HEALTH INSURANCE REFORM PROJECT

NATIONAL ACADEMY for STATE HEALTH POLICY

Administering a Medicaid + Tax Credits Initiative

Lynn Etheredge
Judith Moore
Health Insurance Reform Project
at The George Washington University

Sonya Schwartz
Alan Weil
National Academy for State Health Policy

February 28, 2007

THE GEORGE WASHINGTON UNIVERSITY
WASHINGTON DC

Support for this project was provided by a grant from the Robert Wood Johnson Foundation to The George Washington University.

2131 K Street, NW ◆ Suite 500 ◆ Washington, DC 20037 ◆ 202/872-3971

Contents

Contents / continued ➤

Introduction

For the past several years, there has been interest in proposals that would cover the uninsured through a combination of new federal health insurance tax credits and expansion of state Medicaid and State Children's Health Insurance (SCHIP) programs. Joining these two approaches may be the only way to reach an enactable compromise.

This report presents the results of a project that focused on the issues and problems of administering such initiatives. The study was undertaken because implementing a nationwide "Medicaid + Tax Credits" initiative to cover 47 million uninsured persons, in more than 50 federal-state programs, would pose unprecedented, large, and complex administrative challenges for both the public and private sectors. Identifying these challenges in advance and discussing how to address them may assist in legislative decision making and preparing for implementation. Many current proposals for expanding coverage also envision new roles for federal and state governments, employers, health plans, and individuals. We thus hope this report will be broadly useful.

The project convened a series of three working meetings with federal, state, and private sector experts who would likely be involved in implementing a Medicaid + Tax Credits initiative in order to identify key administrative problems and to discuss options for how to handle them. A first meeting identified key federal government issues and included national health policy perspectives; a second meeting convened state officials and experts to discuss their concerns and suggestions; a third meeting, in Massachusetts, sought the experience of individuals who are implementing the health care reforms there, the views of other state experts, and the perspectives of employers and health plans. We are enormously grateful to the more than 30 experts who participated in these meetings, and for the financial support of the Robert Wood Johnson Foundation.

This report includes four main sections: an **Overview of Major Administrative Tasks**, a **Summary of Suggestions for Administrative Efficiency**, a **Discussion of Major Administrative Issues and Options**, and an **Appendix**.

The **Overview** identifies key tasks for the federal government, state governments, employers, and health plans. It is intended for legislative decision makers and leaders of all these institutions as they consider their role in implementing a Medicaid + Tax Credits initiative.

The **Summary** is organized around the key administrative system design issues for the Medicaid + Tax Credits initiative: eligibility rules, application and enrollment, payment of premiums, consumer choice, administrative costs, and legislative planning. It presents a vision for a "world class" administrative system and specific suggestions for administrative efficiency in each of these areas. It is intended to invite an early and critical dialogue between legislative decision makers and potential administrators.

The **Discussion** is the project's central working document. It emerged, grew, and was revised in response to the three advisory meetings. It is intended to be a resource for professional legislative staffs and administrators who will need to understand major issues and options at a high level of operational complexity.

At the end of the report, the **Appendix** includes lists of participants in each of the three meetings, as well as the meeting agendas.

A MEDICAID + TAX CREDITS SCENARIO

In order to ground discussions, the project team invented the following scenario for the two state "Advisory Panel" meetings to consider and react to along with the draft working document (the **Discussion** section).

Imagine that the Administration and Congress have reached a consensus that the only politically feasible approach for expanding coverage to the uninsured is through federal health insurance tax credits and state supplements. They want input from states about the administrative challenges and options for making this work.

Now imagine that this group (meeting in Washington on March 27-28, 2006 or in Boston on December 1, 2006) has been convened as an "Advisory Panel" charged by Congress with identifying the administrative issues and challenges for states in implementing such a system, identifying feasible options, and providing a report to Congress.

Congress has provided the "Advisory Panel" only a broad outline of the parameters for such a federal tax credit + state supplement approach, and everyone recognizes that the amount of the tax credits and other financing will be subject to negotiation in a final legislative process; the rest is up to you. The parameters are as follows:

- A new federal health insurance tax credit program will be created for individuals and families who meet the income requirements.
- Individuals and families could use the tax credit to buy health insurance in the health insurance market, coverage in purchasing pools and cooperatives, Medicaid, SCHIP, and other new and existing state programs.
- The federal tax credit will cover part, but not all of the cost, of comprehensive health insurance in the private market.
- The tax credit would be "refundable," meaning that an individual would not need to owe taxes in order to claim it. It would also be available on an "advanceable" basis, meaning that it could be paid out on a monthly basis so an individual does not need to wait until the end of the tax year to receive it.
- Medicaid, SCHIP and other state programs exist as they do today, but you are also able to recommend reforms that would make it easier to align these existing programs with this new federal health insurance tax credit, so that they could provide the state supplements.
- States would be able to supplement this federal tax credit with additional state funding. Additional federal funding may also be available for this purpose.

Overview of Major Administrative Tasks

A national initiative to cover the 47 million uninsured through new federal tax credits and expansion of state Medicaid/SCHIP programs would involve unprecedented, large, and complex challenges for the public and private sectors. The lead responsibility for the most difficult work would fall on 50 state governments. Without well-designed, consumer-friendly administrative systems, this coverage initiative would be an unworkable mess.

Based on a series of working meetings to identify major administrative challenges and how they could be addressed, this overview suggests the following key tasks for the federal government, state governments, employers, and health plans.

Federal Government	
Legislation	Design a federal-state Medicaid + Tax Credits initiative for covering 47 million persons, defining federal-state roles and state options and providing statutory authority, flexibility, and funding.
Tax credits	**For workers:** upgrade the W-4 and W-5 payroll deduction systems for payment of tax credits. **For nonworkers**: upgrade the HCTC system for payment of tax credits.
Demonstrations	Support several state demonstrations to develop, test, and refine policies and systems before national implementation.
Advance funding for states	Invest in developing efficient, consumer-friendly state systems for (1) application and enrollment and (2) consumer choice.

The federal government's key role would be to write national legislation for the Medicaid + Tax Credit initiative. The Internal Revenue Service (IRS) would need to upgrade its W-4 and W-5 systems

for paying workers' tax credits and its Health Coverage Tax Credit (HCTC) system for nonworkers' tax credits. The federal government, state governments, employers, and health plans would benefit from several state demonstrations of the Medicaid + Tax Credits model to develop, test, and refine new policies and systems before national implementation. Advance federal funding for new state administrative systems would be a critical investment.

State Governments	
Legislation	Enact legislation to cover the uninsured, using federal tax credits and possibly additional state supplements. Establish administrative systems that clearly define roles of state and local agencies, individuals, employers, and health plans. Provide authority and funding.
Eligibility rules	Establish income-based eligibility for state supplements (using IRS's adjusted gross income).
Application and enrollment	Upgrade Medicaid to a new consumer-friendly system offering one-page (or one Web page) applications, multiple points of application (including on-line, worksite, and mail-in), and a "one-stop" service agency with excellent information technology systems.
Premiums	Use service agency for application/enrollment to notify applicants, health plans, IRS, Medicaid/SCHIP, and employers about enrollment, tax credits, state supplements, and individual premium shares, and payments: where, when, and how to send them.
Consumer choice	Provide a well-functioning market for affordable coverage, such as an FEHBP-type model.
Communications	Assure that eligible persons, employers, health plans, state and local agencies, health care providers and all others affected by the legislation know about the coverage initiative and their new roles and responsibilities.
Implementation	Assure that all policies and administrative systems are developed, tested, debugged, coordinated, and operational on time, with high performance and consumer-friendly service.

A critical administrative challenge for state governments will be to upgrade or replace Medicaid's application and enrollment systems that are a legacy of its history as a public welfare program. Many states have moved toward simpler, consumer-friendly systems for Medicaid's parents and children, SCHIP, and state programs for uninsured workers that can be models. However, there are still states where Medicaid applicants are required to come to county welfare offices for face-to-face interviews; fill out paper applications (that in some states run 25 pages or more); document paychecks, bank statements, citizenship, and the value of their financial assets; and reapply at specified intervals. That approach is not going to work for 47 million uninsured people. By contrast, the collection of taxes by the IRS simply requires mailing in 1040-series forms (with W-2s).

A second critical challenge for states will be to organize a well-functioning market that can assure affordable coverage for recipients of federal tax credits and state supplements. Fortunately, there are good administrative models in the Federal Employees Health Benefits (FEHBP) system and in a number of states, for example California's (CalPERS), other states' public employee systems, and the new Massachusetts Health Insurance Connector.

Finally, states will be responsible for assuring effective communications to all eligible persons and other parties affected by the legislation and for seeing that all the policies and systems are developed and work well.

Employers	
Application and enrollment	Facilitate workplace application by uninsured workers and families.
Premiums	Deduct workers' premiums and federal tax credits (via W-4s and W-5s). Forward deducted funds to health plans or FEHBP-type agency.

Employers can make a vital contribution to efficient administration. Because 80% of the uninsured are workers (and their families), the acceptance of worksite applications (online, mail-in) would be an efficient method for enrolling uninsured workers. The

payroll deduction system is a marvel of efficiency and is used for trillions of dollars of tax payments and health insurance premiums. We suggest a similar role for administering the new tax credits and premium shares for workers.

Health Plans	
Application and enrollment	Work with state-organized application and enrollment process.
Premium payment	Work with state-organized premium payment system.
Consumer choice	Work with state-organized market system.

Many of the administrative tasks for a Medicaid + Tax Credits initiative arise from its intent to offer a competitive market of affordable health plans for the 47 million uninsured. Health plans have a large stake in helping to make sure that all the administrative systems are first-rate in design and operations.

Summary of Suggestions for Administrative Efficiency

This summary of suggestions for administrative efficiency is organized around the key administrative system issues for a Medicaid + Tax Credits initiative: eligibility rules, application and enrollment, payment of premiums, consumer choice, administrative costs, and legislative drafting and advance planning. As the advisory groups delved into the complexity of the challenges and many difficulties that could arise, it became abundantly clear that the implementation of a Medicaid + Tax Credits initiative could become a huge, horrible mess if not set up to work efficiently. In the final workshop, the project team invited participants to envision a "world class" administrative system and to offer their suggestions about best ideas for efficient administration.

Drawing on the three meetings, this summary offers a world class administrative system concept, followed by key suggestions for efficient administration of the above-mentioned system issues. The suggestions come from the perspectives of those who might be called on to implement a Medicaid + Tax Credits initiative. These key points are not health policy recommendations, but they address issues likely to make or break a new program. The suggestions are intended to invite an early and critical dialogue between legislative decision makers and potential administrators. Many issues that would arise for a Medicaid + Tax Credits initiative have also come up for other coverage proposals. And addressing these issues will be absolutely necessary if a combined tax credit–Medicaid expansion, or other coverage plan, is going to work.

ENVISIONING A WORLD CLASS ADMINISTRATIVE SYSTEM

Our advisors were acutely aware of the complexity and scale of the administrative challenges they were asked to discuss. The U.S. health care financing system—and Medicaid, in particular—is an administrative morass. Many coverage initiatives have had large implementation problems, and new legislation could add more fragmentation,

Toward A World Class Administrative System

- **A one-page application/enrollment form.** Eligible persons would do no more than fill out a one-page (or one Web page) form to apply for benefits, select a health benefits option, and arrange for premium contributions.
- **All other administrative functions would be handled by computerized information and financial exchanges among federal and state agencies, employers, and health plans.** The administrative system's architecture would be designed to perform its other administrative functions "in the background" with outstanding efficiency, effectiveness, and customer service.

more complexity, and repeat past legislative mistakes. While laying out issues and options, the project's dialogue also offered a unique opportunity to think about best designs, from administrators' perspectives. For an overall vision, we suggest a world class concept (see box, left), which has two key elements.

Although the technical capabilities exist for creating the pieces of a first-rate administrative system with these features, there are few examples of states that currently employ these capacities. Systems-level planning and operations, as well as consumer-friendliness, would be even more challenging. State Medicaid programs, the Internal Revenue Service (IRS), the U.S. Department of Health and Human Services (HHS), health plans, employers, and others would need to work together in new ways — to a high performance standard. And legislative statutes would need to provide the necessary direction, authorities, and flexibility. The following sections discuss key administrative areas: eligibility rules, application and enrollment processes, premium payments, consumer choice, and administrative costs. Each section offers suggestions that would contribute toward a first-rate system, but each suggestion also merits consideration as a solution to specific administrative problems.

ELIGIBILITY RULES

A fundamental challenge is to have eligibility rules that are developed and written so that administrative systems can quickly and accurately determine eligibility for federal tax credits and state supplements. The federal tax code and its administrative system are standardized nationally using the basic concept of adjusted gross income. However, Medicaid eligibility rules are an administrative jungle of 56 different systems, and are incompatible with the tax code. Each state has its own rules about covering different categories of individuals for Medicaid (up to 50 categories in most states, with some

states having many more), and other rules for the State Children's Health Insurance Program (SCHIP); each state counts income differently; and asset accounting is strikingly complex to administer.

Eligibility Rules	
Basis of eligibility	Adjusted gross income (IRS)
Accounting period	Prior year's income, current year estimates
Verification	W-2s, 1099s, etc. filed by payers, in government computer files
Redetermination	Annual

The straightforward way to address the fundamental issue of eligibility is for the federal and state governments to standardize on ***income-based eligibility***, using federal adjusted gross income. This would make possible a one-page application form; allow a joint federal-state application/eligibility determination process; eliminate the need for large enrollment bureaucracies specializing in complex, categorical definitions, and income and asset accounting rules; and enable computer verification of income from tax forms, such as 1040s, W-2s, 1099s.

