Implementing Tax Credits for Affordable Health Insurance Coverage

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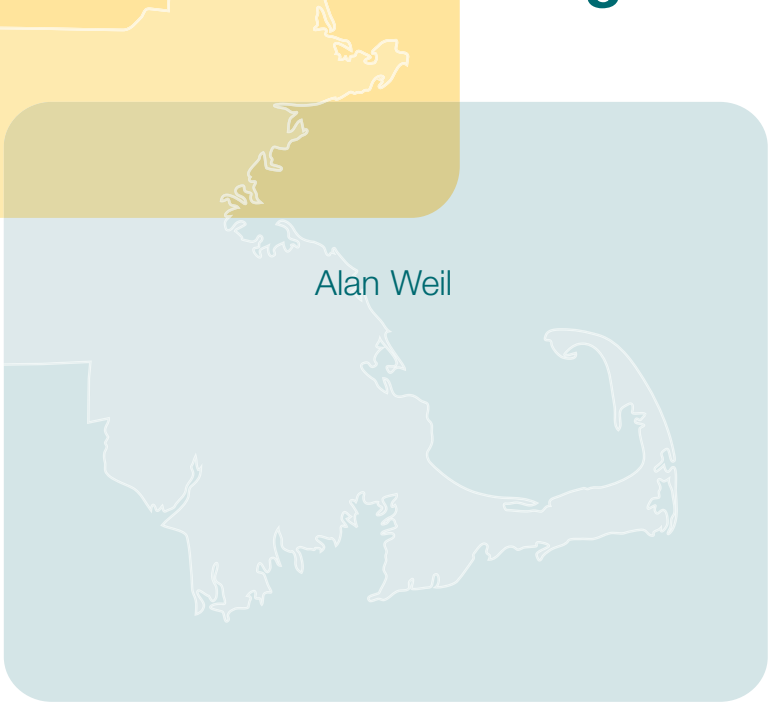

roadmap
TO COVERAGE

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Introduction

Roadmap to Coverage includes three options designed to achieve universal health insurance coverage in Massachusetts.[1] All three include the same structure of subsidies to low and moderate income families designed to make purchasing health insurance affordable. Eligible families can apply these tax credits toward the price of health insurance coverage, but they can only be used for coverage obtained through a new purchasing pool.[2] The credits are designed to cap (i.e., impose a maximum on) the percentage of income a family must pay when purchasing coverage of a benchmark plan (described below). The percentage of income cap used in the credit calculation increases as family income increases and phases out completely at 400% of the federal poverty level, as shown in Table 1.

Table 1. Structure of Tax Credits

Family Income as a Percent of the Federal Poverty Line (FPL)	Premium Payment Capped at:
≤≤ 150% FPL	6% of Family Income
151%–225% FPL	8% of Family Income
226%–300% FPL	10% of Family Income
301%–400% FPL	12% of Family Income

Successful implementation of the tax credit approach requires a number of steps. Families must apply for the credit, their eligibility for the credit must be determined, their eligibility status must be provided to a number of parties, and the tax credit funds must flow to the appropriate recipient in a timely manner. It is in everyone's interest that these steps be carried out as simply and efficiently as possible. In a voluntary system, the ease of the process would affect how many people take advantage of the credit and obtain coverage. In a mandatory system, the ease of the process might not affect how many people obtain coverage but would affect the administrative costs of the system and the time and resource burden borne by individuals and businesses.

[1]Linda J. Blumberg, John Holahan, Alan Weil, Lisa Clemans-Cope, Matthew Buettgens, Fredric Blavin, and Stephen Zuckerman, "Building the Roadmap to Coverage: Policy Choices and the Cost and Coverage Implications," Boston, MA: Blue Cross Blue Shield of Massachusetts Foundation, June 2005. http://www.roadmaptocoverage.org/pdfs/BCBSF_Roadmap2005.pdf.

[2] The features of the pool are described in more detail in Elliot Wicks, "Implementing a Health Plan Purchasing Pool," Boston, MA: Blue Cross Blue Shield of Massachusetts Foundation, October 2005. http://www.roadmaptocoverage.org.

This paper describes the various steps the Commonwealth would have to take to implement the tax credit:

- Develop an application form and process.
- Disseminate and collect applications.
- Process the applications, including determining the value of the credit.
- Develop mechanisms by which credit recipients can use the credit.
- Design the tax credit reconciliation process.
- Assure that the credit and other funds flow to the appropriate parties.

