Issue Brief

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April 21, 2004

Using the Trade Adjustment Assistance Act (TAA) to Provide Health Care Coverage to Displaced Workers

Summary

The Trade Adjustment Assistance Act (TAA) of 2002 is part of broader reform efforts established to provide assistance to certain laid-off workers. The Health Coverage Tax Credit (HCTC) component provides funding for health insurance benefits for eligible individuals. To date, 31 states and the District of Columbia have state qualified health plans in place; another two will shortly.[1] Benefits are provided in the form of a federal HCTC for 65 percent of qualified health insurance premiums. Recipients can receive benefits in advance (to pay premiums as they come due) or in a lump sum when filing federal tax returns.

The advance tax credit became available August 1, 2003, but is not being used to the extent originally anticipated. States have voiced concerns about the timeliness of federal plan and eligibility approvals, and difficulty with interagency collaboration and outreach. States have also expressed concerns that eligible individuals often are unable to afford coverage even with the tax credit, are unable to pay the initial premium, and may lose certain consumer protections if uninsured for longer than 63 days.

To overcome these concerns, states are using unique and innovative solutions to provide their residents with benefits during unemployment. States are:

1. Establishing a revolving loan fund or applying for a National Emergency Grant (NEG) to help pay for coverage until the advance HCTC is accessible for participants
2. Qualifying high-risk pools as a coverage option for individuals eligible for the HCTC
3. Working with employers, unions, and community partners on outreach
4. Publicizing the program through registration events at workplaces, one-stop centers, health fairs, and through unemployment insurance (UI) call centers
5. Encouraging collaboration between the Office of the Governor, the State Workforce Agency, and the State Department of Insurance

This Issue Brief details the different options states have chosen to provide their residents with health insurance benefits under TAA and explores problems or barriers states encountered during the application and implementation processes. It also details state roles and responsibilities and provides information on promising procedures.

Background on the TAA Health Coverage Tax Credit (HCTC)

There are nearly 250,000 individuals potentially eligible to receive the advance tax credit. The Internal Revenue Service's (IRS) HCTC Program Office determines final eligibility for HCTC, but must rely on State Workforce Agencies and the Pension Benefit Guaranty Corporation (PBGC) to provide lists of their potentially eligible individuals. Eligible individuals include those:

1. workers who lose their jobs due to the effects of international trade and
    - who are eligible for certain TAA benefits; or
    - are receiving benefits under the Alternative Trade Adjustment Assistance (ATAA) program.

2. people who receive benefits from PBGC and are at least 55 years of age.[2]

Eligible individuals can receive the HCTC through several types of qualified health plans. Certain types of health plans automatically qualify. The three automatically qualified health insurance purchasing options that do not require state action are:

- Consolidated Omnibus Budget Reconciliation Act (COBRA), federal only;
- spouse's employer's plan if the employer pays less than 50 percent of the total cost of coverage; and
- individual health insurance if in force for at least 30 days prior to separation from employment.

In addition, states may take action to "qualify" certain alternative plans that do not automatically qualify, in order to provide options for coverage beyond the automatic ones. Alternative plans that require state action to qualify include:

- high-risk pools;
- other state arrangements;
- state-based COBRA continuation coverage;
- state worker plans;
- plans similar to state worker plans;
- purchasing pools; and
- state-operated health insurance plans.

State Roles and Responsibilities

States participate in HCTC in at least two ways. First, they must provide TAA/ATAA eligibility files for their state. Second, they may choose to qualify one or more health plans in their state in order to be responsive to eligible individuals in their state. States must:

- ***Identify a single point of service within a state.*** The State Workforce Agency (SWA) is responsible for transmitting information on potential eligibles, disseminating program information, and instituting outreach activities. The Governor's office can support the SWA's activities.

- ***Transmit information on potential eligibles to the HCTC program for final determination.*** The SWA must identify potentially eligible individuals and transmit the information, on a daily basis, to the HCTC Program Office through the Interstate Connection Network (ICON). (The Social Security Administration (SSA) and U.S. Department of Labor (DOL) use ICON for data exchange. It is the telecommunication network used to transmit UI data between the 53 SWAs.[3]) The SWA must also educate and train state personnel (one-stop career center personnel, state call center personnel, and rapid response teams) who interact with potential HCTC participants. (The PBGC, which is a federal corporation, must transmit lists of potential candidates on a monthly basis.)