A second administrative suggestion is for states and the federal government to allow individuals to elect their ***prior year's income*** as a basis for establishing eligibility. This would allow the use of computerized government records, such as 1040s, W-2s, 1099s, rather than requiring applicants to submit additional, nonstandardized paper documents for caseworker review and verification. If there were major income changes during a year, individuals would be expected to adjust advance tax credit payments via W-4 or W-5 deductions, rather than apply for new eligibility determination.

A third suggestion is to require states to make tax credits determinations and eligibility periods normal for ***a full year***. Individuals would not be required, as is now the case in some states, to reapply, resubmit paperwork, and re-establish eligibility at less than yearly intervals. This would reduce the government's administrative tasks and recognize that individuals must usually contract for health insurance coverage on an annual basis.

APPLICATION AND ENROLLMENT

Application and enrollment is a first step in the administrative process, and it is critical to the success of a coverage initiative. Over the past decade, many federal and state coverage initiatives have run into implementation difficulties. These efforts include SCHIP in many states, which struggled to enroll even half of eligible uninsured children, Medicare's 1997 Medicare+Choice initiative for private plan enrollment, and the recent addition of Medicare prescription drug options (Part D). Millions of low-income beneficiaries have not received intended benefits.

The IRS has a straightforward application process for most tax credits. Individuals self-declare eligibility and apply for credits as part of their annual 1040 tax returns. Taxpayers can receive their estimated tax credits in advance, if they wish, by adjusting the income tax deductions from paychecks (via W-4 forms). For low-income individuals who owe few or no income taxes, the tax code provides a W-5 method for advance payment of the Earned Income Tax Credit (EITC). A worker submits the W-5 form to his or her employer, who adds the advance EITC to the worker's paycheck. The employer then (1) deducts this amount from the total tax withholding it forwards to the IRS and (2) reports the W-5 advance credits to the IRS. In addition, the worker files a 1040 tax return, verifying the advance tax credit amounts paid and received.

In the future, the tax administrative system may become even more efficient. Since the substantial sources of income for most individuals (for example, wages, interest, and dividends) are now reported to the IRS by employers, banks, and other payers, it may be possible for the IRS to calculate income and income taxes without requiring lower income taxpayers to submit paper forms and paper documents.[1]

The state Medicaid application and enrollment systems are different and can be much less efficient. Although there has been a great

[1] The recent IRS "Free File" initiative, for example, now allows taxpayers with an adjusted gross income of up to $52,000 to prepare their tax returns online and file electronically. An estimated 70% of taxpayers, 95 million individuals, are now eligible for this paperless tax-determination system. See www.irs.gov/efile/article/0,,id=118986,00.html for more details.

deal of progress for SCHIP and Medicaid parents and children, recent federal proof-of-citizenship requirements are a major reversal. In addition, there are still states where applicants are required to appear in person at county welfare offices; wait in line for individual face-to-face interviews; fill out applications that run 25 pages or more; navigate very complicated eligibility rules; provide paper documentation of paychecks, bank statements, citizenship, and the value of assets; and reapply at specified intervals. Applicants must often repeat this sort of process for other government low-income assistance programs, such as food stamps, low-income housing, school lunch, etc., each of which has its own separate application process, eligibility rules, and eligibility specialists trained to understand and administer its complex rules and procedures. The multiple systems and their complexities need caseworkers to help beneficiaries understand and navigate the application and enrollment processes, and outreach efforts to encourage them to apply. These agencies now have little, if any, relationship to the IRS and tax administration or to employers. Sending 47 million uninsured persons to their county welfare offices to apply for health benefits through complex and non–user-friendly systems would not work.

Application and Enrollment

Application	One page (or one Web page)
Points of application	Multiple (workplace; online; mail-in; federal, state, and local agencies; health plans; providers)
Application/ enrollment processing	"One-stop" service agency with excellent IT systems
High participation rates	Mandatory enrollment with proof of enrollment, automatic enrollment, enrollment incentives
Preventing loss of coverage	Focus on points of transition (new job, job loss, becoming ineligible for Medicaid/ SCHIP, aging off a parental policy)
Insurance records	Health cards with names & ID numbers

The design and implementation of a new application and enrollment system for state-administered benefits, in collaboration with the IRS, employers, health plans, health care providers, and many application sites, should be a top priority. A Medicaid + Tax Credits initiative is not really practical without this approach.[2] This system would make maximum use of computer systems. We suggest the following six elements.

The first three recommendations go together: a ***one-page application, multiple points of application, and a single, one-stop service agency***. These are key elements for a consumer-friendly and efficient application and enrollment system for health benefits (and a possible prototype for all low-income assistance programs). With adoption of income-based eligibility, there could be a one-page (or one Web page) application form. This application would cover federal tax credits, state supplements, and health plan enrollment. Multiple points of application would make it as easy and as simple as possible for individuals to apply. For example, since 80% of uninsured persons are in working families, providing online applications from the worksite would be an efficient way to target and serve the uninsured. A single-stop state agency would make a common eligibility determination for both federal and state benefits; it would also advise federal and state governments, health plans, individuals, and employers about shares of premiums, payroll deduction amounts, and the identification codes to be used for making and proper crediting of automatic online payments. Several states have pioneered in developing prototypes of one-stop service agencies. The recent Massachusetts coverage initiative, for example, is administratively feasible because the state had already developed a one-stop application Web site, with downloadable forms, for MassHealth enrollment.

A well-designed application and enrollment system should achieve high participation rates at low administrative expense. Voluntary health insurance initiatives often have had distressingly poor sign-up rates. Far more efficient are ***mandatory enrollment (with required proof of enrollment), automatic enrollment, and enrollment incentives.*** The

[2] Even a Medicare-for-all program would need an application and enrollment system for low-income enrollees to receive supplemental benefits.

Massachusetts plan, for example, requires all individuals to sign up for basic health benefits, has proof-of-enrollment requirements, and has a financial penalty for failure to obtain coverage. Mandatory enrollment also helps make very clear to individuals that they need to take action, what action they need to take, and when they need to enroll. Automatic enrollment can also be effective; individuals are automatically enrolled unless they actively choose not to be covered. Medicare's beneficiaries are automatically enrolled in Medicare's Supplementary Medical Insurance (Part B), with premiums automatically withheld from social security checks, unless a beneficiary specifically declines coverage. The Medicare take-up rate is about 95%. Automatic enrollment features for employer-provided retirement and savings benefits have also proved highly effective.

Efficient administrative systems also need to prevent loss of coverage through a ***focus on points of transition***, such as starting a new job, job loss, losing Medicaid/SCHIP coverage, or aging off a parental policy. Indeed, most of the uninsured population have had health insurance coverage but have lost benefits at one of these transition points. A Medicaid + Tax Credits gap-filling strategy would need to prevent lapses in coverage and keep individuals insured. It seems worthwhile to make sure people are informed of coverage options at these points of transition.

Finally, an enrollment system needs to set up new enrollees with insurance identification (ID). This could be accomplished with the issuance of personal ***health cards*** that have the individual's name and ID numbers for insurance eligibility. The cards would facilitate receipt of services, billing, and reporting of electronic health information to the individual's electronic health record (EHR). In Maine, such cards serve as debit cards; each month, the state electronically transfers its premium subsidy to the individual's card account so each person can pay his or her full premium.

PREMIUM PAYMENT

The second major step for an administrative system will be to assure timely and accurate payment of premiums and to coordinate premium payment shares from individuals, federal tax credits, state assistance, and, perhaps, from employers. As the advisory groups

considered this problem, it proved useful to think of two different models. One would be for working populations and would make use of the highly efficient payroll deduction system. The other would be for nonworking populations that will not be able to use a payroll deduction system.

Premium Payment

Eligible group	Premium share	Payment method
Workers	Federal tax credits	W-4 payroll deductions
	Advance federal tax credits for low-wage workers	W-5 payroll deductions
	Individual premium share (Employer share, if any)	Payroll deductions
	State premium share	Medicaid/SCHIP
Nonworkers	Advance federal tax credits	IRS (HCTC or via Medicaid/SCHIP)
	Individual premium share	Individual payment
	State premium share	Medicaid/SCHIP

Workers. Our key suggestion for workers' premium payment is to make full use of payroll deduction systems. Employers are now required to make eight standard deductions: individual federal and state income taxes, employer social security and Medicare taxes, worker social security and Medicare taxes, unemployment insurance, and workers compensation. Employer payroll deductions forward to federal and state treasuries more than $3.5 trillion (annually) in tax revenues and more than $600 billion (annually) in employer and individual health insurance premiums. By extending this system, most workers would file a redesigned ***W-4 form*** that requests employers to: (1) deduct from paychecks the worker's share of the premium; (2) reduce the worker's income tax deductions by the amount of the federal health insurance tax credit, as determined by the state's application/enrollment agency; and (3) forward the worker's premium share and the amount of the federal tax credit to the health plan selected by the worker (or an intermediary

designated by the state). Low-income workers whose tax credits would be larger than their income taxes and thus need an "advance" tax credit, would file a redesigned ***W-5 form*** that requests employers to: (1) deduct from paychecks the worker's share of the premium; (2) advance the worker's health insurance tax credit, as determined by the state's application/enrollment agency, from amounts that the employer would otherwise pay to the IRS for income and social security taxes; and (3) forward the worker's premium share and the amount of the federal tax credit to the health plan selected by the worker (or the state-designated intermediary). If an employer chose to make a premium contribution, that contribution could be forwarded as part of these payments. At the end of the year, employers' W-2 forms would show the amounts of the health insurance tax credits paid, for the IRS and for workers to include on their 1040s. State premium assistance would be paid by the Medicaid or SCHIP agency to the health plan or designated intermediary, in the amount determined by the application agency, using the identification and account numbers it assigned. Since more than 80% of uninsured persons are members of working families, most premium payments for a Medicaid + Tax Credits system could be handled in this way.

Nonworkers. For nonworkers, the IRS would pay a monthly advance tax credit, using its Health Coverage Tax Credit (HCTC) system of electronic funds transfer to health plans, the Medicaid or SCHIP agency would forward the state assistance amount, and each individual would pay his or her premium share directly to the health plan. The amounts for each payer would be set by the state application/eligibility agency. Several variations on this arrangement are possible: the individual could send his or her premium share to the IRS, and the IRS could package it with the federal tax credit (today's HCTC system), or the IRS and individual could send their premium shares to the Medicaid or SCHIP agency, which could send the full premium to the health plan or other appropriate entity.

CONSUMER CHOICE

Administrative systems for a Medicaid + Tax Credits initiative would be called on to facilitate consumer choice among competing health plans (and possibly state program options). There are many

controversial political and health policy decisions to be made about how to structure markets and regulate health insurance products so they will be affordable. Here we offer three key suggestions that could make for easier administration and a consumer-friendly market.

Consumer Choice	
Market structure and operation	Government-sponsored FEHBP-type competition
Health plan identification	Identification numbers
Information from health plans	Required as condition of participation

We suggest that a Medicaid + Tax Credits initiative could use government-sponsored FEHBP-type competition to provide consumer choice. The Federal Employees Health Benefit Program (FEHBP) is the nation's largest system for employer-provided health benefits. The program offers eligible persons a competitive choice among leading health plans and handles many administrative functions, including qualifying plans, obtaining competitive premium bids, running an annual open season for consumers to make informed choices, collecting and distributing the employer and worker shares of premiums, assuring open enrollment and portability of coverage, establishing common premium structures and rating policies, and overseeing a well-functioning market. CalPERS, the California public employee's health benefits system, is another large and proven model for the kind of administrative structure that would be needed. In another state, the Massachusetts health initiative has created a Massachusetts Health Insurance Connector to create a similar market-management structure for its Commonwealth Care Health Insurance Program enrollees. We suggest this approach to federal policy makers who are considering a combined Medicaid-tax credit program for other states to: (1) greatly simplify administrative tasks for states, the IRS, employers, and health plans; (2) improve administrative performance; (3) improve value for taxpayers; and (4) better serve consumers.

The two other suggestions address difficulties encountered in the HCTC initiative. The IRS, individuals, health insurance commissioners, and health plans have had difficulty communicating about which individual health plan options qualify for use of the HCTC. In part, this difficulty arises because health plans often have names that sound similar. We suggest this could be addressed by a system of ***health plan identification numbers*** that provide a unique identification. This would be similar to the CUSIP system that now assigns a unique ID number to each security so that ownership and dividends can be accurately reported for tax purposes. With such a system, computers could accurately record and verify chosen health plan options, and payers could use electronic transmission for premium payments. Another suggestion, also from the HCTC experience, is a reminder to legislative drafters to include ***authority for the IRS and other government agencies to be able to obtain information they need from health plans in a timely manner.*** Without such authority, it would be more difficult to run a high-performance administrative system.

ADMINISTRATIVE COSTS

The choices that legislative drafters make about administrative systems would have large implications for administrative costs and all other aspects of performance. We found huge differences in administrative efficiencies and costs of different ways to implement the Medicaid + Tax Credits initiative. ***The IRS's tax administration and the payroll deduction system are models of administrative efficiency***. They operate with great convenience and very low costs (that is, it costs only a few dollars to adjust W-4 withholding and create new deductions, fractions of a cent for electronic funds transmission) to collect and distribute trillions of dollars annually. They also automatically generate reports, such as W-2s, that provide an automatic verification record from payers for the income, tax deductions, and advance tax credits claimed by individuals on 1040s. With 80% of uninsured persons in working families and thus already in the social security and income tax/payroll deduction systems, we suggest making maximum use of these systems. New administrative systems are not needed to duplicate what the IRS can do.

