

Health Coverage Tax Credits in North Carolina: Heroic Efforts, Modest Results

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About the Economic and Social Research Institute

The Economic and Social Research Institute is a non-partisan, non-profit research organization headquartered in Washington, D.C., and founded in 1987. Specializing in health and social policy research, ESRI conducts research and publishes studies directed at enhancing the effectiveness of social programs, improving the way health care services are organized and delivered, and making quality health care accessible and affordable.

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Introduction and overview

On July 30, 2003, North Carolina experienced the largest layoff in its history. The Pillowtex Corporation, which had owned a number of large textile mills, could neither overcome stiff foreign competition nor find a new buyer for the mills. Accordingly, the company shut down its plants and declared bankruptcy. More than 5,000 workers lost their jobs.

Two days later, on August 1, 2003, advance payment of Health Coverage Tax Credits (HCTCs) under the Trade Act of 2002 first became available nationwide. Capable of being furnished directly to insurers when monthly premiums are due, such credits pay 65 percent of premiums for qualified health insurance purchased by certain workers displaced by foreign competition, such as most of Pillowtex's former employees.

As part of a larger community effort to help Pillowtex workers, an extraordinary partnership came together to take advantage of this new tax credit and help laid-off workers obtain health coverage. With the Governor in the lead, a broad range of state and federal agencies, Blue Cross and Blue Shield of North Carolina (BCBSNC), unions, community-based groups, churches, philanthropies, and volunteers mounted a creative and intensive effort to minimize losses in health coverage. Thanks to that remarkable work, North Carolina has been among the nation's leaders in enrolling eligible workers into HCTC health coverage.

While many difficult obstacles were overcome, the basic limitations of national HCTC policy ultimately proved insuperable for most intended beneficiaries. Altogether, by May 2004, advance payment reached only 8.8 percent of North Carolinians who were individually identified as potentially eligible and so were mailed consumer education materials by the Internal Revenue Service (IRS). While that was substantially higher than the 5.5 percent national enrollment rate, the HCTC program in North Carolina nevertheless fell short of achieving its objectives during the first months of program operation.

Understanding what happened in North Carolina is important, because it could help inform national decisions about how to restructure HCTC so that it can more effectively reach its goals. More broadly, information about how these credits function "on the ground" could be important to future decisions about whether and how to use federal income tax credits to provide health coverage for millions of uninsured Americans.

To that end, our report begins by explaining our research methodology and key national HCTC policies. It then describes the early history of the HCTC program in North Carolina; HCTC policies that are in place in the state; demographics of HCTC eligibility and enrollment in North Carolina; and a range of discrete policy issues surfaced by the North Carolina experience, with corresponding lessons learned.

Methodology

In late April 2004, the author spent several days interviewing a broad range of officials and stakeholders. Interviewees included workers laid-off from Pillowtex as well as representatives from the Governor's office, state workforce agencies, local One-Stop Centers, unions, BCBSNC,

and community volunteers. Additional interviews took place by telephone. In addition, the author reviewed a number of documents (published and unpublished) related to the Pillowtex closure, other mass layoffs in the state, and the TAA program in North Carolina. Finally, in June 2004, the author queried the BCBSNC web site for premium quotes that would apply to various age and gender combinations of HCTC beneficiaries.

National HCTC rules

Comprehensive explanations of the HCTC program are available elsewhere.¹ 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.
- **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.

Initial implementation of HCTC in North Carolina

Founded in 1887, Cannon Mills long played an important part in North Carolina's textile industry, achieving global recognition as the world's largest producer of household textiles. In 1982, California financier David Murdoch bought Cannon Mills. After using part of the company's pension fund to finance other corporate acquisitions, Mr. Murdoch merged Cannon Mills with Fieldcrest Mills in 1985 to create Fieldcrest Cannon, which in turn was bought by Dallas-based Pillowtex Corporation in 1997. Pillowtex filed for Chapter 11 bankruptcy protection in November 2000, emerging from bankruptcy restructured in May 2002. Facing a number of business challenges (including severe foreign competition), the company's efforts to stave off collapse or to recruit a new buyer ended on July 30, 2003, when the company announced that it was filing a new bankruptcy petition, closing all of its plants, and terminating approximately 6,450 employees, including roughly 4,800 workers in North Carolina, most of whom lived in the town of Kannapolis and the surrounding counties.²

The company made clear that, after October, COBRA coverage would become unavailable, as Pillowtex would no longer have even the skeletal work crew it was briefly retaining to complete the shut-down of operations. Without providing health benefits to current employees, the company would no longer be obliged to offer COBRA coverage to former staff.

