative services, HHS has proposed that plans either offer habilitative services at parity with rehabilitative services or determine which habilitative services they will cover and report those to HHS. See 77 Fed. Reg. 70644, 70670 (to be codified at 45 C.F.R. 156.115(a)(4)).

⁵⁹Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, *Essential Health Benefits*.

COBRA plans (46 percent of HCTC participants). The majority of HCTC participants in COBRA plans are likely to be in plans with actuarial values of 80 percent or higher on the basis of data from two studies. One study estimated that 80 percent of all enrollees in employer-sponsored health plans in 2010 were in plans that met or exceeded 80 percent (gold).⁶⁰ The other study estimated that about 65 percent of all employees enrolled in group health plans in 2010 were in plans with actuarial values that met or exceeded 80 percent (gold).⁶¹

HCTC state-qualified and VEBA plans (47 percent of HCTC participants combined). The actuarial values of the four HCTC state-qualified plans and the one VEBA plan that we reviewed in the selected states vary. However, all of the plans have an actuarial value of at least 60 percent (bronze) and three of the five plans have an actuarial value of 80 percent (gold) or higher.⁶² See table 5.

⁶⁰Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, *Actuarial Value and Employer-Sponsored Insurance*.

⁶¹Jon R. Gabel et al., "More Than Half of Individual Health Plans Offer Coverage That Falls Short Of What Can Be Sold Through Exchanges As of 2014."

⁶²Most of the plan officials we interviewed told us that the methods they used to calculate the actuarial values of the selected HCTC plans align with the February 2012 CCIIO *Actuarial Value and Cost-Sharing Reductions Bulletin*. However, for one of the selected HCTC plans, its actuarial value reflects the costs and utilization of a high-risk population and uses data reflective of that population in 2010 rather than of the plan's 2012 population.

Table 5: Actuarial Value of Selected HCTC Plans in Selected States, 2012

Selected HCTC plan ^a	Actuarial value level of coverage (percent) ^b				
	Below 60	60–69	70–79	80–89	Above 90
Plan 1					X
Plan 2		X			
Plan 3 ^c		X			
Plan 4				X	
Plan 5					X
Total	0	2	0	1	2

Source: GAO analysis of interviews with health plan officials.

^aThe five selected plans include four HCTC state-qualified plans and one VEBA plan. Plan officials provided all actuarial values during interviews with GAO. All values reflect the plan coverage available in 2012 with the exception of Plan 3's value.

^bFor the purposes of our analysis, we used actuarial value ranges of 10 percentage points for each level of coverage. Plan officials told us the actuarial value range that each plan was in (i.e. 70-79 percent) rather than the specific actuarial value estimate. However, HHS has proposed a *de minimis* variation of +/-2 percentage points (e.g., a silver-level plan will be able to have a value from 68 to 72 percent) in actuarial value rather than the wider range of actuarial values at each level of coverage that our analysis used. CCIIO officials told us that plans that have actuarial values that do not fall within +/-2 percentage points of one of the levels of coverage will not be sold inside or outside of an exchange.

^cPlan 3's actuarial value was calculated using estimated 2010 costs and utilization for the plan's standard population rather than estimated costs and utilization for the current (2012) standard population of the plan. A plan official told us that it is likely that actuarial value has increased slightly since 2010, as the plan's deductibles have not increased since 2010 to accommodate any increases in inflation.

Individual market plans (1 percent of HCTC participants). The small number of HCTC participants that have individual market plans are likely to have a plan with a lower level of actuarial value. A recent study⁶³ found that about half of the plans (51 percent) in the individual market have an actuarial value of less than 60 percent and another third (33 percent) have an actuarial value at the 60 percent (bronze) level.⁶⁴

⁶³Jon R. Gabel et al., "More Than Half of Individual Health Plans Offer Coverage That Falls Short Of What Can Be Sold Through Exchanges As of 2014."

⁶⁴This study used 2010 data on individual market plans from a sample of five states. We found that at least a third of the HCTC monthly participants enrolled in individual market plans in 2011 were from the five states that were sampled for the study.