Traditional state and county-run application and eligibility systems for Medicaid rank poorly in consumer service and administrative efficiency, with hundreds of dollars of government expense (and much hassle for applicants) to establish (and periodically re-establish) eligibility. These systems are also a hassle for enrollees. A number of states, like Massachusetts, have redesigned their application and enrollment systems to work better for Medicaid parents and children, SCHIP, and health insurance programs for working populations. Our suggestions for a new state application/enrollment process, with income-based eligibility, one-page applications, multiple points for application, one-stop consumer centers, Web-based and mail-in applications, and excellent information technology systems continues and builds on this type of progress. This type of system would be especially needed for the 20% of eligibles who are not in the workforce.

The HCTC advance payment system appears to be today's most expensive administrative option. Calculated on a per-beneficiary basis, IRS administrative costs for HCTC are 88% higher than are state and federal administrative costs for Medicaid/SCHIP systems.[3] The HCTC advance payment system would become even more expensive if it also needed to perform low-income testing for individuals who do not now file 1040 tax returns. (However, IRS processing of HCTC credits claimed through W-4s and 1040 filings seems to work well.) These suggestions would use the HCTC advance payment system for low-income nonworkers. State agencies would handle applications and eligibility, and the IRS would provide electronic transfer of advance tax credits, which it does with great efficiency.

LEGISLATIVE DRAFTING AND ADVANCE PLANNING

Our advisory panels also offered a number of suggestions (and reminders) for those who may be involved in legislative drafting and early planning of new administrative systems. These suggestions reflect a wealth of experience in implementing health coverage initiatives in the public and private sectors.

[3] Stan Dorn, personal communication, January 31, 2007.

- **Simplify.** Simple administrative systems are far easier to understand, implement, and operate than complex systems. Coverage of 47 million persons in a new Medicaid + Tax Credits program will be a large challenge under the best of circumstances.
- **Institute clear responsibilities.** For administrative systems to work well, everyone involved needs to know exactly what they are expected to do, when they are expected to do it, and how they are expected to work with others. All of this starts with legislative drafting.
- **Limit the number of state options, with waivers.** One of the reasons to enact a "federalism" initiative, like Medicaid + Tax Credits, is to give states the flexibility to address problems in different ways. However, if 50 states adopt 50 different solutions to all the complex issues, the results could be too complex to understand or for the federal government to write regulations and assure accountability for public spending. The federal government balanced these considerations in the SCHIP statute, which spells out a limited number of state options but also allows states to propose modifications or seek waivers. Some states, for example, may want a state-run administrative system that uses state tax systems to pay the health insurance tax credits on behalf of the IRS. Others may prefer a stronger federal administrative role.
- **Utilize demonstrations before full implementation**. It would be a valuable learning experience for several states to pioneer forms of a Medicaid + Tax Credits initiative before the nation fully implements a 47-million person, nationwide initiative. The federal government, states, employers (and their payroll service firms), health plans, and future beneficiaries would all benefit. The current Massachusetts plan would be an excellent opportunity for a Medicaid + Tax Credits initiative; federal tax credits could easily be added to the Massachusetts reform plan.
- **Provide advance funding and advance planning.** A Medicaid + Tax Credit initiative cannot be implemented quickly without advance funding and advance planning. New state application and enrollment systems, for example, need many months or years in lead time and preparatory funds because of the need for state legislative review and approval of new

budget requirements and changes. For system-wide planning, the federal government (HHS and the Department of Treasury) could convene a work group of representatives from states, employers, payroll system specialists, and health plans for detailed planning of administrative options and interoperable computer systems. There should be ongoing dialogue between congressional decision makers and those at states and in the private sector who would implement a Medicaid + Tax Credits design.

Although this project focused specifically on a Medicaid + Tax Credits initiative, most of the initiatives now being discussed for expanding health insurance coverage also involve new administrative roles for federal and state governments, employers, health plans, and individuals. The planners of these initiatives will need to consider use or redesign of tax administration, payroll deductions, state Medicaid/SCHIP application and enrollment processes, consumer choice and other administrative issues discussed in this report. We thus hope that this report will be of broad use in the design of new initiatives for coverage of the 47 million uninsured.

Discussion of Major Administrative Issues and Options

WHY DISCUSS MEDICAID + TAX CREDITS?

National health policy has relied mostly on two different approaches for coverage of the under 65 population: (1) employer-based private health insurance for working populations, supported by tax subsidies, and (2) coverage by Medicaid or the State Children's Health Insurance Program (SCHIP), both of which were originally focused on nonworking populations and are supported by federal grants to states. Employer-based benefits cover about 165 million people under age 65; Medicaid benefits cover about 55 million people.

Most of the 47 million people without health insurance fall between these two benefit/financing systems: they are not eligible for Medicaid, and they are not eligible for (or cannot afford) tax-subsidized employer-based coverage. It might be supposed that it would be easy for public decision makers to close these gaps. Financing for both Medicaid and tax credits comes from taxpayers. However, it has proven very difficult to reach agreement about how to finance expanded health insurance coverage. Some people strongly prefer expanding Medicaid, whereas others strongly prefer expanding tax benefits, an approach that relies primarily on the private sector. (In addition, some people prefer other routes, which are not discussed in this paper.) Such differences about public and private sector roles have engaged political ideologies and partisanship.

In the past several years, there has been interest in how to combine the Medicaid approach with tax credits for covering the uninsured. For the most part, this new Medicaid + Tax Credits interest is a pragmatic view that political compromises would be needed to expand coverage. There is also recognition that both the pro-Medicaid and pro–tax credit proponents have good points to make and have offered good proposals to consider. Possibly, the best of the Medicaid expansion and the tax benefit expansion ideas could attract enough support for enactable legislation.

Administrative Issues to Discuss *Before* Legislative Drafting and Implementation

The aim of this document is not to debate whether a Medicaid + Tax Credits approach is the best concept for expanding health insurance coverage; this combination approach is a political formula that incorporates quite different ideas about what is best. Rather, the document seeks to capture advice of experts who would administer this kind of initiative in order to identify key administrative problems and options for how to handle them well before any legislative drafting.

There are at least five specific reasons for inviting state and other experts to participate in advance administrative planning for a large federal-state initiative:

- **A Medicaid + Tax Credits initiative, without adequate attention to administrative feasibility, could be a very big mess for states and beneficiaries.** All of us in health policy have lived through (and lived with) too many instances of federal initiatives that involved administrative difficulties unforeseen by legislative drafters, such as the new Medicare Prescription Drug benefit (Part D) and the Health Coverage Tax Credit (HCTC) in the Trade Act.
- **Medicaid and the federal tax code are very different.** Philosophically, administratively, in computer systems, in how they work with employers and payroll deductions, and in many other ways, Medicaid and the federal tax code are not aligned. Professional staffs have work to do to figure out how the pieces could function together.
- **Large, complex initiatives need adequate lead time for states to make choices and to design and implement new administrative systems.** A new Medicaid + Tax Credits system would need to serve up to 47 million uninsured people, which is a formidable administrative challenge. Supporters will want to see it implemented rapidly. However, new state, county, Internal Revenue Service (IRS), employer, and health plan systems would all be needed to make Medicaid + Tax Credits legislation work well. Advance planning and advance funding will be required for operating systems to be ready quickly. Advance work for a new initiative could also be an opportunity to upgrade many legacy systems to new

designs and best practices. For example, a redesign of the national Medicaid Management Information System (MMIS) could be an opportunity to design new Medicaid capabilities for interacting with the IRS and employers and also improve the management of Medicaid for currently eligible individuals.[1] Assuming that the federal law leaves room for states to make choices about major policy options, such as the type of health coverage people could purchase with the tax credit, states would need to have time built in before implementation was required in order for public debate and decision making to occur. A federal-state partnership, in which many policy issues are to be decided at the state level, devolves a number of politically and technically complex issues to state decision making processes.

- **States have different programs and preferences.** Medicaid, SCHIP, public programs for low-income workers, tax benefits, health insurance regulation, tax laws, and so on are different from state to state. States will best be able to take advantage of new federal monies if there are state options that fit what they want to do and what they are already doing.
- **Feasible administrative options could improve legislative drafting.** If states and federal agencies can work out feasible approaches to administer a Medicaid + Tax Credit design, good legislation would be much easier to write.

A National Demonstration Strategy?

There may be much to be learned—by states, IRS, the U.S. Department of Health and Human Services (HHS), employers, health plans, and federal and state decision makers—from demonstrations of a Medicaid + Tax Credits approach, particularly in a few states. As will

[1] A redesign of MMIS is now underway and can be a vehicle to prepare for implementation of a Medicaid + Tax Credits initiative, CMS's Medicaid Information Technology Architecture (MITA) initiative. With MITA, eligibility will soon be part of the new system and not separate, and income data, which is usually maintained at the county level, could become part of state eligibility files. There will be a 90% federal Medicaid assistance percentage (FMAP) available for the design of MITA and a 75% match for ongoing administrative costs, but 50% FMAP will be available for operating the eligibility system. Over time, the entire basis of the Medicaid program could be reconsidered, since, with a new system that covers all of the uninsured below the federal poverty level, it would be possible to dispense with many of the dozens of categorical eligibility definitions in the Medicaid program that complicate its enrollment applications and administrative structure.

be evident in this document, there are a lot of administrative details that need to be worked out in order to make a Medicaid + Tax Credits approach work. If each state has to invent its own answers to these questions and develop unique software systems and procedures, if the federal government needs to collaborate with more than 50 very different approaches, and if there is a single start-up date for covering 47 million persons through over 50 brand new systems, then the startup could be an unusually challenging experience.

The Massachusetts health reforms offer an excellent opportunity for a first demonstration of a "state health reforms + tax credits" strategy. Several other states may also be interested in such an approach. For these demonstrations, federal and state officials would go through a very important process of identifying administrative issues, considering options, and selecting preferred approaches. There would be learning from this process, as well as from implementation experiences, that could have very large benefits before taking such initiatives full scale for more than 50 new programs and 47 million persons.[2]

A PLANNING SCENARIO

What Do We Mean by Medicaid + Tax Credits?

In order to ground our discussions for this paper, we invented the following scenario for the state "Advisory Panels" to consider and react to.

Imagine that the Administration and Congress have reached a consensus that the only politically feasible approach for expanding coverage to the uninsured is through federal health insurance tax credits and state supplements. They want input from states about the administrative challenges and options for making this work.

Now imagine that this group has been convened as an "Advisory Panel" charged by Congress with identifying the administrative issues and challenges for states in implementing such a system, identifying feasible options, and providing a report to Congress.

Scenario / continued ➤

[2] L. Etheredge, "Massachusetts Reforms Plus President Bush's Tax Credits: A National Model?" *Health Affairs* Web Exclusive, September 14, 2006.

Scenario / continued

Congress has provided the "Advisory Panel" only a broad outline of the parameters for such a federal tax credit + state supplement approach, and everyone recognizes that the amount of the tax credits and other financing will be subject to negotiation in a final legislative process; the rest is up to you. The parameters are as follows:

- A new federal health insurance tax credit program will be created for individuals and families who meet the income requirements.*
- Individuals and families could use the tax credit to buy health insurance in the health insurance market, coverage in purchasing pools and cooperatives, Medicaid, SCHIP, and other new and existing state programs.
- The federal tax credit will cover part, but not all of the cost, of comprehensive health insurance in the private market.
- The tax credit would be "refundable," meaning that an individual would not need to owe taxes in order to claim it.** It would also be available on an "advanceable" basis, meaning that it could be paid out on a monthly basis so an individual does not need to wait until the end of the tax year to receive it.***
- Medicaid, SCHIP and other state programs exist as they do today, but you are also able to recommend reforms that would make it easier to align these existing programs with this new federal health insurance tax credit, so that they could provide the state supplements.
- States would be able to supplement this federal tax credit with additional state funding. Additional federal funding may also be available for this purpose.

* At the first meeting, the scenario limited the tax credit's availability to people who are ineligible for employer group insurance (and its tax benefits) or who are ineligible for Medicaid/SCHIP. Meeting participants felt strongly that limiting the tax credit to those ineligible for Medicaid would likely create a requirement that all tax-credit eligibles go through the Medicaid enrollment process, or at least some type of rigorous Medicaid screening process. State participants wanted flexibility to design new programs beyond Medicaid that are simpler in terms of documentation and eligibility criteria.

** Millions of low-income uninsured people do not earn enough to owe federal income tax, or owe a small amount of tax. In these instances, the tax credit system would need to function as a "negative income tax," that is, it would need to transfer money to an individual in an amount that is greater than the amount he or she owes in taxes. In tax jargon, tax credits that can exceed tax liabilities are referred to as "refundable" tax credits.

*** Health insurance premiums are typically due monthly and can be very expensive. Lower income people may not be able to afford to purchase insurance if they have to wait until after April 15 of the following year to receive a tax credit. Advanceable tax credits may also need to be "nonreconcilable" so that a recipient would not have to repay credits if his or her final annual income were higher than anticipated when the monthly advances were paid.

State and Federal Role Options

There are a number of options for how the federal and state governments could collaborate in administration of a new Medicaid + Tax Credits initiative. A prime reason for a federal-state approach is that political consensus has been unattainable in the 30 years of debate on national health insurance proposals, with high degrees of national uniformity specified in federal statute. A Medicaid + Tax Credits approach emphasizes federal financing for expanded coverage but is intended to leave a good bit of discretion to states and allows for state-to-state variations.