In developing its implementation plans, the Commonwealth would also need to make certain policy decisions related to the tax credits that are more detailed than the ones described in the *Roadmap*.

The Target Population

In considering how to implement the tax credits, it is important to understand the characteristics of the target population. The *Roadmap* would extend MassHealth eligibility for families to 200% of poverty. With this expansion, a family of four with income up to $38,700[3] would be eligible for MassHealth, which provides comprehensive benefits and does not charge a premium. A family with this level of income could choose to decline MassHealth and accept a tax credit. In this case they would face a maximum premium of $3,096 (8 percent of $38,700), in addition to modest deductibles and copayments. Most families in this circumstance would elect to be covered by MassHealth. However, once a family's income exceeds the MassHealth threshold, the tax credit is the only subsidy option. A family of four with income of $45,000, for example, would not be eligible for MassHealth. It would, however, be eligible for the credit and would face a maximum premium of $4,500 for family coverage under the benchmark plan (10 percent of $45,000). At the other end of the credit-eligible income spectrum would be a family of four with income of $77,400 (4 times poverty). The tax credit would cap the cost of coverage for this family at $9,288 (12 percent of $77,400) – a substantial amount but still less than the average family premium in Massachusetts today.

Tax credit recipients would also vary in how they relate to the pool. Many would be low or moderate wage workers for firms that do not offer health insurance coverage. These families would obtain coverage directly from the pool and be responsible for the full cost of their coverage minus the value of the tax credit. This group will receive the most attention in this paper. Others would be employees of firms that have chosen to provide health insurance coverage to their employees through the pool. For people in this circumstance, the employer would provide a financial and operational link to the pool that is separate from that of the employee.

[3] Dollar values in this section are based on 2005 poverty levels. These amounts are updated each year.

This range of scenarios suggests that successful implementation of tax credits would require tailoring to a variety of circumstances. The tax credit must reach families with income near the MassHealth eligibility threshold, as well as families whose income approaches the Massachusetts median. It must reach families seeking to obtain coverage on their own, and it must be able to integrate with employer contributions from firms that purchase coverage for their employees through the pool.

Designing the Tax Credit Application

The typical mechanism for obtaining a tax credit is integrated into filing a tax return. This is an efficient mechanism in that it requires minimum additional work for the applicant. For a tax credit with a value tied to income (as this proposed tax credit would be) the tax return is an ideal mechanism, since income information is already present on the tax return.

While applying for the tax credit on the tax return is convenient, waiting to obtain the credit as part of a tax refund would not meet the goal of making health insurance coverage affordable for moderate income families. A family with $45,000 of annual income cannot be expected to pay more than $10,000 out of its own pocket for coverage during the year, on the promise of receiving a $6,500 tax credit when it files its tax return the following April. Thus, most health care tax credit proposals provide that the credit be "advanceable," meaning that it can be obtained during the tax year rather than only when the tax return is filed.

We have experience with one important advanceable tax credit: the Earned Income Tax Credit (EITC). Workers can receive the EITC during the year, added to their regular paycheck, rather than receiving a lump sum at the time they file their return, if they fill out a form W-5 and submit it to their employer. Despite the relative ease of this process, and the large value of the EITC relative to applicants' modest income, less than one percent of EITC—eligible taxpayers obtained the credit in advance—a figure that has remained low for at least a decade.[4]

If the health insurance tax credit is to achieve its intended goal of promoting the purchase of coverage, a much larger share of eligible families must elect to obtain the credit over the course of the year. Rather than viewing the credit as a year-end windfall, families must view the credit as a vehicle for reducing their required monthly health insurance premium to an affordable amount. Some families at the higher end of the income eligibility spectrum might be satisfied with receiving their credit the following April—and the traditional mechanism for obtaining the tax credit should certainly remain open to them. However, for most people, the credit would only work as intended if it is received in advance. Throughout this paper I will refer to "applying for the tax credit" as the process of obtaining the credit in advance over the course of the year.

[4] United States General Accounting Office, "Earned Income Tax Credit: Advance Payment Option Is Not Widely Known or Understood by the Public," GAO/GGD-92-26. February 1992; United States Department of the Treasury, Memorandum for Commissioner, Wage and Investment Division, "Taxpayers Were Assessed Additional Tax for Advance Earned Income Credit Payments Not Received," Reference Number: 2003-40-126, June 2003.

