

**Maryland's Experiences with Implementation of the
Trade Act of 2002 and the Health Coverage Tax Credit**

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**Tanya Alteras
Senior Policy Analyst
Economic and Social Research Institute
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Overview

In 2002, the Maryland General Assembly created the Maryland Health Insurance Plan (MHIP) to cover “medically uninsurable” residents. Less than one year later, in February 2003, the federal government provided guidelines to states for establishing state-based plans qualifying for Health Coverage Tax Credits (HCTCs). Soon after these guidelines were released, Bethlehem Steel announced that it was eliminating retiree health insurance for all of its former employees, effective April 1. At this time, representatives from the Maryland Insurance Administration and MHIP petitioned the Maryland General Assembly and Governor Ehrlich to make MHIP available to individuals eligible for the HCTC. Through these efforts, Maryland became the first state risk pool awarded Trade Act funding.

In addition to the loss of retiree health insurance, in 2003 approximately 1,000 Bethlehem Steel employees working in Maryland were laid off due to company plants going overseas. Altogether, between February and March of 2003, over 5,400 steelworkers lost their health insurance coverage, as did Easton, Maryland-based Black and Decker workers, and former employees of Baltimore Maritime Industries. Many of these individuals became eligible for the Health Coverage Tax Credit (HCTC), which under the Trade Act of 2002 offers eligible individuals a 65 percent subsidy toward the premium cost of qualified health plans.¹ By May 2004, HCTC advance payment covered 10 percent of state residents who had been individually identified as eligible for HCTCs. This was the third-highest² such percentage of any state in the country and significantly higher than the national average of 5.5 percent. (Figure 1.)

This report examines the elements of Maryland’s infrastructure for supporting displaced workers (including those eligible for HCTCs), the state’s experience with setting up a qualified health plan and the advanceable tax credit, the health coverage options available to HCTC eligibles, enrollment and utilization thus far, and suggestions for improvements

¹ As is explained more fully in Appendix A, a qualified health plan for which HCTCs may be used can either be automatically qualified (typically a COBRA plan) and available without any need for state action or a state-qualified plan. Maryland has several state-qualified plans operated by MHIP and CareFirst, as explained below.

² In December 2003, Maryland’s 10 percent enrollment into advance payment was the highest of any state.

to the program in the future. Because the program is relatively new and relatively small, readers should be cautioned against making broad inferences regarding the national HCTC program. What this report will provide, however, is the story of early HCTC implementation in one of the most successful states in reaching eligible workers, which may inform the future efforts of other states and combine with multiple state accounts to guide federal policy development.

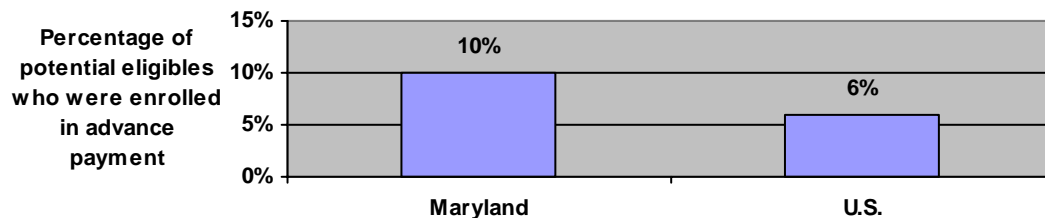
Before describing Maryland's implementation of HCTC, this report begins by explaining our research methodology. At the end of this report, Appendix A describes key elements of the national HCTC program.

Methodology

In May 2004, a team of researchers from the Economic and Social Research Institute held interviews with a broad range of officials and stakeholders. Interviewees included representatives of the Maryland Health Insurance Plan, CareFirst BlueCross BlueShield, the State Workforce Agency (which is the Division of Workforce Development within the Maryland Department of Labor, Licensing and Regulation), Accenture, and the IRS. Most interviews took place in person, but some occurred by telephone. In addition, the authors reviewed a number of relevant documents.

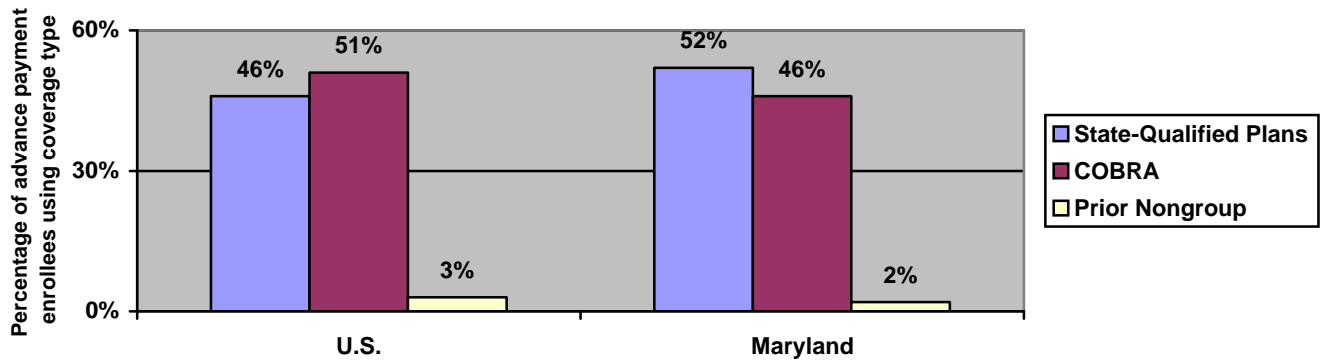
Key Program Features

Figure 1. Advance Payment Enrollment, Maryland versus U.S.: May 2004



Source: HCTC Program, June 22, 2004. Calculations by ESRI, August 2004. Note: Potential eligibles are individuals who are identified by state workforce agencies or PBGC as potentially qualifying for HCTC and to whom IRS has mailed HCTC Program Kits.

Figure 2. Advance Payment Enrollment into Types of Qualified Coverage, Maryland versus All States with State-Qualified Plans: May 2004



Source: HCTC Program, June 22, 2004. Calculations by ESRI, August 2004. 1. Note: “Prior nongroup” refers to automatically qualified nongroup coverage that beneficiaries received during at least their final 30 days before job loss or other qualifying event.

Qualified Plans

In addition to COBRA coverage available from Bethlehem Steel and other employers, and spousal coverage, Maryland has two types of qualified coverage for HCTC recipients, which are described in turn below.

MHIP

The Maryland Health Insurance Plans was created in 2002 by the state’s General Assembly as a high risk pool for medically uninsurable residents, and it began enrolling individuals in July 2003. In April 2003, the state passed HB 1100, the first bill signed into law by Governor Ehrlich upon the General Assembly’s adjournment and which made MHIP available to individuals eligible for HCTC. Enrollment for HCTC eligibles began on July 1, 2003. During the July 2003 through June 2004, MHIP had two different products, both of which are offered to HCTC enrollees: the Preferred Provider Organization (PPO) plan and the Exclusive Provider Organization (EPO) plan, which is essentially a closed-panel HMO. Both products offer comprehensive coverage and have a \$250 drug deductible, but beyond that there are differences in both cost-sharing requirements and specific coverage levels. (see Table 1 under “Benefits and Cost Sharing”). Like Minnesota’s longstanding high-risk pool, MHIP benefits from a much

higher state subsidy level than most high-risk pools enjoy, permitting the program to offer broad coverage with comparatively low premium costs. In fact, on September 20, 2004, the MHIP Board voted to reduce plan rates for all members by an average of 15 percent (the precise reduction will vary from 4 to 27 percent, depending on the enrollee's age), effective December 1, 2004.