A Medicaid + Tax Credits strategy, with state supplements, could achieve near-universal coverage for the uninsured. However, new assistance categories ("low-income uninsured persons not covered by Medicaid or SCHIP") and new financing could make this a more fragmented and complex system than currently exists. States may wish to think through an integrated approach that would simplify and coordinate the different systems of application, eligibility determination, enrollment, premium payment, and financing sources.

Because there could be significant issues in federal uniformity versus state discretion, it would be desirable for drafters of federal legislation to have in mind several models for how states may want to proceed. This would allow states to plan for a collaborative arrangement and would benefit implementation planners by giving them guidance as to how much variation to incorporate in administrative planning and how much discretion they will have in finalizing arrangements with each state. In the SCHIP legislation, for example, the federal government specified several basic state structural options and left other options more open.

Below are two possibilities, at opposite ends of a spectrum, to frame this discussion.

- **Maximize state government role.** A state with a strong vision for how to expand health insurance coverage could view the tax credits as a financing opportunity for its plans. The new Massachusetts health reforms are an example of this kind of state initiative. In this kind of system, new federal tax credits could become an added financing source for an overall

state plan to achieve near-universal coverage. Most of the administrative responsibilities would fall to state governments.

- **Maximize federal government role.** A state that did not want to take on new administrative roles or to institute healthcare reforms might be allowed to opt for complete federal administration of the new Medicaid + Tax Credits. Under this approach, state supplements would be based on the federal tax credit administrative system. The state would "monetize" its supplements into "premium assistance"; for example, an individual who was eligible for a $1,000 federal health insurance tax credit would automatically receive an additional $250 in state assistance. For workers, all benefits could be handled by the IRS through its W-5 and 1040 tax systems. All non-worker benefits could be handled by the IRS through its HCTC system. The creation of Medicare Part D for dual eligibles is an example of a nationalization option. Most of the administrative responsibilities would fall to the federal government.

LESSONS LEARNED FROM RECENT COVERAGE EXPANSIONS

Over the past decade, there have been major federal and state initiatives to expand coverage that offer important lessons for administrative planning for a Medicaid + Tax Credits initiative. These include the establishment of SCHIP, the enactment of HCTC benefit as part of the Trade Act of 2002, and the implementation of the new Medicare Part D.

For persons charged with planning successful implementation of a new Medicaid + Tax Credits initiative that would require states and the federal government to work together, the following proposed lessons from these experiences seem to be among the most important to keep in mind.

- **Implementation of a federal-state initiative is a joint effort, and every state is different.** The federal-state Medicaid program now allows each state a lot of discretion in the structure and operation of its Medicaid and SCHIP programs. States also differ in policy preferences, political leadership, health insurance and medical delivery markets, regulatory approaches, health care costs, employer-based

coverage, numbers of uninsured, and many other ways. With expanded use of Medicaid waivers over the past decade, the diversity has grown. There will be more than 50 different state/territorial programs for the federal government to partner with. At least two least federal agencies, Treasury and HHS, will need to be involved, and possibly the Labor Department as well. There are successful examples, such as SCHIP and HCTC, where many aspects of federal-state partnership have gone well: excellent federal leadership, well-developed consultative processes, lots of dialogue between federal and state governments, and professional commitment to first-rate public administration have been characteristics of successful aspects of these efforts. However, a Medicaid + Tax Credits initiative to cover 47 million uninsured would be a much larger and more complex undertaking.

- **Enrollment is critical to success.** All of the recent federal and state voluntary coverage initiatives, whether federal (Medicare, tax credits) or federal-state (SCHIP), have struggled with the task of informing, enrolling and serving new beneficiaries. Many millions of low-income children, senior citizens, and displaced workers did not receive benefits to which they were entitled, or were enrolled only after several years of marketing and outreach efforts. According to a recent article in *Health Affairs*, one quarter of the nation's uninsured are already eligible for public coverage but not enrolled.[3] Enrollment systems need to be a high priority, with consumer-friendly arrangements, such as workplace sign-up, payroll deductions, and marketing. In a voluntary market, attention must be paid to the price and value judgments made by potential enrollees as consumers about whether the financing and products available are desirable. As evidenced in the recent Massachusetts initiative, mandatory enrollment mechanisms and penalties for failures to enroll in coverage and/or automatic enrollment processes may need to be considered in order for the program to become really effective.
- **Eligibility rules "rule."** A critical administrative task for government programs and tax benefits is to make a clear, prompt

[3] Lisa Dubay, John Holahan, and Allison Cook, "The Uninsured and the Affordability of Health Insurance Coverage," *Health Affairs*, November 30, 2006.

determination of whether an individual is eligible and the amount of the benefit. This can be particularly complex for state Medicaid programs because federal law requires use of "categorical" eligibility; there are now over 50 optional state categories. Each state has rules about how income is to be determined, for what period, how applications are made, and the time period in which they must be processed, etc. At the same time, the federal tax code now has its own—different—rules and procedures for applications and eligibility determinations for tax benefits. Uninsured persons need to be sorted out through administrative systems that direct each person to the federal tax credits, state supplements, Medicaid, SCHIP, and/or other state programs for which they or family members may be eligible and that determine their eligibility and benefits. Ambiguities about eligibility have many adverse implications for being able to inform and enroll beneficiaries, for expense and difficulty of administering the new programs, and for gaming, shifting of enrollment among programs, and fraud and abuse. Thus the tasks of aligning state and federal eligibility rules and processes so they are clear and consistent is central to having a new Medicaid + Tax Credits system work well.

- **Large initiatives need administrative systems that do not rely on individual casework.** Administrative systems can have enormously wide variations in the effectiveness and costs of delivering health benefits. For enrollment, as an example, automatic enrollment procedures can produce take-up rates of 80% or more.[4] In contrast, programs that require individuals to apply through a county welfare office often struggle to reach 50% enrollment. And sign-up rates for health insurance (such as HCTC subsidies) and retirement tax benefits (such as self-organized IRAs) that individuals must seek out, arrange independently, and finance through voluntary contributions can be in the range of 10% to 15% or less. In terms of expense, the payroll deductions system that government uses for tax collection (and benefits) and employers use for fringe benefits can operate very efficiently (a few dollars to set up a new deduction, and fractions of a cent per electronic transaction). In contrast, an application for income-related benefits

[4] In Medicare's Supplementary Medical Insurance (physician insurance) program—where individuals are signed up at age 65 with deductions from social security checks, unless they decline—there is an enrollment rate of over 95%.

through a county welfare office for Medicaid typically costs several hundred dollars per family. Administrative processes that can be handled almost automatically and with computers are keys to standardization, accuracy, and efficiency. In contrast, processes that require individualized casework for millions of persons by large bureaucracies, need coordination among a number of public and private sector organizations, and confront customers with complicated, confusing and difficult choices, limited assistance, and multi-step procedural requirements are inherently much more expensive and time-consuming. At least six different kinds of administrative systems will potentially need some redesign in a Medicaid + Tax Credits initiative: the IRS, state Medicaid agencies, state tax agencies, county income eligibility-determination agencies, employers' payroll deductions systems, and health plans.

- **Simplicity versus complexity.** A cross-cutting theme, endorsed and amplified by nearly everyone who has been involved in large-scale implementation of coverage efforts, is that new, large systems work much better when they are simple than when they are complex and difficult to understand and explain. For a consumer-oriented, voluntary initiative, it will be particularly important that the consumer experience be simple and easy, although there will undoubtedly be complex "wiring and plumbing" among the public and private sector administrative agencies that operates in the background.

KEY ADMINISTRATIVE CHALLENGES AND POSSIBLE SOLUTIONS

Based on the "Advisory Panel" discussions and other sources, this section outlines key administrative challenges and options for a health coverage expansion using federal tax credits and state supplements. This is intended to offer a framework and starting point to assist legislative drafters, federal officials, and state officials who may be called on to come up with an operational system.[5] The topics covered are: eligibility rules, application and enrollment processes, premium

[5] For a related discussion, see A. Weil, "Implementing Tax Credits for Affordable Health Insurance Coverage," Blue Cross Blue Shield of Massachusetts Foundation (Roadmap to Coverage report series), October 2005.

payments, consumer choice and benefit coordination, and administrative costs, funding, and coordination.

Eligibility

Eligibility systems will need to coordinate the IRS and federal tax system with state tax systems and supplements, the Medicaid/SCHIP programs and employer health benefits, as well as with other state insurance programs (for example, Washington's Basic Health plan, Wisconsin's BadgerCare, MinnesotaCare, state high-risk pools). The question that will need to be answered is: *For which benefit(s) is an uninsured person eligible?* With today's Medicaid/SCHIP rules and new federal tax credit and state supplement options, this question can be far from easy to answer. For example, the federal government requires state Medicaid programs to use an anachronistic and complex approach of categorical eligibility that was based on old welfare assistance categories (there are about 50 federally defined Medicaid eligibility categories) and to determine assets for some applicants, as well as income. This requires a specialized Medicaid eligibility bureaucracy to know and apply the rules. Many applicants have to come in person to welfare offices. Coverage of the working uninsured—about 80% of the uninsured are in families with one or more workers—can be complicated when some family members are eligible for employer benefits, Medicaid, and/or SCHIP whereas others are not. Coordination of eligibility is also important because individual circumstances can change and it is important to maintain continuity of coverage. In addition, it is possible, if new eligibility rules are not well-defined or equitable, that individuals, employers, and/or state governments could drop current benefits in favor of the Medicaid + Tax Credits benefits. Since eligibility rules and processes are critical, it will be desirable to specify how these issues are to be resolved, such as by federal statute, federal agency regulation, state discretion, and/or federal-state negotiation.

Basis of eligibility/categorical eligibility. The federal tax code uses income as the basis for determining taxes, and the new tax credits would also be based on taxable income. However, federal law now requires Medicaid programs to use categorical eligibility as a primary determinant, plus income (and assets); for SCHIP programs, children's eligibility is primarily based on income. A fundamental question for designing a new federal-state coverage initiative is: *Can the coverage*

initiative use income eligibility, without categorical exclusions and assets tests, as the basis of eligibility for both federal tax credits and state supplements? A unified federal-state approach to eligibility and benefits determination seems desirable for ease of administration of a Medicaid + Tax Credits initiative.[6]

Tax credits and Medicaid/SCHIP. Several key questions will need to be addressed about tax credits eligibility versus Medicaid/SCHIP eligibility.

First, *will health insurance tax credits be available for uninsured low-income persons who are "not eligible" for Medicaid or SCHIP, or who are "not participating" in Medicaid or SCHIP?* Our starting scenario suggested "not eligible" as a starting point for this discussion. However, individuals with experience in eligibility determination suggest it would be much more practical to use the "not participating" criterion. For an uninsured individual to establish first that he or she is not eligible for Medicaid or SCHIP could require each person to submit an application to Medicaid/SCHIP and to await a notice of denied eligibility before qualifying for a federal tax credits. Such requirements for many millions of potential tax credit recipients would be an enormously complex, time-consuming, and expensive administrative process for states.

Second, *legislative drafting and implementation planning will need to address the future status of disproportionate share hospital (DSH) payments, special financing provisions (for example, donations and contributions), and waivers*. These are arrangements that now allow states to use Medicaid funds to help pay for health care of uninsured persons who would not be eligible under normal Medicaid/SCHIP rules. Since many of these populations could become eligible for tax credits, states (and the federal government) may wish to see that these Medicaid funds can be converted into state supplements to the tax credits. Massachusetts, for example, is restructuring some of its federal waiver funds into a new system of health insurance premium subsidies. Federal legislation may be needed so that states can redesign such arrangements without loss of federal funds.

[6] Categorical eligibility would still be important for Medicaid high-needs groups that are not included in a Medicare + Tax Credits initiative.

Third, *if Medicaid/SCHIP and tax credits/supplements are set up as separate systems, administrative arrangements will need to pay attention to the transition points and processes*. These new transitions would occur when a person's income rises above Medicaid levels and he or she loses Medicaid benefits but gains tax credits, or, conversely, when a person's income falls enough to qualify for Medicaid rather than tax credits. It will be important for federal and state governments to work out the details for a "seamless" coverage, perhaps including automatic enrollment and expedited eligibility determinations.

Other possible relations between tax credits and Medicaid/SCHIP, discussed later, include potential use of tax credits to "buy in" to Medicaid/SCHIP, premium support payments by Medicaid/SCHIP to supplement tax credits (for example, where a worker is using a tax credit to buy private insurance and one or more family members have Medicaid/SCHIP); default enrollment of nonworkers into Medicaid/SCHIP (unless they choose private plans); and use of new Medicaid/SCHIP options to "wrap around" or supplement benefits for low-income tax credit recipients.

Definition of income. The federal tax code is uniform across the country. "Taxable income" and "adjusted gross income" are clearly defined, and they each include and exclude particular types of income. Medicaid's definition of countable income varies by state and by an individual's categorical eligibility. The method for counting income in Medicaid typically starts with all income received from any source, including wages, Social Security benefits, and pensions, and then subtracting certain costs (such as transportation or child care). *Can the new system use a standard IRS income definition for determining eligibility for both tax credits and state supplements?*

Standardization of the differing state practices in defining and counting income is desirable to create a simple, efficient administrative system in which individuals need only make one application for federal tax benefits and state supplements.[7] If states need to use other elements and adjustments for their supplemental

[7] This would not alter states' flexibility for Medicaid and SCHIP enrollees who do not receive tax credits.

benefits, these could be set up as adjustments to the federal tax system's definition, rather than a separate system. At the least, it would be desirable to convert or determine federal tax credit and state supplement eligibility for a Medicaid + Tax Credits initiative from a single application and data set.