Certain PPACA Provisions May Incentivize HCTC Participants to Change Their Level of Coverage in 2014

The varied actuarial values of the HCTC plans suggest that the level of coverage for many HCTC participants may change after the expiration of the HCTC depending on the options available to participants and the choices they make in 2014 under PPACA. Also, the way that the PPACA tax credits will be calculated may incentivize HCTC participants to change their level of coverage.⁶⁵ The PPACA premium tax credits will be calculated from a reference plan at the 70 percent (silver) level of coverage, so individuals who choose other plans—with either higher or lower levels of actuarial value—could face higher or lower out-of-pocket costs for premiums. However, plans with higher levels of actuarial value may result in lower out-of-pocket costs for copays and deductibles, and plans with lower levels of actuarial value may result in higher out-of-pocket costs for copays and deductibles. Ultimately, for any HCTC participant, the overall financial effect of a change from an HCTC plan to a PPACA exchange plan will be the net effect of the choice between higher or lower premium costs and higher or lower cost-sharing.⁶⁶ Further, out-of-pocket costs for premiums and cost-sharing for HCTC participants will be affected by whether they are eligible for the PPACA premium tax credits and cost-sharing subsidies.⁶⁷ Considering these factors, current HCTC participants may choose to change their level of coverage when the HCTC expires. For example:

- **Some HCTC participants eligible for PPACA premium tax credits could have an incentive to change to a higher level of coverage.** For example, if the HCTC participants who have coverage at the

⁶⁵A change in the level of coverage, in general, will not affect the services that are covered as all plans in a given exchange will cover services on the basis of their exchange's EHB benchmark plan.

⁶⁶While it is unknown how premium amounts may change in 2014, there will be restrictions under PPACA on the extent to which health insurance issuers who offer coverage through the exchanges can vary premiums. For example, health insurance issuers will still be able to vary premiums to a certain extent on the basis of age, tobacco use, family size, and geography, but they will no longer be allowed to vary premiums on the basis of factors such as health status, gender, or preexisting conditions.

⁶⁷In addition, other PPACA provisions requiring changes across the health insurance market are already affecting or will soon affect health plans, including many HCTC-qualified plans and plans that will be purchased through the PPACA exchanges. For example, lifetime limits that plans placed on essential benefits were prohibited in all individual market and group plans for plan years starting on or after September 23, 2010, and annual limits that plans placed on essential benefits are gradually being phased out for most health plans and will be prohibited by 2014. Pub. L. No. 111-148, §§ 1001(5), 10101(a), 124 Stat. 130, 883.

60 percent (bronze) level of coverage are eligible for PPACA premium tax credits, they may choose a PPACA exchange plan that has a higher actuarial value than their current HCTC plan. This is because PPACA premium tax credit amounts will be calculated on the basis of the reference plan premium (the second-lowest-cost 70 percent [silver] plan) for their exchange. Given this, it could be possible for these HCTC participants to purchase a 70 percent (silver) plan that would have on average lower out-of-pocket cost-sharing expenses than their current HCTC plan.

- **Alternatively, some HCTC participants who will be eligible for PPACA premium tax credits could have an incentive to change to a lower level of coverage.** For example, if the HCTC participants who have coverage at the 80 percent (gold) or 90 percent (platinum) levels of coverage are eligible for a PPACA premium tax credit and want to purchase a plan through a PPACA exchange with a comparable actuarial value, they will have to pay the difference between the premium for a plan with an actuarial value of 80 percent (gold) or 90 percent (platinum) and their PPACA premium tax credit. Again, this is because the PPACA premium tax credit amount will be based on the reference plan premium (the second-lowest-cost 70 percent [silver] plan) for their exchange. For example, if a participant in a family of four with a household income at 300 percent of the FPL purchases a plan in a PPACA exchange with an annual reference (silver) plan premium for a family of four of \$10,000, he or she would receive a PPACA premium tax credit of \$3,716 and would have to pay \$6,284 for the premium if he or she purchased the reference plan. However, if the participant instead decided to purchase a plan with an actuarial value of 80 percent (gold) having an annual premium of \$11,000, the PPACA premium tax credit would remain the same (\$3,716) but the premium amount the participant would have to pay would increase by \$1,000 to \$7,284. Because participants would have to pay this difference in premiums, they may opt to purchase a plan with a lower level of actuarial value than their current plan, such as a plan at the 70 percent level of coverage (silver), even though it may have higher out-of-pocket cost-sharing expenses on average than their current plan. In contrast, HCTC participants may also have an incentive to choose a plan below the 70 percent (silver) level if obtaining the lowest possible premium is their main factor in choosing a health plan. In this case, participants could choose a plan at the 60 percent (bronze) level of coverage because the premium cost would likely be lower than choosing a 70 percent (silver) level plan. However, a plan at this level would