- ***Qualify health plans.*** If the state does not already have a state-qualified health plan in place, the Governor's Office and the Department of Insurance should work together to determine whether it is in the interest of the state's eligible population for the state to qualify health plans. Legislative changes may be necessary to qualify plans.

State Options for Implementing the HCTC

As discussed in the subsequent section of this Issue Brief on state experiences in implementing the HCTC, states have explored different avenues for effective implementation. Their approaches include:

- ***Establishing a revolving loan fund or apply for a NEG.*** (See Maine example below.) The National Emergency Grant (NEG) "bridges" the gap by helping to pay for coverage until the advance HCTC is available for participants.

- ***Qualifying high-risk pools.*** States that operate a high-risk pool can often do this through legislation or, if no pool exists, create a pool using recently enacted federal funds earmarked for this purpose. A briefing can be held for interested health plans, so that they are aware of how they may become qualified.

  Qualified high-risk pools are the likely vehicle for coverage in many states. In states without guaranteed issue laws in the individual insurance market, high-risk pools operate as the product of last resort when an individual is rejected (due to pre-existing health conditions) for private coverage through the commercial insurance market.

  The Centers for Medicare and Medicaid Services (CMS) recently outlined conditions for states seeking grants because their high-risk pools have incurred operating losses. *Additional information is available in the Appendix and at www.cms.hhs.gov.*

- ***Working with employers, unions, and community partners on outreach.*** The Governor's Office should ensure inclusive outreach. A team effort is necessary to facilitate implementation of HCTC provisions and to reach as many eligible individuals as possible. Teams can hold regular meetings or conference calls to review progress.

  The Governor's Office, the SWA, the State Health Agency (SHA), and the Department of Insurance can work with unions and organizations (like health insurers and local business groups) to publicize the HCTC program. The state can hold outreach events to make information available. Outreach efforts should include publicity—a kickoff event, media campaigns, press releases—as well as information posted on state agency web sites. In addition, personnel from one-stop career centers, rapid response teams, and state call centers should be trained so that they can effectively educate and guide HCTC candidates.

- ***Encouraging collaboration.*** This should occur both between and within state agencies, as well as out in the community, to ensure effective implementation. Relevant state agencies should be at the table to consult on and make decisions. In addition, states must transmit information on qualified plans to the U.S. Department of the Treasury, so that that federal agency remains abreast of states' coverage decisions.

Examples of State Experiences in Implementing the HCTC

Following are four examples of states that have used different means to adopt the HCTC, meeting with both success and challenges.

Maine

When Great Northern Paper declared bankruptcy on the first day of Governor Baldacci's administration, **Maine** became a prime candidate for the HCTC program. With other mill closures impacting entire towns, Maine became the first state to submit a grant application.

While waiting for approval, the state designed an interim program for former Great Northern employees. The new product was a "shadow plan" of the existing state employee plan. Maine began enrollment in Summer 2003. Locating eligible individuals has proven challenging. The state is working with labor and unions to find eligible people. After months of operation, about half of the eligible population has enrolled in the program.

One barrier to enrollment is that enrollees must pay the first month's premium, but may find the product too expensive. To cover this population, other groups—such as the teachers union—have opened or extended enrollment to spouses.

Maine is in the process of modifying the current product to include a higher deductible ($5,000 with a primary care rider) and is considering starting a revolving loan fund to help people pay for coverage.[4]

North Carolina

In **North Carolina**, Blue Cross Blue Shield modified its individual *Blue Advantage* product to qualify for the tax credits. Getting the word out has proved challenging, but the Governor's office is working with local communities on outreach. Of 5,000 workers laid off from Pillowtex, a large textile firm, about a third have applied for the HCTC.

A common concern is difficulty paying the first month's premium. Affected workers were primarily union, with highly subsidized, comprehensive health benefits. They experienced "sticker shock" when faced with paying for coverage. North Carolina applied for and received a National Emergency Grant (NEG) to pay eligible individuals' premiums for two months until the advance HCTC is available. To date, the state has issued over 1,500 checks for almost a million dollars.

An additional challenge the state faced was the question of program responsibility. Under what agency's purview did this initiative fall? The state determined that the North Carolina Employment Security Commission, which handles unemployment, would run the program, so that program application, administration and outreach would be integrated into the traditional unemployment benefit process**.**[5]

Montana

Although its initial TAA-eligible population was less than 100, **Montana** passed legislation early on that qualified the Montana Comprehensive Health Association high-risk pool as eligible for the HCTC. The effort was cooperative and succeeded in establishing effective communication among the Governor's office, the Insurance Commissioner, and the Workforce Services Division of the Department of Labor and Industry.