Timing of income calculation. The tax system calculates taxes and tax benefits retroactively on the basis of the previous year's annual income. Medicaid eligibility, however, is prospective and based on monthly income at the time of application. As legislative drafters and administrators draw up plans for expanded coverage, *can the federal and state governments agree on a common income calculation period for determining and adjusting payment of tax credits and state supplements?* A significant percentage of the population, about 40%, experiences large income fluctuations from one year to the next. For example, loss of a job (or a new job) can mean assistance needs vary. In this respect, low-income individuals may need to be able to apply for federal health insurance tax credits based on current and anticipated income, and to seek adjustments more rapidly than the normal once-yearly cycle for federal tax benefits. One possible approach would be to let the eligibility determination be based on the previous year's tax return but to allow people who either did not file taxes or whose income becomes lower to use current-year estimates.[8]

Federal versus state roles in income determination or reciprocity. States and counties make income eligibility determinations for hundreds of billions of dollars annually in federally financed benefits, such as Medicaid; SCHIP; Supplemental Security Income (SSI); public assistance; the Special Supplemental Nutrition Program for Women, Infants, and Children; food stamps; school lunch; and subsidized housing. However, for federal income taxes, the IRS makes federal income, tax and tax credit determinations, and it shares personal income tax data with state tax authorities only under specific agreements. State income tax systems often mirror

[8] There is precedent for a federal entitlement being based on last year's income. In Medicare, eligibility for the new low-income drug benefit was based on being eligible for Medicaid in the previous year.

major features of the federal income tax system.[9] *Could the federal government accept a state (or county) determination of adjusted gross income for purposes of deciding on a federal health insurance tax credit?* If so, authority for this should be provided in statute. If the federal government is expected to share personal information with state agencies that administer health insurance programs, new legislative authority may also be needed.

Filing unit. The federal income tax is based on federal filing unit definitions, for example, single, married filing jointly, dependent, etc. A Medicaid "assistance unit" does not always fit these arrangements because of foster care children, children living with grandparents or other relatives and adopted children. SCHIP eligibility is for children, based on family income. Filing status can also change during a year, due to birth of a child, marriage, or divorce. *Could states use the federal income tax filing units? Will these leave out people who should be included?*

Residency. Federal and state definitions and tests for residency may need to be aligned. Federal tax credits would not depend on the state of residence. Medicaid eligibility, however, is defined as "living in a state with the intention of remaining indefinitely"; persons who move across state lines during a year may be affected. *Residency issues will need to be examined and resolved.*

Immigrants. The federal tax code allows both immigrants and citizens to pay taxes. All immigrants with Green Cards or who meet the "substantial presence" test can now claim the earned income tax credit (EITC).[10] Nonresident aliens (that is, immigrants who do not have Green Cards or who do not meet the substantial presence test) can claim the EITC only if they are married to a U.S. citizen or resident, file a joint return, and elect to be taxed as a resident alien for the entire year. Medicaid excludes many types of legal immigrants from eligibility. *Could a new system standardize on the federal tax rules for immigrants?* To the extent immigrants are not eligible for

[9] It is arguably long overdue to tie together the income-tested federal and state benefits so there need only be one application and eligibility-determination process.

[10] The definition of the substantial presence test is available at www.irs.gov/businesses/small/international/article/0,,id=96352,00.html.

Medicaid because of their immigration status, the tax credit could give them a subsidy to buy health insurance.

Application and Enrollment

In the planning scenario, the new federal tax credits would not be available for individuals who are also eligible for employer-sponsored health benefits. This proviso was intended to assure that individuals do not obtain double benefits; that is, receive both the tax benefit of employer-based coverage (exclusion of employer-paid premiums from taxable income) and the new tax credits. It was also intended to keep down the costs of the new tax credits so that individuals do not forgo employer-sponsored benefits to get a higher federal tax benefit through the tax credit system. Thus, eligibility rules and systems must sort workers into two groups: those who are defined to be in an employer-sponsored health insurance system (with its tax benefits) and those who will be eligible for the new individual tax credits and state supplements.[11]

As a practical matter, our discussions suggest that *an eligibility system will likely need to start with self-declaration by applicants that they are not eligible for employer-provided coverage*. Experts on eligibility note that private plans generally do not know who is eligible for employer-sponsored coverage; they only know who they have enrolled and may only learn of some family members' enrollment when a claim is filed by the contract holder. Similarly, employers know their worker's names but may not know names and other information about family members. (Experts on Medicaid eligibility also note that individuals sometimes do not answer questions regarding eligibility for employer-based coverage accurately because either they do not know if they have access to employer-sponsored coverage or they misinterpret that the question is about affordability and answer "no" because they cannot afford their employer-sponsored coverage.) The Deficit Reduction Act requires the creation of state databases of employer-sponsored coverage that may

[11] There are large (nonadministrative) issues of whether or not employers may drop coverage if there is a federal tax credit for uninsured workers, or if they may induce a worker to decline employer coverage and apply for tax credits; these need to be dealt with in the design of state and federal policies and tax credit amounts.

be useful for this purpose.[12] It may also be possible to redesign the federal W-2 or other tax form to include a box that indicates whether a worker is eligible for employer-sponsored insurance. If the box is checked no, then the individual would be on a list of persons potentially eligible for the tax credit. The SCHIP program now precludes coverage for children who are eligible for employer-provided benefits; the administrative procedures used for that program may also be useful for the tax benefits.

New processes. For the up to 47 million persons who may be eligible for a Medicaid + Tax Credits program, there would need to be arrangements by which they apply for benefits, and through which there will be eligibility determinations of each family member and enrollment in a health plan or program. Potentially, this could be accomplished through a single application and enrollment system. This "one-stop" process would need to coordinate the tax system's application and determination process with application and enrollment for state benefits and private health plans for which individuals may qualify. However, most government programs and health plans are now set up so that each has its own application and enrollment rules, processes, and bureaucracies, and individuals must navigate each separately. One of the important new areas will be applications for workers, since 80% of the uninsured are workers or family members of workers.

Payroll deductions by employers is the foundation of the tax administrative system and application for most tax credits. Employers submit the worker- and employer-estimated taxes to the IRS, either electronically (in most cases) or to IRS-designated financial agents. The worker gives an employer a W-4 form for payroll withholding. Then, at the end of the year, the employer gives the IRS and individual a W-2 form showing wages and withheld tax payments. The worker uses the information on the W-2, and information about other

[12] The Deficit Reduction Act, P. L 109-171, S. 6036, requires a state to provide "assurances" to HHS that it has laws that require health insurers and entities that are "legally responsible for the payment of a claim" to: 1. provide information about who is provided medical assistance and the nature of the coverage; 2. accept the state's right of recovery and assignment of payment; and 3. allow the state to submit a claim for payment up to 3 years after the provision of the service, and bring an enforcement action within 6 years of the state's submission of the claim.

income and deductions, to submit a tax return (1040) electronically or by mail to the IRS. Some people use the assistance of special software or a tax professional. A tax refund is generally received about six to eight weeks after filing. If taxpayers have enough income, tax credits can be provided through lower payroll withholding (W-4).[13] State income tax systems also use payroll withholding and are usually tied closely to the federal tax code. Thus, many states may be able to administer the federal tax credits and state supplements through their own tax systems.

Two existing programs, the EITC and the HCTC, now rely on the federal tax system to administer a monthly advance tax credit. The Advance EITC option has been available since 1979; the HCTC benefit was enacted in 2002. These systems are not yet well-known or widely used.

The EITC for lower income workers is the nation's largest anti-poverty program. In 2004, 21 million taxpayers received $36 billion in tax refunds from the federal EITC. Nearly all of these funds were provided as rebates to individuals after they filed an end-of-the-year tax return. In addition, 15 states have enacted state EITCs.[14]

The EITC provides advance payments for low-income workers who file a W-5 with their employers. Under this approach, a worker can apply through his or her employer to receive an estimated EITC payment each month. If the worker meets certain requirements, the employer adds the EITC payment to the workers' paycheck and debits this amount from its income and social security tax payments due to the IRS. The IRS and the employer handle the bookkeeping. The individual must file a 1040 showing the advance EITC payment.

The HCTC provides an advance tax credit for health coverage for individuals who apply directly through a national IRS center. To administer the HCTC for trade-displaced workers and retirees, who are not able to use a W-4 or W-5 based approach because they are

[13] The W-4 method would not finance advance tax credits that are greater than a worker's income taxes, that is, the lowest deductions would be $0.

[14] Steve Holt, "The EITC At Age 30: What We Know," Brookings Institution, Research Brief, February 2006.

not employed, the IRS built a new eligibility/enrollment system and a new payment system. The IRS not only determines their HCTC eligibility, but also the qualification of their health plans for use of the tax credit, and the tax credit amount. If individuals elect an advance payment option, they send a check to the IRS each month for their full premium share, less the tax credit. The IRS adds the tax credit to the individual's share of the premium and transmits the full premium electronically to health plans each month.

Methods for enrolling in Medicaid vary by state and by category of applicant. Historically, applicants were generally required to go to a welfare office, have a face-to-face interview, and fill out a lengthy application. Recently, in many states, parents and children have been able to use mail-in applications or Web-based enrollment that simplifies this process, particularly for SCHIP enrollment.[15] However, new federal rules on documenting citizenship are now reversing these improvements.[16]

Enrollment for private health plans is now mostly done through employer-based sign-up and payroll deductions. Health plans that enroll individuals in non–group coverage (about 5% of the insured population) typically use networks of insurance brokers, accept individual applications, and conduct medical underwriting to screen out high-risk populations and set premiums on the basis of applicant risks.

In the near future, the IRS may be able to predetermine income eligibility for many people. Most lower income taxpayers do not have a complex tax situation, they don't itemize, and they get income only from simple sources like wages from their job and interest from the bank. This information is already sent directly to the IRS by taxpayers' employers and banks.[17] It may be possible for the IRS or

[15] D. Ross, L. Cox, and C. Marks, *Resuming the Path to Health Coverage for Children and Parents: A 50 State Update*, Kaiser Commission on Medicaid and the Uninsured, January 2007.

[16] D. Ross, *New Medicaid Citizenship Requirement Is Taking A Toll*, Center on Budget and Policy Priorities, February 2, 2007.

[17] Austan Goolsbee, "Why Tell the IRS What it Already Knows?" *New York Times*, April 7, 2006

states to integrate these data into their administrative systems for health coverage tax credits. The IRS already encourages taxpayers with an adjusted gross income of up to $52,000 to prepare and submit tax returns electronically. This paperless system is available for 70% of taxpayers, or 95 million persons.[18]

Application for workers. As mentioned above, the federal and state tax systems provide a convenient method for workers to pay their taxes—and receive most tax benefits—through the employer-based payroll deductions system. Most of the more than $3.5 trillion in annual federal and state revenue is now collected through these systems; employer-based systems also enroll 162 million persons under age 65 in group health insurance.[19] One of the most consequential issues for administering new benefits for workers is: *Will the federal-state tax credit/supplement application process use employer-based information, sign-up, and payroll deductions?* Employers that do not now offer health insurance to workers would be asked to do much the same as those who do.[20] If these methods cannot be used, federal and state governments will need to construct new and parallel systems for most of the 47 million persons to administer a small fraction of the amounts already handled by the existing systems.

In addition to convenience and efficiencies, there are two other considerations in use of a workplace application and sign-up process. First, the workplace is a highly efficient way to locate uninsured workers and their dependents and notify them of their benefits. Employers that do not offer health insurance benefits have very high concentrations of uninsured workers in their workplace. Absent use of the workplace, it is an extremely difficult job to locate and inform persons without health insurance of their benefits.

[18] See www.irs.gov/efile/article/0,,id=118986,00.html for more information.

[19] U.S. Census Bureau, *Income, Poverty and Health Insurance Coverage in the United States, 2005* (August 2006), tables C-1 and C-2.

[20] Employers who don't currently offer health insurance benefits would benefit from being better able to compete in labor markets with employers that do. If the tax credit is available to uninsured workers with an offer of coverage, employers that do offer health coverage may see more workers enroll in these plans.

A second consideration for use of the employment sign-up system is that it could increase take-up rates. For example, in the retirement savings arena, workers who are eligible to contribute to IRAs but cannot do so through payroll deductions often participate at a rate of 10 to 15%. When offered the opportunity to save (with the same tax benefits) through payroll deductions, participation rate climbs to 50%. When there are "automatic enrollment" arrangements, where workers are enrolled in these same savings plans unless they opt out, the participation rate climbs to nearly 85%. Recognizing the importance of such features, Congress recently rewrote national pension laws to enable employers to establish such automatic enrollment features. It seems likely that easy and convenient enrollment for health insurance at the workplace, or automatic enrollment, would increase take-up rates as well.

If there is to be a key role for employers, state and federal government and health plans would need to work closely with employers to make this system as easy and simple to administer as possible. This would include providing employers with the information they are expected to make available to workers; working with software firms to make sure that the new requirements are integrated with payroll deductions and tax administration systems; creating online applications and processing, as appropriate; and integrating federal and state administrative systems with the employer systems and health plans.[21]

The use of employers does not preclude other arrangements for sign-up and application. Community-based organizations and state and county offices could also be used for outreach and applications. Nor does the use of employers mean that they must work directly with each health plan; employers could interface directly with a state-sponsored agency, as they do in Massachusetts with the Commonwealth Health Insurance Connector Authority for small business. Such an agency would handle a number of administrative functions.[22]

[21] This approach works best with group-rated products where individuals can sign up for health plans without medical underwriting and be informed at the time of application about premiums, tax credits, and other state assistance.