Pillowtex preceded these steps with other measures that reduced workers' living standards. Starting in June 2003, Pillowtex lowered its labor costs through rolling, supposedly short-term lay-offs and reductions of hours for many workers, leaving affected families ill-equipped to weather the financial storms ahead. In mid-June, the company stopped paying accumulated vacation compensation, denying workers resources that some had counted on to get them through hard times. Altogether, three-fourths of employees had been without work for six to eight weeks when the company shut down.³ To avoid scaring off potential investors and buyers, the company gave no advance, public notice of the impending shut-down. Most workers learned of the closings on their final day of work or when they reported to a shuttered plant the next day.

However, starting in April 2003, company officials had been meeting privately with federal, state, and local officials to develop a coordinated response to possible mass layoffs. Part of this response involved the company's decision to file a petition asking DOL to certify the company's layoffs as trade-related. If granted, such a petition would permit laid-off workers to receive various forms of TAA, including HCTCs and new ATAA payments, which are limited to workers covered by petitions filed with DOL on or after August 6, 2003.

On August 8 and August 11, 2003, Pillowtex filed petitions with DOL seeking findings of trade-related impact. DOL granted these petitions on September 9.⁴ Delaying the petition filing until

mid-August permitted displaced workers to qualify for ATAA. However, because the federal TAA statute denies TAA eligibility during the first 60 days following the filing of a petition with DOL, workers displaced by the Pillowtex closure could not qualify for HCTC (or other TAA benefits) until October, leaving a two-month gap.

As a new program for which national policy was not fully defined, HCTC presented serious challenges to public and private entities in the state seeking to address the health coverage dimension of the Pillowtex closure. The Governor and his staff encouraged insurers in the state to offer displaced workers coverage that could qualify for the tax credit. BCBSNC came forward to give such workers access to the company's flagship product in the nongroup market, Blue Advantage. BCBSNC rapidly made the changes to Blue Advantage coverage that were needed to qualify under national HCTC rules, and the State's Department of Insurance approved the revisions on July 31, in record time. While most of these changes were modest in scope, BCBSNC accelerated implementation of its plan to make Blue Advantage a guaranteed issue product for all purchasers, not just HCTC beneficiaries. Federal officials also assisted by providing advice and ultimately accepting the coverage as qualified for HCTCs. As a result of this quick action on multiple public and private levels, Blue Advantage began providing HCTC-qualified coverage in October 2003, when displaced Pillowtex workers could first receive HCTCs.

At the Governor's urging, state officials in many branches of government, led by the Employment Security Commission (ESC), worked together to develop policies and procedures that would facilitate workers' receipt of health coverage using HCTCs. One key goal was to prevent displaced workers from experiencing gaps in health coverage lasting 63 days or longer. As explained above, beneficiaries who experience such gaps are not covered by the HCTC statute's consumer protections.

Under the federal government's approach to HCTCs, workers who requested advance payment would be required to pay 100 percent of the premium for qualified health coverage while the IRS was determining their eligibility. Many state officials believed that, even for one or two months, such payments would be unaffordable for nearly all workers laid-off by Pillowtex. To address this problem, officials developed the idea of state-administered subsidies to pay 65 percent of such workers' premiums while they waited for the IRS determination.