When Stimson Lumber laid off more than 350 employees, many of whom needed to maintain coverage because they suffered from or were at risk of developing asbestos-related health problems, Montana was prepared. It became the first state to apply for a NEG bridge grant, which it isolated to that population. (Bridge grants were originally offered to help states make premium payments from the start of the program until the advance HCTC kicked in, in August 2003. Ten states received bridge grants (one of the 10 has a request for additional funds pending), and two other states have applications pending.[6] However, the DOL is currently reviewing a new guidance that will clarify that NEG bridge funds are available to eligible individuals to assist with the first one to three months' qualified premium until the advance HCTC is available to the participant.[7]

Stimson's insurance plan, administered by Bledsoe Trust, agreed to cover more than 150 eligible individuals. However, only a fraction of those eligible took advantage of the bridge grant. Department program staff were successful in extending the bridge grant twice, once as a result of delays in setting up the IRS HCTC office and the second time to allow Bledsoe time to set up its administrative infrastructure to allow for implementation of the credit. Forty-six participants were served in June and less than 20 remained covered through August and into the latter part of the year. Most participants stated that while helpful, paying 65 percent of the premium through the grant was not enough given the limited UI income they were receiving.[8]

Texas

The TAA authorized the U.S. Department of Health and Human Services (HHS) to provide seed money to states to create high-risk pools and recently awarded grants to help offset losses states incurred operating

pools.[9] The **Texas** legislature already had high-risk pool legislation in play, making it easier to amend the draft language so the pool would qualify. The state added compliance provisions and soon had a qualified option. In the interim, the state had time to develop other options, such as a new Blue Cross private option.

Texas realized the importance of agency collaboration, outreach efforts, and media coverage. The IRS mailed 3,800 program kits to TAA-eligibles prior to convening two on-site registrations in September 2003. Support staff attended the on-sites from the State Health Care Risk Pool, the State IRS, and Blue Cross Blue Shield. Staff from Accenture (the HCTC contractor) and local health and human service and community college providers also participated.

One hundred people turned out for the two on-site registrations. Reasons for low attendance included the high cost of COBRA and high-risk pool options, and difficulties in traveling from rural areas. In addition, many dislocated workers on the Rio Grande border travel to Mexico for affordable care, which is one-fifth the cost of similar HCTC options.[10]

Resources for States:

- **For general HCTC information:** Internal Revenue Service (IRS): www.irs.gov (keyword: HCTC) or 1-866-628-HCTC (4282), 7:00 a.m. to 7:00 p.m. Central time Monday-Friday
- **For information on transmitting lists of TAA recipients:** Department of Labor's (DOL) Education and Training Unemployment Insurance Program Letter (UIPL) 24-03: www.doleta.gov (click on Trade Reform Act 2002, click on UIPL 24-03)
- **For information on applying for NEG grants:** DOL's Training and Employment Guidance Letter (TEGL) 20-02: www.doleta.gov (click on Trade Reform Act 2002, click on TEGL 20-02)

Appendix: Additional Program Information[11]

Who is Eligible?

There are two basic categories of HCTC-eligibles:

1. Workers who lose their jobs due to the effects of international trade and
   - Who are eligible for certain TAA benefits; or
   - Are receiving benefits under the ATAA program.
2. People who receive benefits from the PBGC and are at least 55 years of age.[12]

The benefit period is two years or the remainder of the individual's TAA certification period (if less than two years), or the period of time a person is in an eligible category for PBGC eligibles, which could be up to 10 years depending on their age.

Eligible individuals must be enrolled in a qualified health plan to claim the HCTC.

What Health Plans Qualify?

Certain types of health plans automatically qualify. States may also use alternatives. Currently uninsured HCTC candidates must enroll in a qualified plan.

Automatic Options

There are three automatic qualified health insurance purchasing options where state action is not required: COBRA (federal only), spouse's employer's plan if the employer pays less than 50 percent of the total cost of coverage, and individual health insurance if in force for at least 30 days prior to separation from employment. The "qualified" definition does not apply to these options.

Therefore, if an eligible individual elected one of these options and had only three months of prior coverage, any remaining pre-existing conditions limitation on the policy would still apply.