CareFirst BlueCross BlueShield of Maryland (BCBS)

BCBS entered the HCTC market in April 2004 with a duplicate of its *Personal Comp* product, which covers 75 percent of allowed charges after the customer meets the \$800 deductible. The plan also includes a \$500 annual drug benefit. The drug benefit is also subject to the deductible and the 25% coinsurance, and is available for prescription legend drugs only (not for over-the-counter (OTC) drugs). The *Personal Comp* product was originally created to be offered as a HIPAA plan to qualifying individuals. When BCBS entered the HCTC market, it established two rating bands for *Personal Comp*: the high-risk, or medically underwritten rate, and the low-risk, non-underwritten rate, both of which are guaranteed-issue rates. The high-risk rate, which is 200% higher than the low-risk rate, is equivalent to the premium charged to HIPAA enrollees. As of July 2004, however, BCBS stopped offering *Personal Comp* to consumers who qualify for HIPAA.³ The insurer did not, of course, disenroll existing members (including those covered through HIPAA), and *Personal Comp* remains available as a state-qualified plan for new HCTC enrollees.

Advance Payment Enrollment Based on Benefits Under the Trade Adjustment Act (TAA)

The TAA process begins when an employer announces forthcoming lay-offs. Such notices go to state officials, as provided under both federal and state law. Upon receiving such a notice, the State Workforce Agency (SWA) sends a Rapid Response team to meet with the employer and discuss the benefits to employees of filing a petition with the U.S. Department of Labor (DOL) asking DOL to find that the lay-off was trade-related. According to state officials, in virtually all cases in which such an employer has not gone out of business, it is cooperative in providing state officials with lists of laid-off workers

³ MHIP is now the only HIPAA plan available in Maryland.

so the state can educate those workers about available benefits, including those related to TAA. The state claims subpoena power to obtain that information, but as a practical matter, that power generally does not need to be used.

To qualify for HCTC, all TAA-based enrollees must either: (a) receive a Trade Readjustment Allowance (TRA), which is income support for trade-impacted workers; or (b) receive unemployment insurance (UI) and meet all TRA qualifications except exhaustion of UI. Such other TRA qualifications include a certification by DOL that the worker's layoff was related to trade liberalization. The applicant must also sign up for training or a training waiver. Such waivers are granted at the outset, soon after the application filing, for the HCTC population. By contrast, with the remainder of the TAA population, waivers are typically not granted until TRA benefits begin to be paid.

On a parallel track, an SWA information technology worker runs a daily query on the Maryland Automated Benefit System (MABS)⁴ of all UI recipients to cross check for potential HCTC eligibles. This query determines whether a UI recipient's last employer was on the list of employers certified as experiencing trade-related layoffs. If so, the individual may qualify for HCTC. If such an individual has not been enrolled in the program because he or she has not yet signed up for training, the UI office does outreach to that individual letting them know about the availability of HCTC, the need to apply for job training or a training waiver, and the available health coverage options (MHIP, BCBS and COBRA). According to state staff, setting up and running this query has not been difficult or costly.

Once an individual applies for HCTC and is found potentially eligible based on receipt of TRA or meeting all TRA eligibility requirements except exhaustion of UI, the data about the individual is transferred electronically to the IRS. Those who are found potentially eligible are notified automatically when IRS mails them HCTC Program Kits. There is no notification process for those who are not deemed eligible for HCTC. IRS sends these kits only once per individual, which may turn out to be problematic for laid-off workers

⁴ MABS is the benefit payment data source, and contains a subset of data for TRA beneficiaries.

covered by severance packages, who, in many cases, may have disregarded those materials as irrelevant to their personal situation but whose coverage is slated to expire in November 2004, at which point they will need HCTC.

Effective beginning in August 2003, Alternative Trade Adjustment Assistance (ATAA) has been available, under federal law, for certain workers age 50 and older who lose their jobs because of trade and who find a new line of work for lower pay. ATAA recipients qualify for HCTCs. Maryland officials have attempted to maximize the number of petitions filed with DOL that request certifications for purposes of ATAA, not just TAA. However, as of June 2004, Maryland has not yet made the implementation decisions needed to begin paying ATAA (hence HCTC) to workers certified by DOL.

SWAs are subject to some national oversight in their operation of the HCTC program. At the end of each month, federal officials review data provided by the Maryland SWA (and other states' SWAs) to identify individuals who, according to the data, no longer qualify for HCTC. The focus of federal officials' investigation is whether those individuals have been removed from the rolls by mistake and, in fact, still should qualify. Raising such questions caused state officials to review the cases in question to ascertain the circumstances of affected individuals. A number of mistaken terminations have been identified and rectified through such federal audits of Maryland data.

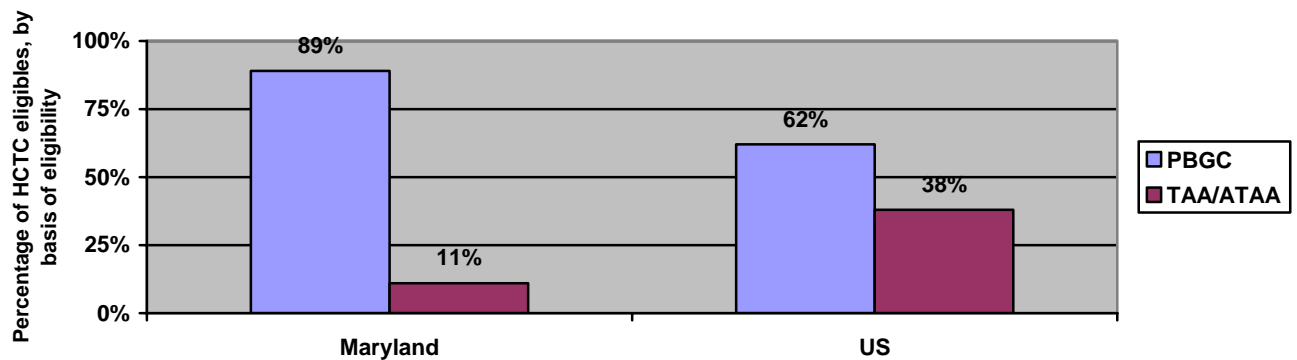
All of this work has required many person-years of senior staff time at the Maryland SWA.