On June 23, 2003, state officials asked DOL to fund such state-administered subsidies with a \$7.6 million NEG grant. However, federal officials had not previously authorized such uses of NEG funds. In fact, DOL had indicated that NEG "bridge grants" may have been limited to coverage purchased before August 1, 2003, reasoning that the legislative intent behind such grants was to aid eligible workers before the statutory start-date for advance payment.⁵ North Carolina's innovative request would use NEG funding to bridge a different gap – namely, the first few months of qualified coverage received at any time by a worker with a pending application for HCTC advance payment. Despite this proposal's novelty, DOL approved it rapidly, announcing the grant on August 15, 2003.⁶

At the local level, public and private officials came together quickly to provide laid-off workers with information and assistance. A Community Services Center was opened within four days of the Pillowtex closing, staffed by 13 public and private agencies. Government funding was supplemented by about \$900,000 collected from a local foundation, a local hospital, and other corporate and individual sponsors. Pillowtex Plant Number 4 became the site of outreach

meetings with workers and a “one stop shop” featuring staff from multiple agencies helping workers with a range of benefits, including unemployment insurance, training, job search, health coverage, and more. The union for laid-off Pillowtex workers, the Union of Needletrades, Industrial and Textile Employees (UNITE), reached out intensively to its members and helped them qualify for available assistance. A number of churches “sponsored” individual laid-off workers by paying their premiums for several months.

After visiting Kannapolis in early August 2003 and meeting with displaced workers, BCBSNC’s Chief Executive Officer decided that, since displaced workers could not obtain HCTCs until October, the company would offer them short-term insurance, on a guaranteed-issue and community-rated basis. The company also provided these former Pillowtex workers free prescription drug discount cards, which were estimated to cut prescription costs by an average of more than 20 percent.⁷ At the same time, BCBSNC guaranteed workers that, if they submitted all necessary applications by September 30, Blue Advantage coverage would begin on October 1, regardless of any delays in processing those applications. If such processing was completed after October 1, BCBSNC promised to make coverage retroactive to the start of the month. As a result, workers would not experience a gap in coverage of 63 days or more and so would remain shielded by HCTC’s consumer protections.

BCBSNC’s Blue Advantage product was originally planned to have seven tiers of risk, with corresponding variations in premium amounts. After HCTC beneficiaries completed the medical underwriting process, the plan’s officials were surprised to see how many fell into the highest risk categories. To lower the resulting costs to workers, BCBSNC eliminated for HCTC beneficiaries (but not for others purchasing Blue Advantage) the two most expensive premium tiers. HCTC workers originally classified in Tiers 6 and 7 were placed instead into Tier 5, the highest remaining HCTC tier. This reduced premiums for affected workers by 35 to 55 percent.⁸

Some observers described the Pillowtex closing as an economic disaster, akin to a natural disaster both in its harmful impact and in how the affected community pulled together to help those in need.⁹ As a result of this energized, effective, broad-based effort, an HCTC infrastructure was put in place that now helps, not just former employees of Pillowtex, but also other North Carolinians eligible for HCTC. The following section describes key features of this infrastructure.

North Carolina policies and practices related to HCTC

As with any state participating in HCTC, two policy arenas are important to explore: state-qualified coverage; and the state workforce agency’s approach to enrolling potentially eligible displaced workers. Each of these broad topics is discussed in turn below.

State-qualified coverage

During the period covered by this report, HCTC beneficiaries in North Carolina could enroll in Blue Advantage. Using a Preferred Provider Organization (PPO) to furnish coverage, Blue Advantage was by far the most highly subscribed nongroup product offered by BCBSNC. As of 2001, BCBSNC had a 59 percent share of the state’s entire nongroup market,¹⁰ so HCTC beneficiaries in North Carolina had access to the state’s most popular nongroup plan.

Consumers purchasing Blue Advantage, whether through HCTC or the general nongroup market, could choose from two basic plans, each of which had multiple deductible options and an option

for women to elect or decline coverage of routine maternity care. The following table shows some of the key features of each plan.