For those eligible individuals coming from an employer where a COBRA option is available, a new 60-day election period begins on the first day of the month the worker was TAA certified. These individuals must not have elected for coverage by COBRA during the initial 60-day period following an ATAA/TAA-related loss of coverage. This allows individuals who become ATAA/TAA-eligible after their initial COBRA election period has expired to take advantage of the HCTC.[13]

State Coverage Alternatives
Alternatives to the automatic options are:

1. High-risk pools *(See below)*
2. Other state arrangements
3. State-based COBRA continuation coverage
4. State worker plans
5. Plans similar to state-worker plans
6. Purchasing pool
7. State-operated health insurance plans

States that elect to use one or more of these alternatives must meet the following additional criteria:

1. Guaranteed issue
2. No imposition of pre-existing condition exclusion
3. Non-discriminatory premium
4. Same benefits for HCTC and non-HCTC members

High-Risk Pools[14]
Under a recently revised CMS rule, states must provide a history and description of their high-risk pool that includes: the date the pool was established; enrollment criteria; a description of how coverage is provided administratively; and benefits options and packages offered in the pool to both Health Insurance Portability and Accountability (HIPAA)-eligible individuals and non-HIPAA eligible individuals.

In addition, states must provide to CMS an outline of plan benefits and coverage offered in the pool, as well as the plan benefits and coverage of the two most popular policies in the state's private individual market. They must also provide information on premiums charged in their pools and in other cost-sharing mechanisms. They must detail how the standard risk rate for the state is calculated and when it was last calculated. States must advise CMS of their high-risk pools' revenue sources, including both current and future funding mechanisms. They must also provide current projections of future income, along with other information outlined in the regulation.

States seeking to recoup losses from fiscal year 2003 must submit an application by June 30, 2004. States seeking to recoup losses from 2004 have until June 30, 2005. Standard applications are available at: http://www.cms.hhs.gov/researchers/priorities/grants.asp.

This paper was written collaboratively with Neil Ridley, formerly a Senior Policy Analyst with the NGA Center for Best Practices' Social, Economic and Workforce Programs Division.

[1] Alabama, Alaska, Arkansas, Colorado, Connecticut, Florida, Idaho (effective July 1, 2004), Illinois, Indiana, Iowa, Kentucky, Maine, Maryland, Michigan, Minnesota, Montana, Nebraska (mini-COBRA), New Hampshire, New Jersey (mini-COBRA), New York, North Carolina, North Dakota, Ohio, Pennsylvania, Rhode Island, South Carolina, Tennessee, Texas, Utah, Vermont, Virginia, Washington (effective July 1, 2004), and West Virginia. From the Internal Revenue Service's HCTC Program Office (data as of April 7, 2004).

[2] *Health Coverage Tax Credit (HCTC) Overview*; www.irs.gov.

[3] http://workforcesecurity.doleta.gov

[4] Personal communications with Ellen Jane Schneiter, Deputy Director, Governor's Office of Health Policy and Finance, Maine.

[5] Personal communications with Phil Telfer, Senior Policy Advisor, Office of the Governor, North Carolina.

[6] Maine, Maryland, Minnesota, Montana, New Jersey, North Carolina, Utah, Virginia and West Virginia received bridge grants. New York and Pennsylvania have applications pending.

[7] Personal communications with Mason Bishop, Deputy Assistant Secretary, Employment and Training Administration (ETA).

[8] Personal communications with Gordy Higgins, Bureau Chief for Job Services Programs, Montana.

[9] Alaska, Arkansas, Colorado, Connecticut, Illinois, Indiana, Iowa, Kansas, Kentucky, Minnesota, Mississippi, Montana, Nebraska, New Hampshire, North Dakota and Oklahoma received grants in December 2003.

[10] Personal communications with Victoria Ford, Health Services Policy Director, Office of the Governor, Texas.

[11] Primarily from *Eligibility Under The Trade Adjustment Assistance Act*, National Association of Health Underwriters (NAHU) and personal communications with Janet Trautwein, Vice President of Government Affairs, NAHU and from personal communications with Karin Cano at the Internal Revenue Service's HCTC Program Office.

[12] *Health Coverage Tax Credit (HCTC) Overview*; www.irs.gov

[13] *Topic: COBRA and the Trade Act of 2002*; Newsletter for Health Plan Administrators, Issue 5; Internal Revenue Service's HCTC Program Office; April 15, 2004.

[14] Information derived from the Centers for Medicare and Medicaid Services (CMS); March 2004.