PBGC-based Enrollment

Most of the HCTC enrollees in Maryland become eligible for the program via their PBGC beneficiary status. Nearly nine in ten (89 percent) of HCTC-eligible residents qualify by virtue of PBGC, compared to less than two-thirds (62 percent) nationally. (Figure 3). Many PBGC recipients are Bethlehem Steel/International Steel Group retirees in their 50s. Through diligent effort well before advance payment began, MHIP obtained a list of PBGC beneficiaries in June 2003, identified those who would be potentially eligible for HCTC, loaded the information into laptops, and then pre-qualified potentially

eligible individuals at enrollment events, often before the individual had even contacted the IRS. At enrollment events, MHIP could simply ask the individual for their 35 percent check and completion of the application. Because of the great stability of the PBGC population, it was very rare for an individual to be on the list and not qualify for HCTC. Effective use of the list was an important reason for the state's success in enrolling eligible individuals. MHIP officials noted that their colleagues at other health plans have been required to ask for proof of potential PBGC eligibility, which prevented outreach events from culminating in coverage. MHIP officials have also been able to use the list to send program information to potentially eligible individuals. Since the start of the program, state officials have been unable to obtain from PBGC a new list of potential HCTC eligibles.

Figure 3: Basis for HCTC Eligibility, Maryland versus United States: May 2004



Source: HCTC Program, June 22, 2004. Calculations by ESRI, August 2004. Note: This figure portrays the basis of eligibility for individuals who are identified by state workforce agencies or PBGC as potentially qualifying for HCTC and to whom IRS has mailed HCTC Program Kits.

Outreach and the Role of the State Workforce Agency

The State Workforce Agency (SWA) plays an important coordination role, communicating with the one-stop shops that serve as local offices for the SWA, statewide offices responsible for TRAs and unemployment insurance (UI), and the HCTC program nationally in order to oversee both outreach and enrollment efforts. It is the SWA which contacts employers, once they become TAA- certified, to collect names of affected workers and begin the process of getting them enrolled in HCTC. SWA representatives

noted that many of the individuals with whom they come into contact have already heard about HCTC before applying for UI or other benefits. One advantage of enrolling first in the UI system, however, is that mailings are sent to these enrollees – approximately once a month – with information on other programs and benefits for which they may be eligible.

As in the other states we profiled (Michigan and North Carolina), the SWA’s rapid response team holds orientation sessions with laid-off workers in advance of the actual layoffs, at which time the workers are provided with an overview of the benefits and programs that are available. SWA workers report that between 80 and 90 percent of affected workers attend this orientation session. It is not until the employer is TAA-certified, however, that they receive more information on the benefits specific to the Trade Act. In cases where the individual’s employer has been certified and the individual is unaware that he or she can now apply for TRA, the SWA’s TRA unit does cross check those who are applying for UI with the list of certified employers, as noted above. In addition, the individual would receive information at orientation sessions along with other laid-off workers.

Not only are state officials working extremely hard to conduct outreach to eligible workers, holding outreach meetings in the middle of the night if necessary to reach “graveyard shift” workers about to be laid-off, the SWA is being aggressive in setting up a daily monitoring system in order to ensure that individuals do not fall through the cracks of the system. For example, some HCTC-eligible workers were given generous severance packages that included health coverage. They understandably but wrongly believed that HCTC was not relevant to them until after the conclusion of the severance package. State officials brought to their attention several pertinent timelines that could ultimately make a great difference to their ability to retain coverage after the end of their severance packages. Such timelines included the impact of 63-day coverage gaps on consumer protections as well as HCTC’s requirement (stemming from the underlying TAA statute) that workers must apply for TAA training or training waivers within several months of the DOL petition being granted and the layoff taking place.

Along with state officials, union officials and human resource departments have also had to devote time to assisting individuals potentially eligible for HCTC and answering their questions. At outreach events and walk-in centers, health plan staff would frequently help people fill out their IRS forms needed to apply for HCTC, even photocopying their 35 percent checks.

In addition to conducting and coordinating outreach, the SWA, in its operation of the MDHCTC or “gap” program described below, is responsible for calculating the 35 percent premium share of the enrollee after an applicant submits their health coverage invoice. The SWA then contacts the applicant, informs them of the amount of their cost sharing responsibility and the form in which it must be submitted (either a certified or bank check) 15 days prior to the start of benefits.

Benefits and Cost Sharing

Table 1. State-qualified coverage in Maryland: Summary of MHIP benefits and out-of-pocket cost-sharing, 2004

Plan name		<i>MHIP PPO</i>	<i>MHIP EPO</i>
Type of coverage		PPO	HMO
Deductible		\$1000	None
Factors affecting premium (beyond choice of plan)		Age	
General cost-sharing	In-network	20% co-insurance	\$20 copay primary care \$30 specialist
	Non-network	40% co-insurance	Network coverage only
Annual limits on enrollee costs		\$4,500	
For beneficiaries w/ coverage gaps	Guaranteed issue?	Issue guaranteed	
	Pre-existing conditions?	No exclusion	
Special provisions applying to specific services ⁵	Inpatient care	No extra cost-sharing	\$250 copay per admission
	ER use	\$35 copay (unless admitted to hospital) then 20% co-insurance	
	Mental Health, Substance Abuse	30% co-insurance in network, 50% non-network Inpatient days capped at 60 per year	Same as PPO , with extra \$250 copay for inpatient care
	Prescription drugs	\$250 deductible Must use network pharmacies \$15 copay for generics, \$20 for preferred brand-name, \$35 for other brand-name Maintenance drugs: 2 months copay for 3 months supply	
Special provisions applying to specific services ⁵	Preventive care for children	\$10 copay through age 2, \$20 thereafter \$10 copay for immunizations through age 13	\$10 copay through age 2, 20% coinsurance thereafter for well-child care and immunizations
	Other services		No copays for DME

⁵ Except as noted otherwise, each of these services is covered and subject to the plan's general cost-sharing rules.

Table 2. State-qualified coverage in Maryland: Summary of BCBS benefits and out-of-pocket cost-sharing, 2004

Plan name		<i>BCBS Personal Comp</i>
Type of coverage		Indemnity
Deductible		\$800 (not required for preventive care)
Factors affecting premium		Age and health status
General cost-sharing		25% co-insurance \$10 copayment for preventive care
Annual limits on enrollee costs		\$2,000 (plus \$800 deductible)
For beneficiaries w/ coverage gaps	Guaranteed issue?	Issue guaranteed
	Pre-existing conditions?	No exclusion
Special provisions applying to specific services⁶	ER use	First \$300 of allowed benefits for emergency care is covered in full when treatment begins within 72 hours); remainder of the charges are subject to the allowed benefit and 25% coinsurance.
	Mental Health, Substance Abuse	Inpatient care must be preauthorized and there is a limit of 60 days. Outpatient services must be preauthorized after visit #11. Reimbursement is at 80% of the <i>allowed benefit</i> for the first 5 visits that occur in a calendar year; 65% of the <i>allowed benefit</i> for the 6th through 30th visit; and, 50% of the <i>allowed benefit</i> for the 31st visit and any visits thereafter.
	Prescription drugs	\$500 annual benefit limit per enrollee

⁶ Except as noted otherwise, each of these services is covered and subject to the plan's general cost-sharing rules.