[22] Among other innovations, the Massachusetts Health Insurance Connector will allow individuals to buy insurance with pre-tax payroll deductions, allow part-time and seasonal employers to combine contributions from different sources, and enable workers to keep their coverage when they change jobs.

Application for nonworkers. The tax system currently requires nonworkers who owe taxes to submit a tax return, but many nonworkers do not owe taxes and thus do not file a tax return. Medicaid provides a place and a process for nonworkers to apply. Among the key questions that should be addressed in drafting legislation and implementation planning are: *Where would nonworkers apply for the new federal tax credit (with the IRS, a state agency like Medicaid, SCHIP, or unemployment insurance)? Do the state or local welfare offices need to be upgraded to handle millions of low-income individuals and the working population, that is, to be seen as service centers rather than welfare offices? Can they offer online and mail-in applications?*

Just as our discussions about administrative issues point toward a workplace-based application process for workers, so also do they point toward a state-run process as a leading option for application by nonworkers. Most uninsured nonworkers will have such low incomes that they fall outside the federal income tax system. The federal government does not have the administrative capacity or systems to do outreach, enrollment, and income-testing for millions of low-income populations who do not file federal income taxes because of low income. It could create such a system, perhaps building on the HCTC experience, but this would be quite expensive. It is also not necessary. State and local governments already operate income-qualification and enrollment processes for hundreds of billions of dollars annually in government payments (Medicaid, SSI, Temporary Assistance for Needy Families [TANF], food stamps, etc.). For this system to work for federal tax credits, the IRS would need to rely on determinations of income that are made by these state and county government offices. The IRS and state governments would need to consider whether the use of such administrative arrangements will work well as part of a national tax code.

One promising approach may be for states to use whatever income-testing and eligibility process they are now using for SCHIP children. These systems are set up to do income-related eligibility and to deal with non-welfare clients. Among the "best practices" in states are simplified enrollment, such as one-page forms and online enrollment. Community outreach programs and health care provider site enrollment can also be of assistance, as may other state programs that already deal with low-income clients. For example, food stamp

eligibility determination (which is income-related) might be accepted as a basis for health insurance tax credit eligibility. States that operate health insurance programs for low-income workers (Massachusetts, Washington, Wisconsin, etc.) may also be able to make use of these systems.

Coordination for two-person families. If two (or more) persons in a family are eligible for tax credits or supplements, each could claim an individual credit separately or one family member could claim for a family. *What rules will be established for application by two-adult families? If there is a child tax credit, which worker claims the credit?*

Our discussion of these issues suggests that administrative systems for the tax credits likely may need to allow for individual and family applications. This is because the tax code allows married couples to file either jointly or separately. It also seems desirable to allow for a single application for family coverage, so tax credit recipients can purchase family coverage together through a common application process. Possibly, an administrative rule could tie the application process to income tax filing. For example, persons who file separate income taxes would apply separately for the tax credit, based on his or her own incomes; persons who file jointly would apply jointly for the tax credits. Perhaps whichever adult made the premium payment could be allowed to claim the child's credit. Such "tiebreaker" rules already apply for EITC applications.

Eligibility/enrollment period. Individuals are usually eligible for tax benefits on an annual basis. Individuals and families may be eligible for Medicaid on a three-month basis or longer, depending on the particular state's rules. Health insurance plans typically ask people to enroll on a yearly basis. *Can the eligibility/redetermination period for tax credits be for three months, six months, a year? If an individual loses eligibility for a tax credit, or the amount changes, will he or she be guaranteed a right to drop health benefits without penalty?*

There are several specific options for addressing these concerns without applying the welfare program rules. For example, there could be an end-of-year government "reminder" process that notifies tax credit recipients of the tax credit amounts and the application information on which it was based (for example, income) and requests a response

from the individual if there is some change. Or a "reminder" could be sent from an insurance company when policies come up for annual renewal (and premium increase) that advises recipients of the need to review whether an adjustment would be needed in the tax credit amount. If an individual has a reduction in tax credits, there could be a statutory guarantee that he or she would be able to drop health benefits without penalty. There could also be a "grace" period at the end of a tax credit; that is, tax credits would continue to be paid for at least one month after an individual loses eligibility. The coverage purchased by tax credit recipients also could be included in the HIPAA (Health Insurance Portability and Accountability Act) protections that provide continuity of coverage without pre-existing condition exclusions or waiting periods. This would mean that, if an individual elects a new health plan because of change in tax credit amount, the new policy would take effect immediately at the end of the previous one.

Application for advance payment of tax credits/state supplements. For low-income people, the tax credits (and possible state supplements) would need to be made available monthly in order for health insurance premiums to be affordable. For an individual to decide to enroll in a health plan, he or she would need to know the amount of the federal and state aid. The health plans will likely want to receive individual premiums (and, perhaps, employer contributions), the federal income tax credit, and any state supplement before the start of the month, or soon thereafter.

Verification for advance payment. Most information on a tax return is self-declared (without providing documentation except for employer W-2 wage income). The IRS also receives copies of 1099 forms (interest and dividends), and others, to verify other major income sources on an individual's tax return. Most tax returns receive quick desk reviews, that is, for arithmetical errors; taxpayers are required to provide additional information only as requested by IRS.

The Advance EITC requires an application to the employer (W-5) and a statement that an applicant's income from non-wage sources is less than designated amounts. With these conditions met, the worker can receive an advance EITC payment, included in his or her paycheck, each month. There is final reconciliation upon filing the tax return,

meaning an individual may have to repay the EITC to the IRS if his or her income has increased.

In Medicaid, the applicant must provide documentation to verify income and other information at the time of application. However, for some populations, the county or a provider can make a preliminary determination that an applicant is eligible for Medicaid based on a self-declaration of income without verification (called presumptive eligibility), with verification occurring at a later date. A potential source for income verification is the recent federal-state reporting system for child support enforcement that collects W-4 information for new hires, quarterly wage information for employees, and unemployment insurance benefits. These data are reported to state and national Directories of New Hires.[23] Our experts raised the questions: *Can the health insurance tax credit system and state supplements use the same self-declaration methods as the 1040 and W-5 Advance EITC system? Can IRS and state tax systems be used to check incomes? Can the state and national Directories of New Hires databases be used to verify wages and unemployment insurance benefits? Are there other options?*

The Advance EITC (W-5) provides a helpful framework for providing the health insurance tax credit on a timely basis each month. Individuals could apply for the health insurance tax credit through a similar form that could be called the "W-5H." The W-5H could be used as a standard form for uninsured workers, enabling a one-stop application process through an employer that includes the earned income tax credit, the health insurance tax credit and state supplements, and health insurance coverage.[24]

Quick eligibility decisions. As mentioned above, some tax credits, like the Advance EITC and HCTC, can be paid out on a monthly basis over the course of the year, but this is currently a lesser-known and infrequently used alternative. In the case of the advance HCTC, there are a few months of enrollment lag-time before funds are

[23] Office of Child Support Enforcement, Department of Health and Human Services www.acf.hhs.gov/programs/cse/pubs/2002/reports/ndnh_data_accuracy.html. The Social Security Administration uses the national database for checking income eligibility for SSI benefits.

[24] In Massachusetts, because of the new health insurance mandate, there will be a health insurance 1099 sent for tax purposes.

available, so the individual needs to pay the premium out of pocket and claim it later on his or her tax return. Medicaid provides three months' retroactive coverage from the date of application. Also, the state generally has up to 45 days to process an application from the date it is filed, or 90 days if an application is filed on the basis of a disability. In thinking about options for rapid eligibility determinations, *is it possible to establish presumptive eligibility or an expedited procedure so that an individual's tax credit and supplements can be determined before he or she must decide on health coverage enrollment and be made available in time for the first premium payment?*

These issues underscore the importance of designing administrative systems to achieve operational performance standards, for example completed processing of 95% of applications, eligibility determinations, and enrollments within 48 hours. As noted earlier, in recent government efforts to expand enrollment, the enrollment process has often proved the weakest element. A Medicaid + Tax Credits initiative could aim to create a state-of-the-art, world-class application and enrollment system.

Premium Payment

Once the administrative systems discussed above have completed the application, eligibility determination, and enrollment processes, there will need to be systems to collect and disburse the funds for premium payments.[25] The potential sources for premium financing include: individual premiums, employer contributions, individual tax credits (and perhaps some employer tax credits), state supplements and premium assistance paid by Medicaid and SCHIP, for example, for family members and/or as wrap-around or supplemental benefits (if that is an allowable option). Funds from all of these different possible sources would then need to be paid to a health plan (public or private) selected by an individual, usually on a monthly basis in a timely way, such as before the first of the month

[25] If relying on private coverage in particular, it will be critical to have a system that helps low-income individuals and families pay premiums on-time, or allows for some lag time, to ensure that individuals do not lose coverage. See the NASHP examination of the premium payment process for families in Susan Kannel and Cynthia Pernice, "What Families Think About Cost-Sharing Policies in SCHIP," NASHP, October 2005.

or soon thereafter. As with the application and enrollment process, one option is to think about a one-stop agent that will collect and disburse the funds. Alternatively, some of the payers could operate separately with an overall coordination mechanism to be sure all of the parts function together, or each enrollee's health plan or program could be left to ensure it receives all of the premium shares.

Employer role for workers. As with application and enrollment for workers, one model would be for employers to handle all of the key premium payment functions of this new system for their employees. These functions might include: (1) making payments to the health insurance plan on behalf of the individual (and employer, if that is allowed) through payroll deductions, or (2) paying tax credits and state supplements on behalf of the federal and state governments through a new W-5H advance payment system. One of the most important administrative issues is: *Is it feasible for employers to serve as a lead administrative agent for premium payment?*

Here again, the near-universality and convenience of the employer-based payroll deductions system make it an appealing candidate for a new role. There are already eight government-required deductions and dispersals from most paychecks: the employer's share of federal social security and Medicare taxes, the employee's federal income, social security and Medicare taxes, state income taxes, unemployment insurance, and workers compensation. With computers and inexpensive software widely available, the entire system operates at extremely low cost and high efficiency.[26] Thus a starting point for collecting and dispersing worker premiums in this new system would be to consider using the employer payroll deductions and tax administration system, rather than creating a duplicative system to handle a modest new benefit.

If the W-5H system is not used, the federal and state governments will need to devise another mechanism for adding their contributions to the worker (and employer) premium shares. One option

[26] According to an expert participant, about one-third of the workforce's payroll is processed by a payroll administrative service firm, about one-third by employers using off-the-shelf products like "Quickbooks," and about one-third through employer-based proprietary software program.

might be to rely on an expanded HCTC system where employers would send the employee (and employer) premium share to the IRS or to a state agency. This entity would then add federal tax credits and state supplements and send the full premium to the health plan.

Another option would be to give the health plans a central billing/collection role. The individual would sign up for health plans and payroll deductions at work and the employer would also submit a certification of tax credit/supplemental coverage eligibility for the worker (obtained from a federal or state agency) along with the health plan enrollment. The health plan would then bill the IRS and the state government for the rest of the premium, based on this information.

The current HCTC payment system, where the federal government consolidates the payments, is generally viewed as more complicated and expensive than payroll deductions. If the HCTC is taken "to scale" as a central payment agent, there could be tens of millions of checks being written each month to government entities for each enrollee's premium share, as well as premium shares from employers and state supplements. A lot of lead time would be needed to obtain funds by mail, to process them, and to be sure they get to a private health plan on time. If health plans do not receive payments on time, they could invoice the individual, resulting in more payments to reconcile.

Assignable or transferable tax credits. A key idea to facilitate many of the administrative options for premium payment is that the individual's tax credit and state supplements should be *assignable* or *transferable*. With an assignment arrangement, the tax credits would not be paid directly to the individual. They would, instead, be paid by the IRS or its designee on behalf of the individual to a selected health plan or public insurance program. The IRS systems can move funds electronically to institutions with computerized databases. This is vastly easier than sending individual checks through the mail each month to tens of millions of people, who in turn then write checks forwarding these funds to health insurance plans.

There are different ways an assignment procedure could work. As described earlier, the W-5H model would assign the tax credit to an employer (or health plan) at the worksite and the employer, rather

than the worker, forwards it to the health plan. With the Advance HCTC system, the enrollee assigns his or her tax credit when applying for the HCTC so the IRS can then send it directly to the health plan.[27] Another option is if an eligible individual declined to use the health insurance tax credit, the federal funding could be automatically assigned to a state program or defaulted to the state to pay for safety net care; this would ensure that the state had some funding to cover the individual's care even if he or she had not enrolled in coverage. It would likely be useful to clarify these assignment and transfer options for tax credits in legislative language.

Federal or state role for nonworkers. For nonworkers, the federal government and/or state government would need to coordinate with individuals and each other on making premium payments to health plans. In designing this administrative system, a key question is: *Should this be a federal administrative responsibility (through IRS and the HCTC system), a state responsibility, or a state option?*

Low-income nonworkers can be disconnected from information sources and have difficulties in understanding complex options and navigating administrative systems. For example, some individuals may be unfamiliar with the details of the federal tax system, may not have checking accounts, may not understand the basic concepts of health insurance, may have language or literacy problems, may fear having to provide personal information, etc. Getting these individuals enrolled in private health plans may be a challenge. An administrative system for uninsured nonworkers could provide for a "default" enrollment in Medicaid/SCHIP or a designated plan, to make sure they have coverage. The tax credit would automatically be assigned to the state unless the individuals made another coverage selection.