MassHealth provides the obvious starting point when designing an application process for the tax credit. Massachusetts has been very successful relative to other states and in absolute terms in achieving enrollment of people eligible for MassHealth.[5] This success is in part due to a simplified application form, a strong outreach program, and a relatively prompt eligibility determination process. Massachusetts particularly stands out from other states in how the application process insulates the applicant from the complex eligibility standards that exist for the variety of programs for which people might be found eligible.[6] The message to families is clear: needy families are eligible for assistance and a relatively simple application will determine the precise form of that assistance. This clear message needs to be retained if Massachusetts is going to experience the high take-up rates for the health care tax credit that it has achieved for MassHealth.

Families should be permitted to apply for the tax credit on the same form they currently use to apply for MassHealth and related programs. If low-income families apply for MassHealth but are found ineligible due to excess income or assets, they would likely be eligible for a substantial tax credit and should be strongly encouraged to use it. The Medical Benefit Request (MBR) form currently used to determine eligibility for MassHealth and related programs collects almost all the information that would be necessary to determine eligibility for the tax credit; only minor modifications would be needed. Therefore, it would be fairly straightforward to integrate eligibility determination for all these programs into a single form. The result would be that families determined ineligible for MassHealth might learn of their tax credit eligibility without having to take an additional step to apply for the tax credit. And families applying for the tax credit might discover that they are eligible for MassHealth.

Many families that have income substantially above the standards for MassHealth would instead be eligible for the tax credit. These families may be familiar with tax credits, but uncomfortable with public benefit programs. While completing the relatively short MBR does not impose a heavy burden, some families may bristle at the notion they are completing the same application they would use for MassHealth or the free care pool—programs they may associate with "welfare." This argues for giving families the option of using a separate application designed solely for the tax credit.

There is a risk in creating a separate application for the tax credit, however. Some tax credit applicants would meet the MassHealth eligibility requirements. If they use a separate application, their eligibility for MassHealth would not be known. This error would have negative consequences for families and for the Commonwealth. Families would face substantially higher costs, in the form of premiums and cost sharing, if they purchase coverage using the tax credit rather than obtaining MassHealth. The Commonwealth receives matching funds from the federal government for MassHealth expenditures, whereas costs associated with the tax credit would be either unmatched,

[5] Lisa Dubay, Genevieve Kenney, and Jennifer Haley, "Children's Participation in Medicaid and SCHIP: Early in the SCHIP Era," Urban Institute Assessing the New Federalism Issue Brief, Series B, No. B-40, March 2002, http://www.urban.org/UploadedPDF/310430.pdf.

[6] Randall Bovbjerg and Frank Ullman, "Recent Changes in Health Policy for Low-Income People inMassachusetts," Urban Institute Assessing the New Federalism State Update No. 17, March 2002, http://www.urban.org/UploadedPDF/310431.pdf.

or at best matchable within a federal cap. Offsetting this loss to the Commonwealth would be the lower taxpayer-financed cost of the tax credit relative to a full MassHealth benefit.

Despite the risks, the Commonwealth should plan to allow people to apply for the tax credit separately from MassHealth and related programs. If it should choose to permit a separate application, it would need to decide what information and what documentation to require as part of the application. Options range from the broader requirements of the MBR to something much simpler along the lines of what the federal government requires for the W-5.

As is typical for benefit programs, MassHealth applicants must provide supporting documentation of income and assets through pay stubs, bank statements, and the like. Supporting documentation is required at the time of application because the benefit is provided prospectively.[7] This prospective design for benefit programs is critical to their effective functioning. Enrollees and providers rely upon having accurate real-time information regarding eligibility so they know their costs will be covered. If the Commonwealth could look backwards and reverse a determination of eligibility (for reasons other than fraud) it would be impossible for enrollees and health care providers to act with confidence.

The approach is different for a tax credit. Typically, there is no application, per se, for a tax credit. Calculation of the credit is integral to the tax return, which occurs on an annual basis. An applicant can obtain a portion of the expected value of the EITC in advance during the year by completing a very simple form that requires no documentary evidence to support it. But advance payments only affect cash flow—they do not represent a determination of eligibility. Eligibility for the EITC, even if payments are made in advance, is not determined until the tax return is filed.