Table 1. State-qualified PPO coverage in North Carolina: Summary of benefits and out-of-pocket cost-sharing, 2004

Plan name		<i>Blue Advantage, Plan A</i>	<i>Blue Advantage, Plan B</i>
Deductible options per individual insured		\$250; \$500; \$1,000; \$2,500	\$500; \$1,000; \$2,500; \$5,000
General cost-sharing	In-network	\$15 copay for primary care \$30 copay for specialists 20% coinsurance for other care	\$25 copay for primary care \$50 copay for specialists 30% coinsurance for other care
	Non-network	30% coinsurance	30% coinsurance for office visits 40% coinsurance for other care
Out-of-pocket expense limits, in-network	Individual	\$2,000	\$3,000
	Family	\$4,000	\$6,000
Lifetime cap, in-network benefits		No limit	\$5 million cap
Special provisions applying to specific services*	ER use	\$150 copay	
	Mental health, substance abuse	50% coinsurance \$2,000 annual benefit cap per person Lifetime benefit cap of \$10,000 per person	
	Maternity care	Not covered, unless pay extra Coinsurance of 20% in-network and 30% non-network Deductible applies	Coinsurance of 30% in-network and 40% non-network Otherwise, same as Plan A
	Prescription drugs	No separate deductible \$2,000 annual cap on benefits \$10 copay for generics \$35 and \$50 copays for brand-name drugs	Separate \$200 deductible Otherwise, same as Plan A
	Preventive care for children	No coverage outside network. Immunizations covered without copay	
	Preventive care for adults	No coverage outside network	

Premiums for Blue Advantage varied by age, gender, area of residence, and level of risk. HCTC receipt did not affect the premiums that were charged, with two exceptions: as explained above,

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

the highest-risk members were charged lower premiums if they received HCTCs; and HCTC beneficiaries were personally responsible for only 35 percent of premium costs. The following table shows such 35 percent premium costs, in annualized form, for various age and gender combinations purchasing Blue Advantage coverage.

Table 2. Annualized cost, 35 percent premium share, various HCTC beneficiaries purchasing Blue Advantage Coverage: Preferred risk tier, June 2004

		25-year-old man	25-year-old woman		55-year-old man	55-year-old woman	
			Buying maternity coverage	Not buying maternity coverage		Buying maternity coverage	Not buying maternity coverage
Plan A	\$250 deductible	\$483	\$1,949	\$701	\$1,520	\$2,822	\$1,575
	\$500 deductible	\$458	\$1,894	\$668	\$1,436	\$2,713	\$1,487
	\$1,000 deductible	\$424	\$1,798	\$613	\$1,323	\$2,554	\$1,369
	\$2,500 deductible	\$374	\$1,436	\$538	\$1,151	\$2,092	\$1,193
Plan B	\$500 deductible	\$391	\$1,625	\$563	\$1,210	\$2,314	\$1,252
	\$1,000 deductible	\$357	\$1,520	\$517	\$1,109	\$2,150	\$1,147
	\$2,500 deductible	\$315	\$1,281	\$454	\$966	\$1,827	\$1,000
	\$5,000 deductible	\$281	\$941	\$403	\$853	\$1,420	\$882

Source: Blue Cross and Blue Shield of North Carolina web site,¹¹ June 28, 2004. Calculations by ESRI, June 2004. Note: Quotes were for residents of Wake County, which includes the state capital, Raleigh.

These numbers show considerable disparity based on age, gender, and desire for maternity care coverage. Moreover, they were all based on the second-best tier of medical risk. Depending on the results of individual medical underwriting, actual payments could have been 15 percent below the stated level or up to three times as large. For example, a 25-year-old man buying Plan A with a \$250 deductible could have had an annualized 35 percent premium cost as low as \$411 or as high as \$1,449.

Finally, Blue Advantage was a guaranteed-issue product, both for HCTC beneficiaries and other purchasers. However, if HCTC beneficiaries did not meet the continuous coverage requirements of the HCTC statute (that is, three months of continuous coverage, without a gap of 63 days or longer, immediately before enrolling in an HCTC plan), Blue Advantage excluded treatment of preexisting conditions for up to 12 months.