The Ryan White CARE Act program, through which people with HIV/AIDS use federal funding to buy health coverage if it is cost-effective and they are not eligible for Medicaid because their income is too high, may be a program worth consideration for ideas.

[27] If the tax credits were assigned to a public program, assuring that each individual's payment reached the program by a specified date would not be as necessary; the IRS could make estimated payments with periodic adjustments and reconciliations.

In Maryland, eligible individuals can use this federal funding to buy COBRA or high-risk pool coverage. Outreach is conducted by the state health department at community events. Such access and efforts could be mirrored by other entities for health coverage of nonworkers.

Premium assistance from Medicaid/SCHIP. Premium assistance is a state option (and can also be a federal waiver) where Medicaid subsidizes the cost of employer-sponsored coverage for individuals and families who are eligible for Medicaid. States have attempted to use premium assistance as a cost-cutting device in which they calculate whether a Medicaid program will save money by buying an employer's health plan for which a family member may be eligible. For premium assistance to become a general method for supporting low-income persons—at the individual's option—to purchase private health insurance would require legislative and administrative changes. If an adult had tax credit eligibility, a child's Medicaid or SCHIP benefits might be converted into a share of a family premium. Such options might be included in the tax credit application process. For implementation planners, it will be important to know answers to such questions as: *Will there be premium assistance funds paid by the Medicaid and/or SCHIP programs? What new authorities would states need to make premium assistance a widely used option for supplementing federal tax credits? What new processes would need to be established for Medicaid/SCHIP to coordinate with IRS, employers and health plans?*

Individual versus family premiums. In SCHIP, premiums can be paid for the whole family or for the child only. In an insurance system with split coverage, payroll software may need to handle separate deductions for SCHIP and private insurance plans.

Health Plan Consumer Choice and Benefit Coordination

Because tax credits are a monetary benefit, they can be used to purchase a variety of different health plans. Under the HCTC, the federal government specified qualifications for eligible health plans and required states to decide which optional plans would be eligible for tax credits. Each state Medicaid program generally has a standard comprehensive benefit package and, in some cases, relies on managed

care plans to administer the benefits, although under the Deficit Reduction Act, some states will likely introduce more limited coverage for certain populations in "benchmark plans." SCHIP allows states to designate a benefit package (for instance, Medicaid or a private health plan standard). The current HCTC is not payable to Medicaid/SCHIP plans. Only infrequently does Medicaid/SCHIP provide premium assistance payments for eligible individuals to enroll in private health plans. Some of the key legislative and administrative questions are: *What consumer choices will there be for use of the new tax credits? Will they include a buy-in option to Medicaid/SCHIP or other public programs? What insurance market reforms will be needed for recipients to be assured of being able to receive affordable coverage?*

What choices will be available? The controversial issues of what options will be offered need to be considered as health policy, but they have many administrative implications.

In terms of administrative complexity, one of the critical concerns is whether federal tax credits can be used in the individual insurance market. Because individual market rates vary widely depending on health status, state rules and requirements, and many other factors, there would be many mismatches between a federal tax credit and an individual's premium costs. This may necessitate much more complex systems of state subsidies, application, enrollment, premium collection, and plan qualification. If health plans are allowed to use medical underwriting—setting health premiums after obtaining and reviewing information on an individual's health status and history—this could complicate and delay the application and enrollment processes. It may also affect pooling and rating in the small group market in many states. Insurance agents may try to channel healthy people to the individual coverage market and the sickest people into state programs, where that option is available. Market segmentation can also occur due to the benefits offered by different plans and differential marketing. However, states may also choose health policies and administrative arrangements that minimize such difficulties. In the Massachusetts health reforms, these issues were handled by creating a Health Insurance Connector arrangement for small group and individual coverage, like the FEHBP plan, which will offer consumer choice among group-rated products.

A second large set of issues relates to using tax credits to buy in to Medicaid/SCHIP or other public programs. Such issues are likely to arise for uninsured adults eligible for tax credits whose children are covered by SCHIP. Should these adults be allowed to use their tax credits to buy in to SCHIP as coverage for an entire family? It may be that adults are more likely to cover children as part of an employer-based or other system in which they are themselves signing up for health insurance benefits. Buy-in issues also arise where there is already state-sponsored coverage for workers (such as Basic Health in Washington or Healthy NY in New York), and where there are new or existing state purchasing pools and cooperatives or high-risk pools. Buy-in options may be very important for special needs populations who use the Medicaid provider networks specializing in serving such groups, and for whom wrap-around and supplemental benefits can be more readily provided via the Medicaid enrollment option than through benefit coordination with private health plans.[28]

Issues may also arise if a state wishes to cover some tax credit–eligible populations (but not others) through a new public plan option or through buy-ins to Medicaid or SCHIP. For example, a state may want to cover childless adults below 35% of poverty in Medicaid through a waiver so it does not mix this population into a pool with working adults eligible for new tax credits and private health benefits, because the lower income population may pose higher risk due to mental or physical disabilities and other health needs that prevent them from working.

Questions will arise about the use of tax credits for purchase of COBRA coverage and state-required "mini-COBRA" coverage for smaller employers. If these are allowed, administrative processes will need to be worked out in an implementation plan.

[28] If states allow individuals eligible for tax credits to buy in to Medicaid health plans, questions arise about setting a fair premium for such buy-ins. Medicaid's per-member per-month cost is different for people with disabilities, children, and adults in the program, but *how would a state develop a fair price, at least until it had experience with the new populations?* If a state does allow public plan enrollment, insurers may raise the issue of whether Medicaid should pay private sector provider rates for these populations, to avoid unfair competition; if Medicaid provider rates need to be increased for these populations, this also will need to be part of an implementation plan.

Informing and protecting consumers. As described earlier, new health policies will need to decide whether individuals eligible for tax credits and state supplements could potentially use the funding in many different ways. Assuming choices are available, implementation planning will need to consider questions such as: *Who will be responsible for creating a well-functioning consumer choice market? What information and protections will consumers need? Will new standards, regulations, and quality reporting be required for the health plan market? What new statutory authority and administrative systems will be needed?*

A certain floor of legislated consumer protections, such as guaranteed issue, pre-existing condition protections, and limits on individual underwriting may be necessary to ensure that recipients of tax credits and state supplements will be able to purchase affordable coverage. One such change, for example, could extend the HIPAA rules and regulatory oversight that bar pre-existing condition exclusions in the group insurance market to the health plans and programs that are eligible for tax credit use. For ease of comparison shopping, it may be useful for states to structure choices so that consumers can select among options based on cost and quality differences. This would likely involve new regulations, reporting requirements, data compilation, and communications.

Informing consumers has been touched on earlier in this document in discussions of application and enrollment processes: use of the workplace has some major advantages in handling the logistics of getting information packets to eligible persons. The process of informing up to 47 million persons about new choices—and assuring these can be informed choices—should be a priority for systems design and implementation planning.

Health plan qualification/certification. The health policy issues of what private and public options will be available for purchase with tax credits and which standards will need to be met by eligible private plans carry over into administrative issues about the health plan qualification and certification process. These issues presented a key administrative problem in implementing the HCTC when individuals and the IRS needed states to finalize qualifications and certification of eligible plans. It also became clear that there is no

unique numbering or ID system for health insurance plans.[29] Such a system could allow computers to automatically determine whether a health plan option is qualified and to get payments to the right plan. Key administrative issues include: *Is it possible to have a standardized system of unique identifiers that individuals, states, the IRS, employers, and health plans can all use to determine whether a particular plan is certified for use of a tax credit and state supplement? Who would create such a system and determine its requirements, and would health plans agree to participate?*

There is a lack of clarity about work that may already be underway to create a Health Plan ID. HIPAA Administrative Simplification called for "a standard unique health identifier for each individual, employer, health plan, and health care provider for use in the healthcare system."[30] While regulations have been issued for the employer and provider identifier, the National Health Plan (Payer) Identifier and the National Health Identifier for Individuals have not yet been proposed. HHS has indicated that it will develop an identifier for health plans.

If a state decides to use an organized sign-up process, such as a uniform open season, or if it requires employers to offer health insurance sign-up, there will need to be administrative rules and procedures for requiring that insurers submit required information, such as the cost of particular products and information about benefits, on a timely basis. There may also need to be an administrative process for overseeing what health plans are allowed to do in marketing to consumers to avoid unfair competition and risk segmentation among health plans eligible for tax credits.

Medicaid/SCHIP benefit flexibility. Some states may want additional flexibility to provide less expensive benefit packages for individuals eligible for the tax credit who are not eligible for Medicaid and SCHIP.[31] Such benefits might be in the form of buy-in options to Medicaid/

[29] A national identification system for securities has been developed by CUSIP, the Committee on Uniform Securities Identification Procedures, www.cusip.com.

[30] HIPAA, Section 1173, 1996.

[31] Under the Deficit Reduction Act, states can only provide more limited benchmark coverage to certain eligibility groups already established in state plans before the enactment of the DRA.

SCHIP, supplemental benefits such as preventive services or disability-related benefits (such as AIDS drugs, mental health or drug abuse benefits, return-to-work benefits during the two years of disability before Medicare coverage can be established, or cash and counseling benefits), or wrap-around benefits that filled in deductibles and cost-sharing for lower income beneficiaries. Other states might prefer to supplement the federal tax credit through a premium contribution. Because the federal tax credit itself is assumed to be inadequate to purchase full benefits, such options should be incorporated into new legislation and implementation planning. It is possible that a state will want to have several such options for different need populations. A key concern for states will be: *What new administrative authorities and systems will states need to administer these kinds of benefits?* States may need to apply for federal waivers to make modifications to their Medicaid/SCHIP programs.

There are "coordination of benefits" precedents among public and private benefits that are now used by Medicare and Medicaid. By law, the private plan is usually required to be the first payer, also known as the primary insurer. After the private health plan pays its benefits as primary insurer, it sends the rest of the bill to the designated state agency for payment of the supplemental benefits. A leading example for how the administrative system for federal benefits and state supplements could work is the Medicare-Medicaid system for dual eligibles.[32] Medicare is the primary payer; after Medicare pays its share of the bill, the remaining amounts are forwarded to state Medicaid programs for their payment. States could also provide "spend-down" eligibility for individuals with high health expenses and wrap around by providing additional benefits. For implementation planning, it will be important to know: *Will states want to use any or all of these options to supplement federal tax credits and private health plans? Would specific statutory language be required? What new MMIS and other systems will be needed for administering these features?*

[32] Medicare Classic has a uniform national plan with high deductibles and cost sharing ($952 hospital deductible, $124 Part B deductible and 20% co-payments, plus $1,062/year Part B premium); for low-income people (such as QMBs, SLMBs), state Medicaid programs coordinate with Medicare by filling in deductibles and cost sharing, and by paying the enrollee's 25% Part B premium share.

State purchasing pools. States may want to implement state purchasing pools, modeled after the FEHBP, that would allow individuals to sign up at their workplace and other locations for private health insurance and public program options. Massachusetts, for example, adopted a state health insurance Connector model in its reforms of small group and individual insurance. Many states have experience with such arrangements for public employees, and in some states as already-existing reform models. State purchasing pools could simplify and facilitate many federal, state, employer, and health plan administrative tasks, including qualification of health plans, informing consumers, handling application, eligibility, enrollment, and premium collection. However, such new health purchasing arrangements for the small group and individual market would also require legislative authority and implementation planning. Among the key concerns for implementers would be: *What new authority, organizations, staffing, and budgets would be needed to establish state purchasing pools, and how much lead time would be needed to be operational? Could states limit tax credit use to health plans selected through these arrangements?*

IRS and health plans. Experience with the HCTC shows that the Department of Treasury can have administrative difficulties coordinating a federal tax credit with multiple health plans, even when offered by the same insurer. A lot of back-and-forth conversations can be involved, particularly if health plans are not required to give the government the information it needs for efficient administration. Coordinating a tax credit initiative for millions of persons with many private plans, state pools, and Medicaid and SCHIP plans could be very difficult and costly if it involves individual casework. Key administrative issues include: *Should there be statutory authority to require health plans to provide requested information in a timely manner to state and federal governments for administration of this program? Should there be federal and/or state authority to limit the number of participating plans?* This issue is particularly important for advance tax credit payments, that is, the automatic payment each month, which would require the IRS or a state agency to develop electronic methods for transferring funds as well as an administrative system that has all the information, standards, and software systems for online administration.

Administrative Costs, Funding, and Coordination

Costs. The administrative system options can differ substantially in costs. Overall, the IRS tax collection system is extraordinarily efficient, with expenditures of $10 billion annually to raise about $2 trillion in revenues, or about 0.5%. If one uses this average cost to estimate the cost of administering the Medicaid + Tax Credits initiative, a $2,000 tax credit for a two-person family would cost $10 in administrative expenses. These costs would be higher if there are additional IRS tasks to efficiently implement advance tax credits.

Administrative costs for processing applications, enrolling beneficiaries, and paying for benefits in Medicaid are estimated to be 4 to 6% of Medicaid spending, but this cost includes tasks such as enrolling and paying providers and health plans. The Lewin Group estimated that it costs $190 per person to enroll in a means-tested public program.[33]

Early estimates of HCTC indicate that its administrative costs—at $844 per person to enroll or 21 cents per dollar spent in the program—are likely to be much higher than the IRS tax collection system or Medicaid.[34] These costs are high for two main reasons: (1) working with consumers at the call center; and (2) the payment mechanism. The insurance market rules are different from state to state and there are many different health plans, so individuals may have to make multiple and/or lengthy calls to the center. In addition, the money must flow from the individual, to the IRS center, to the health plans each month. Individuals are confused; they often receive an invoice from the health plans and the Treasury Department, and do not know which party to pay. This creates a lot of individual casework to clear up confusion.