Table 3: HCTC beneficiaries' 35 percent share of premiums for a one person policy, MHIP and BCBS, annualized amounts for various ages combinations: August 2004

Age	MHIP EPO	MHIP PPO
25	\$1,268	\$811
45	\$2,024	\$1,214
55	\$2,557	\$1,415

Age	BCBS – low-risk	BCBS- high-risk
25	\$344	\$688
45	\$525	\$1,050
55	\$667	\$1,336

Consumer Protections

The state waived all pre-existing condition restrictions in MHIP for those who enrolled in August, September, or October of 2003. After that waiver ended, enrollment declined, in part because preexisting conditions were then excluded for new enrollees with recent coverage breaks, but in part because the Bethlehem Steel bankruptcy had already taken place and affected workers interested in HCTC had already had their opportunity to enroll. On June 1, 2004, the state decided to once again lift the pre-existing condition exclusion, this time for the next 13 months. State officials believe that by motivating individuals to enroll in MHIP, the high risk pool will have increased capability to keep uncompensated care costs down and reduce the utilization of emergency departments by those who may be eligible but not enrolled in MHIP due to pre-existing condition exclusions. In part, this policy stems from one of MHIP's goals. Unlike high-risk pools in many other states, one function of MHIP is to keep uncompensated hospital costs to a minimum. Under Maryland's unique "all payer" rate system, such costs are born by all insurers and ultimately reflected in premiums. In addition, the renewed coverage of preexisting conditions is influenced by the continuing under-enrollment in MHIP, compared to plan capacity.

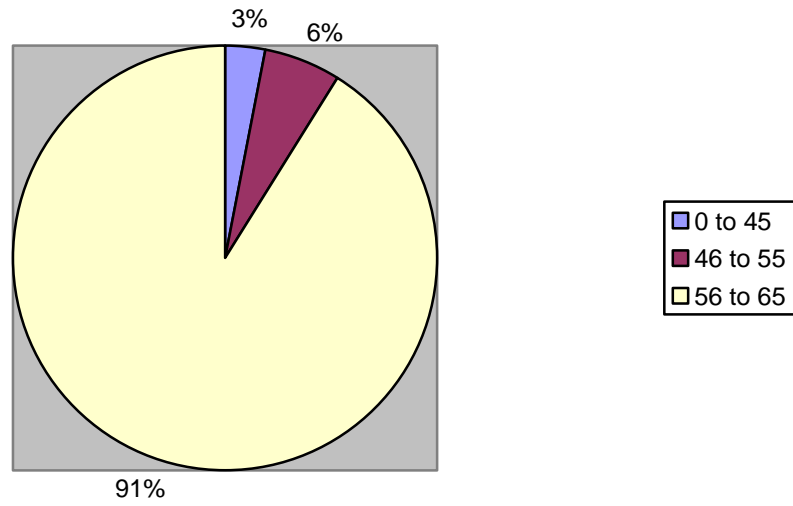
Although it serves a quite different function from MHIP, BCBS also lifted its pre-existing condition exclusions after recognizing the administrative costs would outweigh the benefits of having such a restriction. CareFirst representatives also noted that high-cost enrollees with pre-existing conditions might not be a big issue for the HCTC population because of their history of group coverage (as opposed to an individual coming in through open enrollment).

Enrollment Demographics

Of the approximately 500 HCTC recipients (which includes dependents and spouses) enrolled in MHIP, 437 (87 percent) came in through the PBGC, and 63 entered through TAA. And of these PBGC beneficiaries, most were employed by Bethlehem Steel/International Steel Group and are in their 50s.

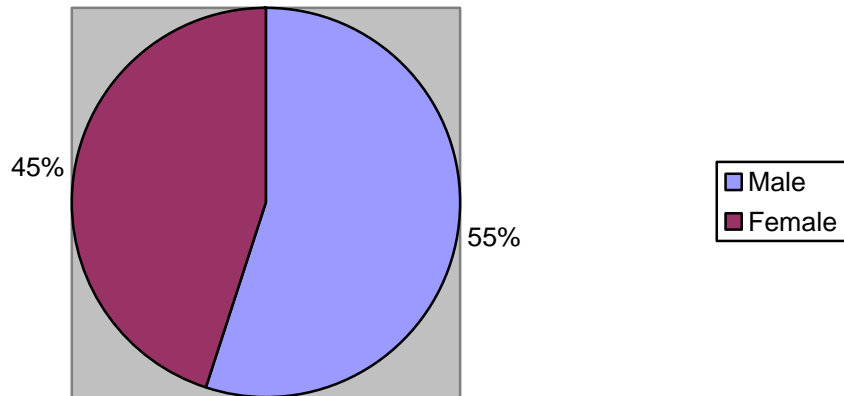
Among HCTC beneficiaries enrolled in MHIP, a considerable amount is known about their demographic characteristics. The vast majority are over age 55, the minimum age for PBGC-based HCTC eligibility; more than half are male; and more than half have annual incomes between \$12,000 and \$35,000. (Figures 4-6.)

Figure 4: Ages of HCTC beneficiaries enrolled in MHIP, June 2004



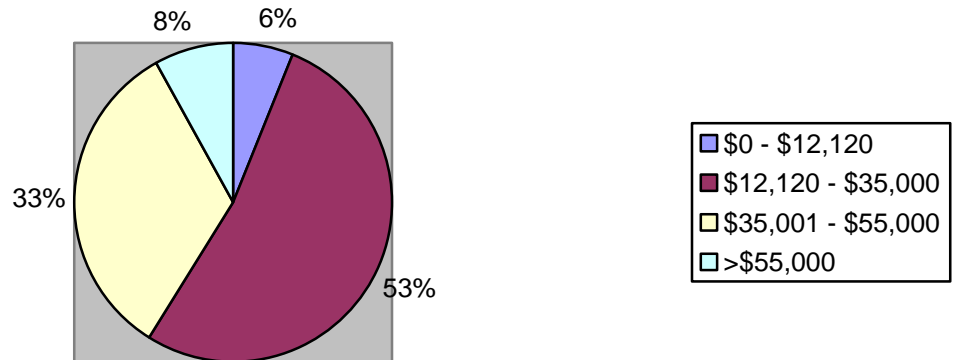
Source: MHIP, July 2004. Calculations by ESRI, August 2004. Note: this figure shows the distribution of both workers and their dependents.

Figure 5: Gender of HCTC beneficiaries enrolled in MHIP, June 2004



MHIP, July 2004. Calculations by ESRI, August 2004. Note: this figure shows the distribution of both workers and their dependents.

Figure 6: Annual income of HCTC beneficiaries enrolled in MHIP, June 2004



MHIP, July 2004. Calculations by ESRI, August 2004. Note: this figure shows the distribution of workers only.

The income data has important implications. More than half of Bethlehem Steel retirees have pensions that fall below \$11,000 a year,⁷ yet very few in this income band use HCTCs to enroll in MHIP. This suggests that the HCTC program, in its current configuration, may not meet the needs of lower-income individuals.

There are no data available on how many individuals eligible for COBRA instead chose MHIP for their HCTC coverage. It is known, however, that Bethlehem Steel **retirees** are eligible for COBRA throughout their lifetime, while **laid-off employees** are only eligible for 18 months. COBRA premiums for laid-off employees cost \$338 per month versus the MHIP premium of \$458 per month, while the COBRA cost for Bethlehem Steel retirees was higher than MHIP's monthly premium for similar coverage. According to MHIP officials, most HCTC eligibles who enrolled in the state's plan were Bethlehem Steel retirees.