To achieve its objective of making health insurance coverage affordable at the time families are attempting to purchase it, the Commonwealth must encourage applications for advance payment of the credit. This argues for adopting a simple self-declaration of expected income similar to the W-5. There is a risk that some families would make errors when submitting their form and have substantial tax liability at the end of the year. The Commonwealth would need to monitor the extent of this problem and potentially revise its policies if it becomes a significant problem. Still, at the outset the goal must be to encourage participation, which argues for a simple application form.

As with the federal EITC, the Commonwealth would need to encourage families to submit new forms when their income or other circumstances change that might affect their eligibility for the tax credit or its size. This would help keep the value distributed over the course of the year as close as possible to the actual amount of the credit due the applicant.

[7] The actual rules are more complex. Eligibility can be retroactive up to 90 days prior to the date of application. Enrollees are required to report a change in income or other information that might affect eligibility within ten days of the change, and the Commonwealth can initiate its own eligibility review. The Commonwealth also matches information provided on the application with information it obtains through other means, such as tax and labor records. And eligibility must be renewed periodically, or it will lapse. Despite all these provisions, the general point remains valid. Eligibility must be documented at the outset because the determination of eligibility is prospective.

Disseminating, Receiving, and Processing the Application

One aspect of the Commonwealth's success with MassHealth enrollment is that applications are broadly available. The same should be true for the tax credit. Under each of the *Roadmap* options, the number of people obtaining coverage directly from the purchasing pool is predicted to be within the same range as the number of people covered by MassHealth. This is a large number of people spread throughout the state, calling for many and varied pathways to obtaining the credit application form.

The Commonwealth would want to develop a comprehensive outreach plan for the tax credit. This would include integration with existing MassHealth outreach as well as efforts targeted at families with income substantially above the MassHealth threshold. Tax credit applications should certainly be available at all locations where the MBR can be obtained, including on the internet.

In contrast to the broad availability of applications, Massachusetts has in place a centralized MassHealth eligibility determination process. This differs from most states, which have county-based eligibility systems. Whether tax credit applications are fully integrated with the MBR or submitted through a separate application, it makes sense for eligibility determination to piggyback on the existing, centralized system. This would require modifications to the automated systems currently in place.

How applications are designed and processed has important implications for two situations that would frequently occur under the tax credit. Many families would first become interested in applying for the credit at the same time they are examining their options for coverage through the purchasing pool. This might occur on line, over the telephone, or in an office where people can discuss their options in person. Other families would first become interested in the tax credit when they arrive at a hospital or clinic in need of service but without health insurance. The provider would want to (or, under a mandate, be required to) assist the family in gaining coverage. In either of these scenarios, it is essential that people be able to determine the effective price of their health insurance options.

Given this need, the Commonwealth would want to create tax credit calculators that can be used to approximate the value of the credit and the cost of coverage for families based upon a few pieces of information. These calculators would be similar to loan payment and other benefit calculators that have proliferated on the internet. The advantage of these calculators is that they are easy to use and distribute. However, prospective applicants need to be made aware that they offer only an approximation of the ultimate results that would be obtained if someone went through the entire application process.

Determining the Value of the Credit

The dollar value of the tax credit is somewhat difficult to explain. It is the result of a calculation that takes the family's income, converts it to a percentage of the federal poverty level, multiplies it by a percentage cap based on the family's income as a percentage of poverty, and subtracts the cost a family of that income level would have to pay for a benchmark plan available through the purchasing pool. Fortunately, from the applicant's perspective what matters is the price of health insurance net of the credit. This calculation simply requires knowing the family's income and what that income is as a percentage of poverty.

The value of the tax credit would be tied to the cost of a benchmark plan offered through the new purchasing pool. The *Roadmap* describes this plan as the median plan selected by those who obtain insurance coverage through the pool. Individuals and families purchasing coverage through the pool would have a range of plan options with varying prices. The same credit would be available regardless of the plan chosen.

For example, if a family of four has an annual income of $45,000 (about 230% of poverty), the benchmark plan would be available to them at an annual cost of 10% of their income (see Table 1 above), or $4,500. The dollar value of the credit would be the premium for that benchmark plan (let us say $11,000) minus the maximum they would have to pay for that plan ($4,500), which equals $6,500. The same credit would be applied against the cost of non-benchmark plans. Thus, if the family was choosing between two of the non-benchmark plans, one of which has a premium of $10,500 and the other a premium of $12,000, the family's share of the premium for those options would be $4,000 and $5,500 respectively ($10,500 minus $6,500 and $12,000 minus $6,500).