Further, the HCTC program is not currently set up to evaluate eligibility on the basis of income. That would require an ability to work

[33] John Shiels and Randall Haught, "Cost and Coverage Analysis of Ten Proposals to Expand Health Insurance Coverage," appendix K, p. 12; available at www.esresearch.org/publications/SheilsLewinall/K-Wicks.pdf.

[34] Stan Dorn, "Administrative Costs for Advance Payment of Health Coverage Tax Credits: An Initial Analysis," Commonwealth Fund (forthcoming).

individually and directly with many applicants, employers, and others, which would add many more expenses. Expanding the HCTC operation to serve millions of new people nationwide would largely duplicate the efforts of state welfare offices that now provide income testing for hundreds of billions of dollars in federal and state benefits annually for many individuals who would be eligible for the new tax credits and state supplements.

Such differences are important considerations to factor into legislative drafting and implementation planning. Assuming there is a clear hierarchy of administrative costs, *does it make sense for designers of administrative systems to rely as much as possible on the lower cost approaches? Are there reasons to choose a more expensive approach?*

Funding for state technology improvements and operating costs. If states were asked to play a large role in assisting with eligibility screening, enrollment, and organizing plan choices, it could have a large impact on their budgets. Currently, Medicaid provides a 90% match for computer systems and a 75% match for their operations, but only a 50% federal match for administrative activities like application and enrollment. In view of the importance of application and enrollment, the 75% match rate could be extended to these functions. Advance administrative funds would be important to develop systems and operational capacities, as well as to screen and enroll potential beneficiaries before the program launched.

Agency coordination and information sharing. The ability for state and federal agencies to share and access information about individual and family taxable income, enrollment in health insurance (and possibly other programs they are enrolled in and are eligible for) would smooth eligibility and enrollment in this program. *How would federal and state agencies work together to set this up? What protections for individuals need to be built into the system? Would existing privacy and confidentiality laws need to be modified to make this system work while keeping the information appropriately private?*

Appendix

- **Federal advisory panel members and agenda**
  [December 5, 2005 meeting]
- **State advisory panel members and agenda**
  [March 27-28, 2006 meeting]
- **State and private sector panel members and agenda**
  [December 1, 2006 meeting]

December 5, 2005

Federal Expert Advisory Meeting:
Tax Credits+Medicaid: Administrative Issues

Purpose: To identify important administrative issues and options for "Tax Credits + Medicaid" initiatives to expand coverage. A planning meeting for a national state-federal NASHP/GW conference in Spring, 2006

Note: this is a "how to make it work" technical expert meeting, focused on eligibility and financial administration, aiming for world-class efficiency & service!

Participants

Joe Antos	American Enterprise Institute
Stan Dorn	Economic and Social Research Institute/Urban Institute
Steve Finan	Department of the Treasury
JoAnn Lamphere	The Lewin Group/AARP
Trish MacTaggart	EDS/Health Management Associates
Jennifer Ryan	Health Insurance Reform Project/GW University
Gene Steuerle	Urban Institute
Matt Salo	National Governors Association
Alan Weil	National Academy for State Health Policy
Sonya Schwartz	National Academy for State Health Policy
Judy Moore	Health Insurance Reform Project/GW University
Lynn Etheredge	Health Insurance Reform Project/GW University

Agenda
(and individuals invited to start the discussion)

I. Introduction
-Lynn

II. HCTC lessons
-Stan, JoAnn

III. Federal income tax/payroll withholding system
-Steve (Bush plan)
-Gene (payroll withholding)
-Alan (Mass. W-5 H model)

IV. State administrative systems
-Judy (Medicaid eligibility/ MMIS)
-Trish (state systems)
-Matt (State ideas for Tax Credits+Medicaid administration)

VI. Next Steps
-Alan & Sonya

NATIONAL ACADEMY *for* STATE HEALTH POLICY

Medicaid + Tax Credit Meeting

In Partnership with the Health Insurance Reform Project

The Westin Grand Hotel
2350 M Street, NW, Washington, DC

March 27-28, 2006

Participants

State Participants

Beth Dupre
Assistant Administrator
Health Care Authority/Basic Health
Washington

Stephen Fitton
Director
Bureau of Medicaid Policy & Actuarial Services
Michigan Department of Community Health

Mike Fogarty
Chief Executive Officer
Oklahoma Health Care Authority

Jon Peacock
Research Director
Wisconsin Council on Children and Families

Robert Seifert
Director of Policy and Research
Massachusetts Medicaid Policy Institute

Richard Popper
Executive Director
Maryland Health Insurance Program

Experts/Resources

Stan Dorn
Senior Policy Analyst
Economic and Social Research Institute

Patricia MacTaggart
Client Industry Executive
EDS

Christina Nyquist
Legislative Policy Director
Insurance Market
Blue Cross and Blue Shield Association

Cindy Shirk
Consultant
Columbia Health Policy

Observers

Stephen Finan
U.S. Treasury Department

Health Insurance Reform Project

Sadia Aslam
Research Assistant

Sally Coberly
Deputy Director

Lynn Etheredge
Consultant

Judith Moore
Senior Fellow

Jennifer Ryan
Senior Research Associate

National Academy for State Health Policy Staff

Annette James
Research Assistant

Lisa Plush
Intern

Sonya Schwartz
Program Manager

Alan Weil
Executive Director

Medicaid + Tax Credits

In Partnership with the Health Insurance Reform Project
March 27-28, 2006

The Westin Grand
2350 M Street NW, Washington, DC

Agenda

March 27, 2006

6:00 – 6:30 pm	**Reception**
6:30 –7:00 pm	**Dinner Served** **Welcome and Introductions:** Judith Moore
7 – 7:30 pm	**Setting the Stage** **Presenters:** Lynn Etheredge and Sonya Schwartz • Outline goals of the meeting • Provide a Medicaid+Tax Credits scenario that we will work from
7:30 – 8:30 pm	**The Medicaid and Tax Credits Approach: Developing a State Response for Effective Administration** **Discussion Leader:** Lynn Etheredge • Discuss key concerns and needs of states in implementing this type of health coverage expansion • Share ideas about the best system for beneficiaries

March 28, 2006

8:30 – 9:00 am	**Breakfast**
9:00 – 9:15 am	**Welcome and Introductions:** Alan Weil
9:15 – 9:45 am	**Lessons Learned from the Recent Coverage Expansions** **Discussion Leader and Presenter:** Judith Moore • Discuss lessons learned from recent federal efforts to expand coverage that relied on state implementation/coordination such as the implementation of Medicare Part D, the SCHIP program, and the HCTC

9:45 – 10:00 am	**Brief Recap** **Presenter:** Sonya Schwartz • Outline the key issues identified in the evening's discussion • Provide reminder of Medicaid+Tax Credits scenario that we will work from
10:00 am – 12:00 pm	**Key Problems and Solutions** **Discussion Leader:** Alan Weil • Identify and discuss key problems in coordinating federal health insurance tax credits with Medicaid • Identify possible solutions/resolutions **Eligibility** **Brief Comments Invited From:** Trish MacTaggert and Steve Fitton **Application and Enrollment Process** **Brief Comments Invited From:** Mike Fogarty and Jon Peacock **Premium Payments** **Brief Comments Invited From:** Cindy Shirk and Beth Dupre
12:00 – 1:00 pm	**Lunch/ Break**
1:00 – 2:00 pm	**Key Problems and Solutions ctd.** **Discussion Leader:** Lynn Etheredge • Identify and discuss key problems in coordinating federal health insurance tax credits with Medicaid • Identify possible solutions/resolutions **Health Plan Consumer Choice and Benefit Coordination** **Brief Comments Invited From:** Christina Nyquist and Richard Popper **Administrative Costs** **Brief Comments Invited From:** Stan Dorn
2:00 – 3:00 pm	**Focus on Two Key Challenges** **Discussion Leade**r: Alan Weil • Identify options for designing a system for workers and non-workers • Identify options for implementing coverage expansion given differing state preferences on federal/ state roles

3:00 – 3:30 pm	**Wrap-Up and Next Steps** **Discussion Leader:** Alan Weil • Identify stakeholders who should be involved in “real” discussions • Discuss which federal agencies should have lead responsibility • Identify the longest lead-time elements that need to be planned/implemented in advance

This meeting is supported by the Robert Wood Johnson Foundation

Medicaid & Tax Credits:
Designing Administrative Systems for Expanding Coverage

Friday, December 1, 2006

Landmark Center
401 Park Drive, Boston, MA

PARTICIPANTS

State Participants

Kathleen Henry
Director
Health Care Eligibility and Access
Minnesota Department of Human Services

Jay Himmelstein
Director
Center for Health Policy and Research
University of Massachusetts Medical School

Brian Rosman
Research Director
Health Care for All

Ellen Jane Schneiter
Associate Commissioner
Maine Department of Administrative and
Financial Services

Nancy Turnbull
President
Blue Cross Blue Shield of Massachusetts Foundation

Beth Waldman
Medicaid Director
Massachusetts Department of
Medical Assistance

Celia Wcislo
Assistant Division Director
Massachusetts Health Insurance Connector Director

Paula Wilson
Vice President for Policy
United Hospital Fund, NYC

Employers/Payroll Service Administrators

Kate Sullivan Hare
Director, Health Care Policy
Wal-Mart Stores, Inc.

Peter Isberg
Vice President of Government Affairs
Automatic Data Processing, Inc.

Rick Lord
President and CEO
Associated Industries of Massachusetts

Health Plans

Mark Reynolds
Chief Executive Officer
Neighborhood Health Plan of Rhode Island

Thomas Wilder
Vice President – Private Market Regulation
America's Health Insurance Plans

Experts/Resources

Patricia MacTaggart
Principal
Health Management Associates

JoAnn Lamphere
National Coordinator
AARP

Health Insurance Reform Project Staff

Sally Coberly
Deputy Director, National Health Policy Forum
George Washington University

Lynn Etheredge
Consultant
Health Insurance Reform Project

George Washington University

Judith Moore
Senior Fellow
National Health Policy Forum
George Washington University

National Academy for State Health Policy Staff

Sonya Schwartz
Program Manager
National Academy for State Health Policy

Alan Weil
Executive Director
National Academy for State Health Policy

Medicaid & Tax Credits:
Designing Administrative Systems for Expanding Coverage

Friday, December 1, 2006

Landmark Center~Conference Room 4D
401 Park Drive, Boston, MA

8:30 – 8:45 am	Breakfast
8:45 – 9:00 am	**Welcome and Introductions** Discussion Leaders: Alan Weil and Judy Moore • What are the goals of the meeting?
9:00 – 9:30 am	**Designing a World-Class Administrative System for Expanding Coverage** Presenters: Lynn Etheredge and Sonya Schwartz • What is the Medicaid and Tax Credits approach to expanding coverage? • What might a world-class administrative system look like?
9:30 am – 11:00 am	**Subsidizing and Connecting: Learning from the Massachusetts Coverage Expansion** Discussion Leader: Alan Weil Presenters: Rick Lord, Nancy Turnbull, Celia Wcislo, and Beth Waldman • What are the greatest implementation challenges you face? • What are the key items on your to-do list, in terms of building systems for application and enrollment, premium collection, providing a choice of health plans? • What are the key challenges each actor (i.e. enrollees, employers, the Medicaid agency, the new connector agency, health plans) faces?
11:00 -11:15 am	**Break**
11:15 – 12:30 pm	**Key Administrative and Systems Issues: Public Sector** Discussion Leader: Alan Weil <u>Medicaid, State Agencies, Federal Agencies</u> Brief Comments* Invited From: Ellen Schneiter, Kathleen Henry, Patricia MacTaggart, and JoAnn Lamphere • What are the tasks that need to be accomplished? • What upgrades to existing systems will be most challenging? • What systems would need to connect with each other? • Which actors would you need to work closely with? • What changes in existing law are needed to help achieve these goals?
12:30 – 1:15 pm	**Lunch**

1:15 – 2:30 pm	**Key Administrative and Systems Issues, *continued*: Private Sector** Discussion Leaders: Lynn Etheredge and Alan Weil <u>Employers, Payroll Service Providers</u> Brief Comments* Invited From: Pete Isberg and Kate Sullivan Hare <u>Health Plans</u> Brief Comments* Invited From: Mark Reynolds and Tom Wilder • What are the tasks that need to be accomplished? • What upgrades to existing systems will be most challenging? • What systems would need to connect with each other? • Which actors would you need to work closely with? • What changes in existing law are needed to help achieve these goals?
2:30 – 3:30 pm	**Charting the Course To A World-Class Administrative System** Discussion Leader: Judy Moore • What are the major systems-design tasks that would need to be accomplished? • What actors should be involved with each task? • Which tasks are the highest priority? • Which tasks require the longest lead time?

** We ask the noted participants to prepare 5 minutes of comments on the key issues to begin our conversation on the topic.*

This meeting is supported by the Robert Wood Johnson Foundation

February 28, 2007

Administering a Medicaid + Tax Credits Initiative

A joint publication of

Health Insurance Reform Project
at The George Washington University

and

National Academy for State Health Policy

This document is available online at

www.nhpf.org/pdfs_hirp/Medicaid_TaxCredits_02-28-07.pdf

and

www.nashp.org