mean that on average participants could have higher out-of-pocket cost-sharing expenses than they would with a 70 percent (silver) plan.

- **The health plan coverage options for HCTC participants not eligible for a PPACA premium tax credit will vary depending on their household income level.** The HCTC participants' not eligible for PPACA premium tax credits because their incomes are above 400 percent of the FPL could decide to purchase a health plan at any level of coverage. However, the loss of the HCTC combined with their ineligibility for PPACA premium tax credits because of their higher incomes could affect the level of coverage that they choose or even whether they purchase a health plan through a PPACA exchange or elsewhere. The HCTC participants who have household incomes below 138 percent of the FPL and live in states that expand Medicaid will not be eligible for PPACA premium tax credits; instead they will be eligible for Medicaid. However, in states that do not expand Medicaid, it is uncertain what health plan, if any, that HCTC participants who have household incomes below 100 percent of the FPL may purchase in 2014. These individuals would not be eligible for PPACA premium tax credit in any instance or Medicaid in most instances, and their ability to pay for premiums will be limited. However, because of their low incomes, these HCTC participants will likely be exempt from certain PPACA provisions, such as the tax penalty that individuals will have to pay beginning in 2014 if they do not have a health plan.⁶⁸

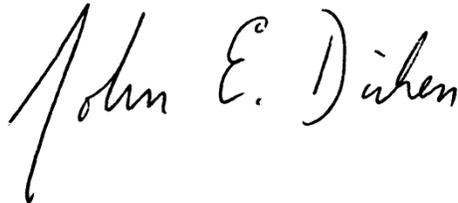
Agency Comments

We provided draft copies of this report to HHS and IRS for review, and both provided technical comments, which we incorporated as appropriate.

⁶⁸Participants who are exempt from the tax penalty will have the option to purchase individual market catastrophic health plans through the PPACA exchanges that will have an actuarial value below 60 percent because these plans will be available to individuals who are exempt from the tax penalty (and available to individuals under the age of 30). However, even though these participants will have the option to purchase this coverage, it is unlikely that they will because the cost of their premium will be high relative to their income and the lower actuarial value of the plans will increase the potential costs of accessing covered services.

As arranged with your offices, unless you publicly announce the contents of this report earlier, we plan no further distribution until 30 days from the report date. At that time, we will send copies to the Secretary of the Treasury and the Commissioner of the IRS, the Secretary of Health and Human Services, appropriate congressional committees, and other interested parties. In addition, the report will be available at no charge on the GAO website at <http://www.gao.gov>.

If you or your staffs have any questions about this report, please contact me at (202) 512-7114 or dickenj@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs are on the last page of this report. GAO staff who made major contributions to this report are listed in appendix II.

A handwritten signature in black ink that reads "John E. Dicken". The signature is written in a cursive style with a large, stylized initial 'J'.