MHIP

By April 2004, approximately 500 workers (plus dependents) were enrolled in MHIP via HCTC. Of these 500, only 193 had enrolled by July 2003, the start date for a two-month pilot test of advance payment arranged by IRS in two states, Maryland and Maine. To

⁷ Sonya Schwartz and Adele Bruce. *The Trade Act Health Insurance Subsidy: An Update from the States*. Families USA, December 2003.

mimic the effect of HCTCs, grant funding from DOL paid for 65 percent insurance subsidies. The vast majority of HCTC enrollment into MHIP happened over the summer and September of 2003, with enrollment falling to an average of approximately 5-6 a month starting in October 2003.

Among HCTC enrollees in MHIP, 60 percent have chosen the MHIP EPO.

Administrators of the program believe this is because the EPO is a more generous plan, and has a premium (post HCTC) of \$183 per month for an individual. By contrast, among unsubsidized MHIP members, only 15 percent enroll in the EPO. According to state officials, most individuals eligible for MHIP (whether subsidized through HCTC or not) would prefer the more generous coverage, but HCTC makes it possible for more of them to do so.

Of the qualified plan options in Maryland (not including spousal coverage, for which advance payment may not be used), MHIP has the highest enrollment of HCTC eligibles. Some reasons for this include the fact that its premiums were less expensive than COBRA coverage for Bethlehem Steel retirees, MHIP was able to advertise on radio and in print, and for the first three months there were no pre-existing condition exclusions for any enrollees – a policy to which MHIP returned in June 2004, after many months of discussion. Including both HCTC eligibles and others who qualify for MHIP (primarily the medically uninsurable), the plan has capacity for 20,000 enrollees, much more than the approximately 5,500 total membership that is currently participating. Approximately 500 additional HCTC-eligible workers and their families may join MHIP in November 2004, when their current COBRA coverage for laid-off workers ends. The latter coverage is quite comprehensive and, for current employees, involves total premium costs of approximately \$300 a month, well below the MHIP EPO's full, monthly premium of \$423 for older workers.

An analysis of MHIP HCTC claims indicates a significantly higher per member per month (PMPM) total claims paid for EPO enrollees versus PPO enrollees (\$2,817 vs. \$433) between July 2003 and May 2004. This is in stark contrast to the PMPM for EPO

versus PPO enrollees in the general MHIP population (\$2,326 vs. \$2,016). The more popular EPO claimed 332 HCTC enrollees in June 2004, while 258 were in the PPO.

CareFirst BlueCross BlueShield

While MHIP dominates the HCTC market at this time, there are some enrollees in the CareFirst qualified plan. As of June 2004, 13 individuals had applied for coverage, with seven of those approved and six still in the pipeline. Of the seven that have been approved, three enrollees are in the lower premium/medically underwritten premium category, and four are in the higher premium/non-medically underwritten premium category. Only one of these seven enrollees has utilized the coverage to a significant degree (e.g. going over the deductible). Thus far, CareFirst has not seen any MDHCTC program applicants. One possible reason for the higher enrollment in MHIP than in CareFirst is the fact that MHIP has an almost unlimited drug benefit with a \$250 premium, while the CareFirst drug benefit is much more restrictive, limited to \$500 of coverage per year. On the other hand, an important advantage offered by CareFirst is the insurer's network of participating providers, which is the largest of any Maryland insurer. Also to CareFirst's advantage is the sharply lower premium that would be charged to many HCTC-eligible workers.

Timing may play an important role in the much greater enrollment in MHIP than in CareFirst). When most of the HCTC enrollment took place (during Summer and early Fall 2003), MHIP was the only state-qualified option available in Maryland.

In any event, the CareFirst enrollees are all between the ages of 54 and 62. A representative of the health plan hypothesized that the younger TAA eligibles are likely to find new jobs in a timely fashion, which is why the HCTC recipients (at least in CareFirst) are on the more senior end of the age eligibility range. In addition, if these enrollees have their eligibility based on PBGC, the policyholders would need to be over age 54, by definition.

Disparity Between Take-Up Rates for Advance Payment and Number of Enrolled Eligibles

Despite the fact that Maryland has one of the highest take-up rates in the country for the HCTC program, only about 10 percent of those identified as eligible for the program have enrolled in advance payment. Interviews with health plan officials suggest that the main factors affecting take-up rates are 1) the complexity of the advance payment application and enrollment process; 2) finding the money needed to pay the monthly premium in full before advance payment begins; and 3) eligible workers either enrolling in their spouses' health insurance, or finding new jobs that offer employer-sponsored coverage.

Another factor that was considered crucial to the take-up rate is marketing and outreach. One interviewee described the mailing from the IRS that goes out to HCTC eligibles as providing just general information on the tax credit itself, and no information on the specific health plans that are available. Without direct contact from a SWA, UI, or labor union representative, many HCTC eligibles do not even know that they are eligible for the tax credit, because they for some reason either did not receive the HCTC packet, or misplaced or ignored it in the chaotic aftermath of a layoff. Thus, the face-to-face contact between eligibles and outreach workers may be a crucial component to increasing take-up rates.

Other factors that were discussed, but were deemed as having somewhat less of an impact than those mentioned above, include difficulty affording the 35 percent share of the premium for which the worker is responsible, workers' lack of desire for health insurance (although this could be very dependent on the individual's age), and appeal of the health insurance options to which the tax credit can be applied.

Program Background and History

As several interviewees remarked, the timing of the HCTC program could not have been better for the residents of Maryland. The implementation of MHIP as a high-risk pool and qualifying plan for HCTC coincided almost exactly with the Bethlehem Steel bankruptcy. Not only did that allow individuals to go a shorter period with a gap in

coverage, but the confluence of events also led to a significant amount of media attention for HCTC and MHIP, which in turn increased enrollment.

Of course, despite the good timing, implementation of the program – and the advance payment in particular – was not without its cost and difficulties. The state spent \$200,000 in administrative costs for outreach and enrollment of HCTC eligibles and to set up the MHIP advance payment mechanism (BCBS has a separate system for administering advance payments, not associated with MHIP’s system). Of that \$200,000, \$50,000 went to opening the customer call center six weeks earlier than planned in order to meet customer demand, most of which came from those affected by the Bethlehem Steel bankruptcy.

In general, setting up the advance payment system was a learning process, which included stumbles and challenges. Many of these challenges were in regard to developing strong communications tools to educate consumers on their responsibilities in the system.⁸ For example, consumers often failed to understand the following basic program features: the need to pay 100 percent of the premiums if they wanted to start receiving benefits before the advance payment kicked in; the need, when applying for HCTCs, to attach a hard copy of the insurer’s monthly invoice; the program’s timing, which involves 35 percent payments due to IRS at least 8 days before the start of the month to which the payments apply; when the health plan and the HCTC program are each billing the consumer for a particular month, which invoice must be paid; and even the basic difference between obtaining credits through advance payment and by filing a year-end tax return. Explaining these basic program features can require significant one-on-one consumer education from the HCTC call center, state workforce agency staff, health plan staff, union officials, or others. If this confusion is not resolved, it can affect an individual’s ability and willingness to make premium payments on time and may result disenrollment for non-payment. A member who is disenrolled may seek to restart

⁸ Some questions have been raised about the adequacy of the HCTC Program Kit in explaining these topics, but it may be that application process is sufficiently complex that even optimal consumer education materials would have difficulty conveying the relevant information. As one notable exception, the availability of these materials in languages other than English and Spanish could be helpful in areas, such as Maryland’s Eastern Shore, with HCTC beneficiaries who have a different primary language.

advance payment, but must make full monthly premium payments until the renewed application is processed and advance payment begins again.