Families Using the Credit

The purpose of obtaining the credit is to enable a family to purchase health insurance coverage through the pool at an affordable price. Once the value of the credit is established, what would the family do?

The process would be different for families in different circumstances. The most critical process is for those families buying coverage directly from the pool (without their employer's involvement). They must obtain information on their coverage options and the price of those options, and make a selection.

Every family that purchases coverage through the pool would owe their share of the premium (that share depending on their income and the plan they choose). The pool would need to make arrangements to receive these payments.[8] In developing policies and procedures to accept payments, planners can look to the experience many states have with a variety of Medicaid buy-in programs.[9] These programs serve a modest income population that obtains coverage by making subsidized payments to the state.

[8] These policies reflect important public policy choices. The Commonwealth may want to define them through regulation or legislation.

The pool would need to establish procedures in a number of areas. First, it would have to decide how to bill enrollees. Some states send regular bills; others use coupon books similar to those used for loan payments. If regular bills are sent, the pool would need to decide how frequently to bill (almost all states do so monthly), how far in advance to send the bill, and when the payments should be due. In its existing buy-in program, Massachusetts mails bills at the start of each month and gives families 30 days to pay. The pool would need to decide whether to set up locations where it will accept payment in person. Some states have found that compliance increased when they began accepting cash payments in person, in addition to the check and money order alternatives by mail.

The pool would need a variety of procedures to handle circumstances in which families do not pay. In establishing these procedures, the pool must balance the importance of obtaining funds and demanding payment from people of modest means with the broader of goal of maximizing pool participation. Again, the experience of various states' buy-in programs can be helpful. The pool would need to decide whether to send reminders to people who fall behind on their payments. It would also need a policy on how far behind families can get in their payments before their coverage is terminated (in Massachusetts it is currently 60 days). The pool might choose to have a general policy with hardship exceptions that can only be obtained upon application by the family. If families fall behind, the pool would need to decide if these families must pay all arrears before they are permitted back into the pool. In addition, families could be barred from participation in the pool for some period, such as 3 months, after they fail to make their payments.

These seemingly mundane details would ultimately have a tremendous effect on how successful the tax credit is in achieving its objectives. States that operate Medicaid buy-in programs almost universally report challenges collecting premiums, even when the premium amounts are substantially lower than what families in Massachusetts would pay under the *Roadmap*. The state should also be prepared to change the original policy choices over time, based on experience.

Policies regarding payment are different under a voluntary as opposed to a mandatory system of coverage. In a voluntary system the pool retains the option of dropping a person's coverage if they fall behind on their payments and barring them from reenrolling until certain conditions are met. In a mandatory system the pool would not drop the coverage but would collect delinquent payments with penalties at the end of the year through the enforcement process.[10] Still, the pool should adopt policies that maximize the rate of timely payment--both to smooth the cash flow requirements for purchasing families and to reduce the enforcement burden.

A different set of mechanisms would apply to individuals and families obtaining coverage through the pool because their employer purchases coverage for the entire

[9] The information on state policies described in the following three paragraphs comes from National Academy for State Health Policy, "Medicaid Resource Center," available at http://www.nashp.org.

[10] Linda J. Blumberg, Randall Bovbjerg, and John Holahan, "Enforcing Health Insurance Mandates," Boston, MA: Blue Cross Blue Shield of Massachusetts Foundation, October 2005. http://www.roadmaptocoverage.org.

firm through the pool. In this case, the pool would function in a manner similar to existing employer purchasing pools around the country, in which the primary relationship is between the pool and the employer. Of greatest importance, the responsibility to pay the pool would fall entirely on the employer. The pool would not need to invoice or collect funds from individual employees or their families. Employee contributions would be collected by the employer and forwarded to the pool along with the employers' contributions.

The role of the tax credit would be different in these circumstances, however. Employees of firms that purchase coverage through the pool would be eligible for a tax credit based upon their family income. Just as the tax credit caps the share of income a family must pay for health insurance purchased directly through the pool, the tax credit caps the family's cost, net of an employer contribution, for employer-sponsored coverage obtained from the pool.