John E. Dicken
Director, Health Care

Appendix I: Characteristics of Health Coverage Tax Credit (HCTC) Participants and Nonparticipants in 2010

We identified HCTC participants and nonparticipants by age groups, household income based on a percentage of the federal poverty level (FPL), and HCTC eligibility type using 2010 Internal Revenue Service (IRS) data. We found that most HCTC participants and nonparticipants were ages 55 to 64 (see table 6), over a third of participants and nonparticipants had household income greater than 400 percent of the FPL (see table 7), and more than half were potentially eligible for the HCTC because of participation in the Trade Adjustment Assistance (TAA) or Reemployment Trade Adjustment Assistance (RTAA) programs rather than being eligible by having their pension payments assumed by the Pension Benefit Guaranty Corporation (PBGC) (see table 8).

Table 6: Number and Percentage of HCTC Participants and Nonparticipants by Age Groups in 2010

Age groups	Participants ^a		Nonparticipants ^a	
	Number	Percent	Number	Percent
34 or younger	1,127	3%	31,577	8%
35–44	3,505	9	48,462	13
45–54	8,370	22	70,316	19
55–64	24,733	66	223,878	60

Source: GAO analysis of IRS data.

^aThis analysis excludes all participants and nonparticipants who were age 65 or older in 2010, any tax filers for whom we could not identify an age, and those for whom we were unable to obtain tax data. As a result, 86 percent of participants and 80 percent of nonparticipants were included in this analysis.

**Appendix I: Characteristics of Health Coverage
Tax Credit (HCTC) Participants and
Nonparticipants in 2010**

Table 7: Number and Percentage of HCTC Participants and Nonparticipants by Household Income Based on the FPL in 2010

Household income by percent of FPL	Participants ^a		Nonparticipants ^a	
	Number	Percent	Number	Percent
<100%	1,312	3%	25,935	7%
100 to <150	2,488	6	38,003	10
150 to <200	4,205	11	42,512	11
200 to <250	4,424	11	38,457	10
250 to <300	4,651	12	36,972	10
300 to 400	7,658	19	65,022	17
>400	14,726	37	143,302	37

Source: GAO analysis of IRS data.

Notes: The percentages may not add to 100 percent because of rounding.

^aThis analysis excludes all participants and nonparticipants who were age 65 or older in 2010, and those for whom we were unable to obtain tax data. As a result, 90 percent of participants and 83 percent of nonparticipants were included in this analysis.

Table 8: Number and Percentage of HCTC Participants and Nonparticipants by Eligibility Type in 2010

Eligibility Type	Participants ^a		Nonparticipants ^a	
	Number	Percent	Number	Percent
TAA or RTAA	22,148	59	214,843	55
PBGC	14,443	38	170,458	44
Multiple Eligibility ^b	1,136	3	4,898	1

Source: GAO analysis of IRS data.

^aThis analysis excludes all participants and nonparticipants who were age 65 or older in 2010, any tax filers for whom we could not identify an eligibility type, and those for whom we were unable to obtain tax data. As a result, 86 percent of participants and 83 percent of nonparticipants were included in this analysis.

^bAccording to IRS officials, HCTC participants and nonparticipants may have multiple eligibility types, for example, individuals may be eligible through TAA benefits and by having their pension payments assumed by PBGC.

Appendix II: GAO Contact and Staff Acknowledgments

GAO Contact

John E. Dicken, (202) 512-7114 or dickenj@gao.gov

Staff Acknowledgments

In addition to the contact named above, Gerardine Brennan, Assistant Director; George Bogart; Andrew Ching; Sandra George; Alison Goetsch; Lisa A. Lusk; John Mingus; and Laurie Pachter made key contributions to this report.

Related GAO Products

Trade Adjustment Assistance: Changes to the Workers Program Benefited Participants, but Little Is Known about Outcomes. [GAO-12-953](#). Washington, D.C.: September 28, 2012.

Medicaid Expansion: States' Implementation of the Patient Protection and Affordable Care Act. [GAO-12-821](#). Washington, D.C.: August 1, 2012.

Health Coverage Tax Credit: Participation and Administrative Costs. [GAO-10-521R](#). Washington, D.C.: April 30, 2010.

Health Coverage Tax Credit: Simplified and More Timely Enrollment Process Could Increase Participation. [GAO-04-1029](#). Washington, D.C.: September 30, 2004.

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