In addition, consumers may not understand that they are required to inform the HCTC program in advance of premium changes because, for example, a new child is added to the policy. In fact, when consumers were informed about premium increases in MHIP, it became clear that some did not understand the impact of the increase until seeing the new invoice with the higher payment listed. If the beneficiary does not inform HCTC at least 26 days in advance of the changed premium, the consumer is billed for 35 percent of the old premium amount, the HCTC program covers 65 percent of the old premium amount and forwards a full premium payment of the old amount to the plan; the plan is then required to collect the shortfall from the consumer. Because HCTC routinely takes approximately 90 days to process a consumer's changes, it is not uncommon for several months of premium payments to fall into this category.

The administrative costs are quite large of proactively educating enrollees what they must communicate to IRS and then responding to the inevitable phone calls expressing dismay and incomprehension at being billed for the shortfalls. Similar problems affect voluntary changes in coverage. Because of IRS rules concerning confidentiality and national officials' desires to use uniform national procedures that make clear the consumers' ongoing responsibility to pay premiums, the consumer is required to bring all premium changes to the attention of IRS. As a general rule, health plans may not convey that information.

Early on in the program's implementation (and before the gap funding was available, see below) the state employed an innovative method of helping enrollees avoid paying the full cost of the premium during the period before advance payment kicked in. The Third Party Administrator (TPA) for MHIP made up "mock" invoices that were sent to HCTC, which enabled the enrollee to delay the start of coverage until advance payment was likely to begin. While it avoided any requirement of premiums paid in full pending the

start of advance payment, the trade-off was the absence of coverage until the effective date on the mock invoice.

A challenge for MHIP's TPA and for BCBS was creating two separate payment systems: one for HCTC, and one for all other payments. For each MHIP enrollee, the TPA must analyze the enrollee's required payment and then compare it to the amount sent from HCTC to ensure that the full premium is being covered. In cases where a payment is received from an individual who is not yet enrolled in the advance payment system, the TPA must administer the refund, which is an administratively awkward process. Another challenge is the fact that there are not open lines of communication among the TPA and the HCTC. For example, when the HCTC sent letters out to enrollees advising them of increases in the premium payments, the TPA had to request permission to include an informational spreadsheet in the mailing that would allow members to compare prices, rather than the HCTC coordinating the mailing so as to provide enrollees with a comprehensive set of information.

Some challenges came about simply due to mis-communication, rather than lack of coordination. In the early stages of the program, enrollees were told that they did not need premium invoices from MHIP to sign up for advance payment, so MHIP stopped providing these invoices. It was brought to the TPA's attention that both an invoice and a cancelled check were required by HCTC, and MHIP corrected its system in order to adhere to these requirements. As in some other states, there was also confusion regarding the HCTC invoice date and the period of time it covered. Enrollees were receiving invoices dated at the end of the month, and they were unclear over whether the payment due was to cover the prior month or the succeeding month. Three individuals were disenrolled in error over this problem (but were subsequently re-enrolled) before HCTC re-designed the invoice to clearly show what period of time the payment would cover.

One central theme in all these administrative problems is that concerns about confidentiality have prevented effective information sharing between the many private and public entities involved in each HCTC beneficiary's coverage, including PBGC or

state officials (depending on the basis of eligibility), IRS, the health plan, and the entity running the state's gap program. The consumer is required to convey often complex and unfamiliar information (including hard copies of pertinent documents, in some cases) from one entity to another, with high administrative costs and unnecessary terminations in coverage the all-too-frequent result.

An important example of the high administrative costs that result from these confidentiality requirements and the consequent limits on information sharing is the use of different identifier codes for both a member's HCTC payment and their personal payment. The IRS uses social security numbers (SSNs) to identify HCTC enrollees. The health plan is barred from using SSNs as a personal identifier and so uses a distinct policy number for each member. To gain the efficiency entailed in nationally uniform procedures, IRS outputs its monthly enrollment information with SSNs, rather than health plan identifiers, forcing the health plan to match the two numbers in order to assign each payment to the proper beneficiary. Moreover, when the Treasury Department sends money from bank to bank, the standard national form does not even have room for SSNs and instead uses bank account identifiers. As a result, with each month's payment, the TPA for MHIP must go through a lengthy process of reconciling the bank account identifier with the member's health plan identifier and social security number. The data systems are not coordinated, so much of this work is done by checking off Electronic Deposit Identifiers sent to the TPA by fax, and then cross checking them by hand with the deposits made by the HCTC. If the program were to increase in enrollment, this cumbersome system would need to be streamlined substantially, or administration would become untenable.

Health plan officials made clear that the staff at both federal agencies and the Treasury Department's private contractors have been extraordinarily helpful and cooperative. When problems emerged, these federal and private-sector leaders have been open, creative, dedicated, and effective in devising and implementing solutions.

The NEG Bridge Grant and the Maryland HCTC (MDHCTC or Gap) Program

After submitting an application in February 2003, the state received a bridge grant of \$5.6 million from the Department of Labor in August 2003, which the state is using to fund what officials call the “gap” or Maryland HCTC (MDHCTC) program. Under this program, the state pays 65 percent of the health care premium (the same percentage that would be covered by the HCTC) prior to enrollees’ formal start of advance payment (in other words, the state program “fills the gap” in premium payment). MDHCTC is offered statewide and administered by the Lower Shore Workforce Investment Agency on behalf of the SWA. Originally these bridge grant funds were only going to be used to cover premium costs before the August 1, 2003 start of the national advance payment system. But because the size of the award was so large and the grant was not received until August, the state decided (with DOL approval) to apply the funds toward premium assistance during each beneficiary’s gap in coverage while awaiting enrollment into advance payment.

The program works as follows: The individual provides MDHCTC with the necessary materials to prove that he or she a) has certification by the SWA or PBGC as potentially eligible for HCTC; and b) is enrolled in a qualified health plan.⁹ Hard copies of these materials are mailed in, and MDHCTC receives a PBGC eligibles list from a Consent Report provided by the IRS via email. Finally, PBGC verification is provided by the individual based on documentation requested through the MDHCTC Application Process. MDHCTC processes the application as quickly as possible, typically between 5 and 15 days, and bills the individual for the 35 percent premium share. The individual makes this payment via guaranteed check, which avoids the need for MDHCTC to collect on checks that are returned for insufficient funds or other reasons. MDHCTC then adds a 65 percent premium payment, funded by the DOL grant, combines it with the individual’s 35 percent payment, and gives the insurer a single, combined monthly payment. MDHCTC lasts for up to three months. The entire process – from initial application to payment of the first check to the insurer – takes 15 days.