There are two ways families with employer-sponsored coverage through the pool could obtain their tax credits. The simplest way would be at year-end. This could plausibly be a more common mechanism for these families than for families purchasing directly from the pool because, if their employer makes a typical contribution to coverage, the size of the tax credit would likely be small. It may not be worth going to the trouble of applying for the credit over the course of the year. But families would need to have the option of obtaining the credit during the year. In this case, they would apply for the credit just as direct purchasers would. They would then inform their employer of their eligibility for a credit and their employer would reduce the amount withheld from their paycheck for health insurance, as discussed below.

Yet another mechanism would need to exist for employees of firms that offer coverage to their workers through non-pool insurance plans. The *Roadmap* is designed to give these employees the option of purchasing coverage through the purchasing pool instead, thereby capping their premium costs and assuring access to a plan with limited cost sharing. This option would be most attractive to relatively low wage workers (who would qualify for a large tax credit), whose employer plans would require them to make substantial contributions out-of-pocket. The pool would relate to these people in exactly the same manner as it would to other people who purchase coverage directly. However, the pool would then bill the employer for an amount equal to the contribution the employer makes toward the cost of coverage for its other employees.[11] The pool would need to obtain information about the employer from the employee.

Finally, the *Roadmap* proposes one alteration in this set of rules if the Commonwealth adopts a pay-or-play employer mandate system. In such a system, people who work for an employer that "pays" would face a lower price for coverage than people who purchase coverage from the pool and do not have an employer paying on their behalf.

[11] This provision is designed to provide equity across employers and avoid employers "dumping" employees into the pool. But it would need to be designed carefully to fit within the constraints on state action imposed by the ERISA statute and it may not be permitted at all.

The pool would have to determine which purchasing individuals and families work for employers that pay. This requires a system for providing this information to the pool—either through a tape match with the Department of Revenue based upon employer payments, or by having employers provide this information to their employees, which they can then use to inform the pool.

Reconciliation

A key component of the tax credit as designed is reconciliation of its value at the end of the tax year. Reconciliation assures that the family receives the appropriate tax credit given its income and the coverage purchased. Any family that obtained the credit during the year would need to report the amount of the credit on their tax return. They would then need to complete a schedule that computes the actual credit due to them based upon their annual income. Any difference between the amount provided in advance and the amount actually due would be added to or subtracted from their ultimate tax liability.

The primary source of variance between the advanced credit and the actual credit would be changes in family income. If family income declines between the time the family applies for the credit and the end of the year, it would be due a larger credit than was advanced and receive the balance as a credit against its taxes at year end. If family income increases, there might be additional taxes due. It would be important to educate families of this possibility, so they can either revise their tax credit application during the year or save funds to assure they have the resources they need to pay their taxes at year end.

While the tax credit would be based on annual income, other sorts of information would need to be considered monthly. For example, families may move into or out of the state during the year, or purchase coverage through the pool only for some months of the year. The tax return would need to gather this sort of information to make sure the credit is reconciled appropriately. Obtaining monthly information about the tax credit would not be difficult. The pool would provide each participating family and the Massachusetts Department of Revenue with a year-end report similar to the one used to report prior year tax refunds. This report would include the dollar value of the credit and the number of months the credit was claimed. This information would be readily available to the pool, and its availability is one of the primary reasons the *Roadmap* specifies that the credit can only be used through the pool. Any credit issued but never used by the family to purchase coverage would be ignored.

While the reconciliation process could rely largely upon the usual practices of the tax code, some areas might require a closer look. For example, from the perspective of the tax code, a child is a dependent for the year whether it is born on the first or the last day of the year, and a couple is not considered married during the year if they were divorced on the last day of the year. Yet, the poverty level is a function of family size and it changes immediately when such events occur. Relying upon the existing tax code practices might ease administration, but could also create financial inequities that should probably be avoided.

Similarly, there are some differences between how the tax code defines filing units and how the insurance industry defines insurance units. In most instances these two are aligned: a person with no dependents purchases single-person coverage and files a tax return; a family of four purchases a family insurance policy and files a single tax return that reports the income of all its members. There are, however, exceptions. The children in a family may be eligible for public coverage whereas the parents purchase coverage on their own. A child of divorced parents may be claimed as the dependent of one parent and included on the insurance policy of the other. A person may claim dependents for tax purposes who are not eligible to be covered as dependents on the insurance policy. Since the tax credit would be based upon the cost of insurance coverage relative to a family's income, rules would need to be developed to define who is included in the calculation in these and similar situations.