⁹ See Appendix C for detailed information on the documents required by MDHCTC to determine Gap program eligibility.

MDHCTC's receipt of information, via the waiver pilot project described below, about when the individual applies for and enrolls in the national HCTC program allows MDHCTC to avoid making 65 percent payments during months in which the national HCTC program is also making advance payments. After conclusion of the individual's MDHCTC, the state agency contacts the insurer to verify that, in fact, the individual was covered during the months for which the MDHCTC was provided.

As of May 2004, the state was not permitted to retroactively reimburse enrollees who had to pay 100 percent of the premium before enrolling in advance payment. The original NEG grant was slated to end after the August 1, 2003 start of advance payment. After granting the state permission to spend the grant through December 2003, DOL later provided verbal approval for extending the grant through June 2004 and then December 2004, which could still leave a significant balance unspent. The state is currently petitioning DOL for an extension, so that it can continue to be used to act as a proxy for the HCTC.

One challenge facing the state is that, under DOL policy, only 10 percent of grant funds that are actually spent may be used for administrative costs. As of May 2004, the MDHCTC program had just begun operations, so only 80 individuals had applied. The 10 percent cap on administrative costs applies to the expenses of serving those individuals, not to the total size of the DOL grant. Other funding has thus been required to cover the significant administrative costs of establishing MDHCTC. Accordingly, in addition to receiving its original \$199,000 "start-up" grant from DOL to set up the UI system to cover HCTC, the state received additional DOL infrastructure grants for \$328,000, to help with the MDHCTC program, HCTC-related MHIP activities, rapid response and other SWA outreach, and other administrative costs.

In addition to facilitating receipt of the DOL bridge grant as a "gap filler," the national HCTC program has embarked on an ambitious demonstration project to examine coordination efforts between states (namely, Maryland and Virginia), the IRS, and the

DOL regarding HCTC eligibles. The goal of the project is to streamline the entire process from application to enrollment, so that it can be conducted more quickly, and in a way that is less potentially confusing to enrollees. When an individual calls the HCTC Call Center, staff now routinely ask the individual whether information about their application can be shared with state officials to see if they qualify for additional assistance. Among individuals asked that question, more than 70 percent consent to such information sharing. Following such consent by a resident of Maryland or Virginia, the HCTC Program sends information about the individual to state officials, who can then follow-up with targeted outreach. Among other benefits, this permits the MDHCTC program to learn about PBGC-eligible households, whose identity otherwise is not shared by PBGC.

Lessons Learned and Policy Surprises

- Incorporate flexibility into the qualified plan's structure: One of the reasons MHIP was so successful in the beginning was that it could “move with the tide” and adjust its enrollment and eligibility requirements based on the needs of the population.
- Take advantage of data resources: MHIP used PBGC enrollment data to make the enrollment and outreach events more efficient. Using contact information provided by PBGC, MHIP was able to inform potential eligibles prior to each outreach event regarding what information they should bring with them, rather than informing them at the enrollment fair and having the customer potentially fall through the cracks if follow-up was less than perfect. PBGC's subsequent reluctance to share information about payment recipients has limited the state's subsequent ability to enroll additional PBGC beneficiaries.
- The importance of scale: An important lesson learned in Maryland, as in other states, is that the systems in place to run the advance payment mechanism are working relatively well only because the volume of consumers is still very small. One stakeholder interviewed commented that that so much labor is required to serve the program, on a per capita basis, that if volume increased chaos would result.

Expert Interviewees' Suggested Changes

- Make HCTC packets more easily available: MHIP administrators reported that HCTC packets were only made available to eligible individuals once, as part of a mailing. However, many eligibles signed up for COBRA coverage and disregarded the HCTC information when it was first mailed to them. According to our Maryland informants, those individuals have been limited in their ability to receive a new packet when they needed it, due to the IRS' rules about packet distribution.
- Make lists of HCTC eligibles available to participating health plans: MHIP's early enrollment successes were largely attributable to its access to a list of PBGC recipients, which enabled the Plan to deem individuals eligible for enrollment. Absent such a list, plans must ask interested parties to obtain documentation from HCTC before the plan can consider enrolling them.
- Fix the "Medicare Widows" problem: Younger spouses of HCTC eligibles have been losing their HCTC subsidy when their spouse becomes eligible for Medicare and can no longer receive HCTC.
- Change HCTC eligibility to a 12-month recertification schedule rather than its current month-to-month schedule. State Medicaid programs currently have a similar option for 12 months of continuing eligibility.
- Create a better communication system between the health plan's TPA and the HCTC, so that both offices do not need to go through the enrollee to make administrative changes. Given the fact that most members are not familiar with having to coordinate their own care (having relied on company human resource managers prior to losing coverage), working through the enrollee, at best, delays the process and, at worst, can terminate coverage for eligible individuals.

Other sources

Much of this report was based on interviews with the following individuals:

Richard Popper, Maryland Health Insurance Program

Susanne Albin, Maryland Health Insurance Program

Patrick Baker, Maryland Department of Labor, Licensing and Regulation

Robin Vahle, CareFirst BlueCross BlueShield

Valerie Kurnas, Maryland Department of Labor, Licensing and Regulation

Jane Looney, IRS
Julie Crom, Accenture, Inc.
Karin Cano, IRS

Appendix A: National HCTC rules

Comprehensive explanations of the HCTC program are available elsewhere.¹⁰ For purposes of this report, however, the following brief summary may be helpful:

- **Eligibility.** Several groups qualify for HCTCs: (a) displaced workers whose layoffs have been certified by the U.S. Department of Labor (DOL) as trade-related and who therefore either receive Trade Adjustment Assistance (TAA) cash payments or would qualify for such payments but for their receipt of unemployment insurance (UI); (b) certain adults ages 55 through 64 who are paid by the Pension Benefit Guaranty Corporation (PBGC), which assists retirees from companies that have suffered severe financial reversals and so no longer pay promised defined-benefit pensions; (c) adults ages 50 through 64 who receive Alternative Trade Adjustment Assistance (ATAA) payments because they suffered trade-related job loss and then shifted to a new line of work for lower pay; and (d) dependents of individuals in the three previous categories. Individuals must also meet other criteria for eligibility, including absence of health coverage through Medicare, Medicaid, or employer-based coverage where the firm pays 50 percent or more of premiums.
- **Health coverage.** HCTCs pay 65 percent of premiums for qualified health plans, which fall into two categories: (a) state-qualified coverage, which is established by state action (through arrangements with an insurer or certain other methods) and which must meet consumer protection requirements described below; and (b) automatically qualified plans, which are available for HCTC use throughout the country (without any required action by state government) and which include (i) COBRA plans offered by former employers and (ii) nongroup coverage in which the HCTC beneficiary was enrolled during at least the final 30 days before job loss or other qualifying event.

¹⁰ Stan Dorn, *The Trade Act of 2002: Coverage Options for States*, Economic and Social Research Institute, for AcademyHealth's State Coverage Initiatives Program, March 2003, <http://www.statecoverage.net/pdf/issuebrief303trade.pdf>. Official and detailed explanations of Trade Act health coverage are available online, including at http://www.irs.gov/pub/irs-utl/governors_letter_hctc_guidance_ltr_ammended_080803_v2.pdf and <http://www.irs.gov/individuals/article/0,,id=109960,00.html>.

- **Consumer protection requirements** apply only to individuals with at least three months of continuous coverage immediately before enrolling in an HCTC plan. Such continuous coverage ends if an individual experiences a gap in coverage of 63 days or more. For HCTC-eligible individuals with continuous coverage, a state-qualified insurer must guarantee issue and may not exclude coverage of preexisting conditions.
- **Modes of providing HCTC**. An eligible individual may either claim the HCTC on year-end tax forms, to reimburse insurance premiums paid during the year, or have the HCTC paid in advance to the insurer, each month, as premiums are due.
- **Advance payment procedures**. The process starts when PBGC or a State Workforce Agency (SWA) gives IRS and its contractors, via electronic transmission, identifying information about individuals who either receive PBGC payments, ATAA payments, or TAA cash payments or who would receive TAA cash payments but for their receipt of UI. IRS then mails an HCTC Program Kit to those identified individuals, encouraging them to call the toll-free consumer call center for further information and enrollment assistance. The individual must then enroll in a qualified health plan and pay all premiums in full until advance payment begins. The individual provides IRS with an invoice from such a plan, which IRS uses to determine eligibility for HCTC and the timing and amount of advance payments. Once the IRS determines eligibility, IRS bills the individual for his or her 35 percent premium share. If the individual pays it in timely fashion (at least 8 days before the start of a month of coverage), IRS combines the individual's 35 percent payment with a 65 percent HCTC, and gives the insurer a full premium payment.
- **HCTC-related grants from the federal government to states** fall into two categories: grants to support the establishment and operation of high-risk insurance pools, which are one frequently-chosen option for state-qualified coverage; and National Emergency Grants (NEG) from DOL, which fund certain state costs associated with HCTCs.

Appendix B: Enrollment in the Advance Payment Mechanism

While each state tailors the process somewhat to fit into its design and infrastructure, the general enrollment process for the advance HCTC payment includes the following steps:

- 1) Each state workforce agency (for TAA and ATAA beneficiaries) and the Pension Benefit Guaranty Corporation (for its beneficiaries) send the HCTC program lists of individuals who may qualify for HCTC. Transmitted electronically, such lists are provided daily by state workforce agencies and monthly by PBGC.
- 2) The HCTC program mails HCTC program kits to each individual listed by the PBGC or a state workforce agency as potentially eligible. These kits contain detailed explanations of eligibility, qualified coverage, application procedures for HCTCs, and related topics. They are available in English and Spanish only.
- 3) The individual enrolls in qualified health coverage. The individual must pay each month's premium in full, pending completion of the HCTC registration process. Currently, at least the first month's premium typically must be paid in full before advance payment starts. If the individual turns out to be eligible for HCTCs, IRS reimburses any such full premium payments at the end of the year, after the individual files annual income tax forms.
- 4) The health plan sends an invoice to the individual showing the full premium amount. (The plan can continue sending these full invoices to such individuals even after advance payment has begun and the consumer is making 35 percent premium payments to the HCTC program, as explained below.)
- 5) The individual contacts the HCTC call center to enroll in HCTC advance payment, mailing the health plan's invoice to the HCTC program. The HCTC program uses that invoice to confirm enrollment in qualified coverage and to determine the proper dollar amount of the credit and the due date for payment to the plan.
- 6) The HCTC program determines whether the individual is eligible and registers the individual, if eligible, for advance payment.
- 7) For each month of advance payment, the following process applies:
 - a) Precisely 27 days before the plan needs to receive its full premium payment, the HCTC program bills the individual for his or her 35 percent premium share. The consumer's payment is due to the HCTC program 21 days after the bill is mailed.
 - b) If the HCTC program receives the full 35 percent payment by that date, the IRS provides a 65 percent advance credit. The HCTC program then combines that credit with the beneficiary's payment, sending the full premium payment electronically to the health plan.
 - c) If the beneficiary pays less than the full 35 percent amount, the HCTC program combines that payment with a proportionate matching credit from IRS, forwards the combined payment to the health plan, and reminds the

beneficiary of the additional amount that must be paid to the plan to retain coverage.

- d) If no payment is received from the beneficiary by the due date, the HCTC program sends the consumer a dunning notice stating that the consumer must pay the full premium amount to the plan or lose coverage. HCTCs may reimburse such full premium payments at the end of the year, after tax forms are filed. However, these beneficiaries are terminated from advance payment until they re-register.

Several details are important to add to this account. First, anecdotal reports suggest that the requirement of paying at least one month's premium in full has deterred applications by a number of laid-off workers eligible for HCTCs.¹¹ This is not surprising, as advance payment was premised on the inability of many such workers to front periodic premium payments without subsidies. To address this problem, the HCTC team is working to expedite processing of initial applications for advance payment and to cut to a minimum any required payment of full, monthly premiums. Moreover, several states are using NEG grants to provide 65 percent premium subsidies before the start of advance payment.¹² It is unclear how long NEG funds can play such a role, however. In addition, some states have had difficulty integrating NEG payments and HCTCs into a single, seamless process that is easy for beneficiaries.

27. *Trade Act Tax Credits: A Path to Broader Health Coverage?* Alliance for Health Reform Briefing. August 1, 2003.

http://www.kaisernetwork.org/health_cast/uploaded_files/080103_alliance_tradeact_trans.pdf.

28. *Health Coverage Tax Credits: Innovations in Public-Private Partnerships*. American Association of Health Plans/Health Insurance Association of America. Audio Conference. November 13, 2003.

<http://www.aahp.org/audio/taxcredit/>.

Appendix C: MDHCTC Gap Program Qualification Checklist

Required documents to certify that applicant is potentially eligible for HCTC:

- If eligible through TAA:
 - Form ETA 858: Proof that individual is a TRA recipient, or could receive TRA but has not exhausted UI
 - Form ETA 857: Proof that individual is in training or is on training waiver
 - TRA 264: Proof of TAA Eligible Certification, required for each month
- If eligible through PBGC:
 - Check Stub/Direct Deposit Statement
 - Statement from PBGC (to be faxed directly to MDHCTC office)
 - Individual's name must appear on list from PBGC given in March 2003
 - HCTC Candidate letter
- For all applicants:
 - Health Coverage Invoice/Bill/Coupon

Required documents to prove enrollment in a qualified health plan:

- Completed Application
- Completed IRS Form 8821- Tax Information Authorization
- Photocopy of Medical Insurer Plan Information
- Address, Phone, Group ID, Member ID (included on application)
- Coupon, Invoice, or Bill (proof of coverage)
- COBRA Information (as applicable)
- Other Qualified Family Member Information (included on application)
- Other Qualified Family Insurance Information (included on application)
- Age verification (photocopy of Birth Certificate or Driver's License) for each family member
- TRA Determination Form ETA857

or

- Proof of registration in training program or training waiver

or

- PBGC (Pension Benefit Guarantee Corporation) verification (may include PBGC check stub, or letter from PBGC)