Fortunately, the tax credit is designed in a manner that should minimize the reconciliation burden. Since the tax credit would only be claimable in conjunction with the purchase of coverage through the pool, by definition it would be impossible to "claim" the credit and then not use it. Someone who applied for the credit but then failed to obtain coverage through the pool would not actually have obtained anything of value that needs to be returned on reconciliation.

Some tax credit proponents have suggested that reconciliation occur within a corridor, meaning that modest size variances between the credit claimed and the ultimate credit due be ignored. This approach would enable the Commonwealth to send a clearer message to families about the cost of their coverage at the time they are making the decision to purchase it. If people are afraid they would face a tax liability at the end of the year, they might be hesitant to take the credit in the first place. The corridor approach has a number of negative consequences. First, families would have an incentive to underestimate their income if they expect to benefit from it, and they would have less of an incentive to report changed circumstances that might reduce their credit if they expect to be able to keep the larger amount. In addition, loosening up on reconciliation would undermine the clarity of the tax credit design as tied precisely to actual family income.

Reconciliation would be integrated into overall enforcement of the tax code. The large value of this credit relative to the income tax burden of moderate income families raises the prospect of a significant increase in tax refunds and taxes due with filing if families make errors in their projections when they apply for the credit. The Department of Revenue would need to be prepared for this possibility and might need to devote additional resources to enforcement, particularly in the early years. With proper education and enforcement, it should be possible to encourage families to be as accurate as possible in their tax credit applications and to update the application when their circumstances change. However, this could take time to achieve.

Some people who obtain the tax credit would fail to file a Massachusetts tax return. This should be reasonably rare, however. Families with income above the MassHealth eligibility threshold are already required to file state income taxes. A person could apply for the credit, obtain coverage through the pool, and then fail to file a tax

return. This would violate existing Massachusetts law. But it would be fairly cumbersome as a mechanism for committing fraud, since the person would need to make monthly premium payments to the pool, for which the only benefit they would receive would be health insurance coverage. Still, the Commonwealth would need to pay some attention to this possibility.

Ultimately, all the rules developed for reconciliation would have to flow back into zthe application process. The goal is to have people receive as accurate as possible a tax credit during the year so a minimum of liability or additional credit exists at the end of the year. As with the EITC, families should be required to resubmit their application form during the year if their circumstances change. The more complex the reconciliation rules, the more complex the original application would need to be to yield an accurate tax credit value determination, and the more likely it is that families would experience changes during the year that require a new form to be submitted. This argues for as much simplicity as possible in the reconciliation rules.

Flow of Funds

A number of different structures would need to be created to assure that the appropriate amount is collected from various payers to cover the cost of the health insurance obtained through the pool.

The funds flow would be fairly straightforward for people who purchase coverage directly from the pool. Each month the pool would provide the Department of Revenue with a list of people purchasing coverage through the pool. The Department of Revenue would transfer to the pool the value of the tax credits due for those people. The pool would combine these funds with the funds collected directly from the families purchasing coverage and transfer them to the health plans in which people are enrolled. To assure timely transfer of funds, the payment from the Commonwealth to the pool would be based upon recent, historical information, and would be reconciled after the fact to align with actual experience.

The flow would be slightly different for tax credit recipients employed by firms that purchase coverage through the pool. The employer would be responsible for remitting to the pool the cost of coverage for its employees less any tax credits available to those employees. The employer would reduce the amount it withholds to cover the employee's share of the health insurance premium for any employee that receives a tax credit. Thus, the employer would need to know the size of the credit for each of its employees. The balance due to the pool would come directly from the Department of Revenue. The burden for reconciliation would fall to the employee, with no employer involvement.

This process would keep the administrative burden on employers small, which is important to encourage their participation. The greatest burden would be that employers must know the value of the credit for their employees. This process is very simple with the EITC, because the W-5 is filed directly with the employer and the employer relies upon the calculations made by the employee. If the health insurance

tax credit application remains simple and relies upon self-declaration of income and other matters, a similar process could be used. If the tax credit application builds upon the MBR or otherwise must be processed by the Commonwealth, however, the determination must be forwarded to the employer either by the employee or directly from the Commonwealth. This process would place a more substantial administrative burden on the employer.

Continuity of Coverage

The goal of the *Roadmap* is to dramatically reduce the number of people in Massachusetts without health insurance coverage. Meeting this goal requires encouraging people to obtain coverage, and to keep it during transitions that might otherwise cause them to lose their coverage. The design of the tax credit could have an effect on how easy or difficult it is for people to maintain their coverage during transitions that might cause them to lose it.

Four transition points require targeted strategies to yield continuity of coverage.

First, since the tax credit would be determined annually, the Commonwealth must make it as easy as possible for families to continue to receive the credit in successive years, assuming they are still eligible and in need of the credit. Promoting this sort of continuity would be fairly straightforward. The Commonwealth could simply treat the tax credit application as in effect until the family withdraws it or until the family submits a completed tax return with information that reveals the family to be no longer eligible. In addition, a family that makes its first application for the credit on a tax return could be given the option on that return of electing advance payment of the credit at the same level in the next year.

The second critical point of potential discontinuity would when a family loses eligibility for MassHealth. Assisting with the transition to using a tax credit would not be difficult if the family remains in contact with the state. Many families leaving MassHealth are eligible for transitional benefits, and they could be informed of their eligibility for the tax credit when those transitional benefits come to an end. The more difficult situation is when a family simply stops communicating with the state and their benefits lapse because they fail to respond to requests for the information that would be needed to retain their coverage. This would be an appropriate point for the state to conduct outreach designed to either renew the MassHealth coverage or encourage the family to apply for the tax credit. In a mandatory system, it would be critical for the state to reach the family at this point to determine which coverage option it would elect.

A third point of potential discontinuity would be when people lose employer-sponsored insurance coverage. This can happen because an employer stops providing coverage or because a person leaves one job where coverage was offered and moves to another where it is not. The challenge for the Commonwealth is that these changes occur frequently and the employee has no reason to interact with the state at this time. Still, the Commonwealth does have means for learning of these changes. Under federal

child support enforcement laws, for example, states have created databases of new hires. In addition, employers itemize their employees when submitting their unemployment compensation and income tax payments. Transforming these processes into opportunities to market the tax credit or communicate the importance of complying with the mandate would require substantial effort, however, and careful consideration of the burdens on small employers.

A final point of potential discontinuity would be when a family that has been purchasing coverage through the pool simply stops making payments. This could happen for good reasons (such as taking a job with coverage), or bad reasons (such as a cash-flow crisis that makes it impossible for the family to pay its share of the cost). Again, the Commonwealth would need to treat these events as critical points to engage the family and determine the reason for the change. In a mandatory system it would be important to make clear to the family that they will have to pay for their coverage through the tax system (possibly with penalties) if they do not pay during the year. In a voluntary system every effort should be made to encourage families to retain their coverage.

The nature of these transitions would be different in an optional system than if the Commonwealth adopts a form of mandatory coverage. Under optional coverage, families would need to be informed of their options and encouraged to take steps that provide them with continuous health insurance coverage. Under a mandatory system, the family would also need to be notified that sanctions will apply if they fail to pursue any of the options available to them. In particular, the transition points described above would become opportunities for enforcement as well as encouragement.

Conclusion

Many of the steps necessary to implement the tax credit provisions of the *Roadmap* are quite straightforward. Systems need to be revised and in some instances created, but most build from a foundation within the current administration of MassHealth and the existing tax code.

The most significant challenge would be to encourage eligible families to apply for and receive the tax credit during the year rather than at the end. This would require extensive outreach and education and a simple application process fully integrated with the purchasing pool. Yet, families would ultimately be liable for any differences between the information they include on their application and their actual circumstances at year end. Making the application too simple could invite error and raise concerns among applicants that they will face a large tax liability when they file their tax return. The existence of an individual mandate would certainly encourage more people to apply for the tax credit. Yet, the tax credit system should still be designed to maximize voluntary participation, so that the burden of enforcing the mandate is minimized.

About the Author

Alan R. Weil is the Executive Director of the National Academy for State Health Policy, a nonprofit, nonpartisan public policy organization dedicated to excellence in state health policy and practice. He spent seven years at the Urban Institute, directing Assessing the New Federalism, one of the largest privately funded social policy research projects ever undertaken in the United States. He was also Executive Director of the Colorado Department of Health Care Policy and Financing—the cabinet position responsible for Colorado's Medicaid and Medically Indigent programs, health data collection and analysis functions, health policy development, and health care reform. Mr. Weil is a graduate of the University of California at Berkeley; the John F. Kennedy School of Government at Harvard University; and Harvard Law School.