North Carolina's state workforce agency

Aside from developing state-based health insurance options, ESC led HCTC implementation in the state. Working as a team with staff from multiple agencies, state officials made sure that HCTC was up and running in time to help Pillowtex workers.

In some important ways, state officials integrated HCTC into standard operating procedures used whenever companies lay off North Carolina workers because of trade. Under these procedures, the state may learn that an employer plans large layoffs because of legally required warnings from employers, state observations about patterns in filed UI claims, or other information. When this happens, the Governor's Rapid Response team meets with the employer and explains the full range of benefits available to laid-off workers, including TAA. In appropriate cases, state officials encourage the employer or others to file petitions with DOL seeking findings of trade-related impact. If necessary, state officials file such petitions themselves, on behalf of affected workers.

Once a layoff is announced, officials from the local One-Stop Center (the state workforce agency's local office) meet with workers to describe available assistance. State officials believe that they have the legal authority to compel employers to provide lists of laid-off workers who can be invited to such meetings. In any event, state officials find that employers typically are glad to cooperate, without coercion or threatened sanctions. If DOL certifies a layoff as trade-related, state officials hold a follow-up meeting educating workers about TAA benefits, including HCTCs. To apply for HCTC or other TAA benefits, workers complete an application for TAA training or for a waiver of TAA training requirements. The One-Stop Center makes clear that, if workers will call or visit to request assistance in the future, Center staff will do their best to help them obtain appropriate benefits.

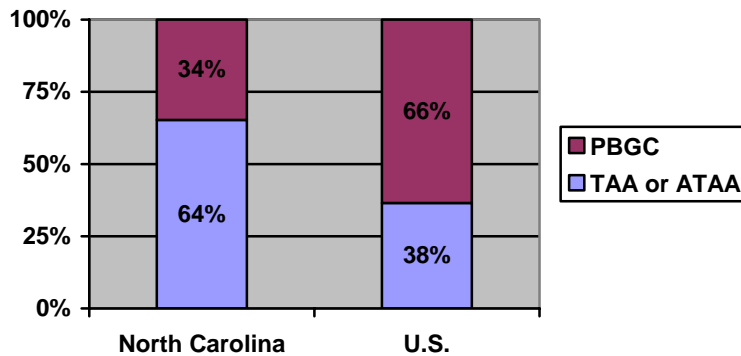
While building on these existing mechanisms to maximize efficient service delivery, state officials also recognized that standard operating procedures needed to be supplemented to make the new HCTC program effective. In particular, officials were concerned that months could pass between a displaced worker's application for advance payment and the start of advance payment; and that most such workers would be unable to meet the HCTC program's requirement of paying full monthly premiums while waiting for the IRS to begin advance payment. To address this problem, state officials developed the idea of using NEG funds from DOL to support a "bridge program" that would pay 65 percent of premiums during the period between application for and commencement of a worker's advance payment.

After DOL granted the requested NEG, state officials implemented the bridge program as follows. A workers seeking bridge coverage must complete a simple one-page application and provide health insurance invoices from BCBSNC or the worker's COBRA plan. Once state officials verify that the worker's name has been sent electronically to IRS as potentially eligible for HCTC, state officials process the worker's application for bridge coverage. If the worker qualifies for a bridge payment, the state provides a check, made out to the insurer, that covers 65 percent of health insurance premiums. The worker then combines that check with a 35 percent premium payment and provides both checks to the insurer. After the first month, if HCTC advance payment has not yet begun, the worker must bring state officials a new health plan invoice each month to trigger the next bridge payment.

Demographics of HCTC eligibility and enrollment

National HCTC data available from IRS and its contractors show that, in May 2004, 18,334 North Carolinians were identified by either ESC or PBGC as potentially eligible for HCTC. Based on those certifications, IRS sent them enrollment and consumer information materials. An unusually high proportion of these workers – 66 percent – were classified as potentially eligible based on TAA, rather than PBGC. By contrast, throughout the country, PBGC recipients constituted 62 percent of individuals potentially eligible for HCTC, as illustrated by the following chart.

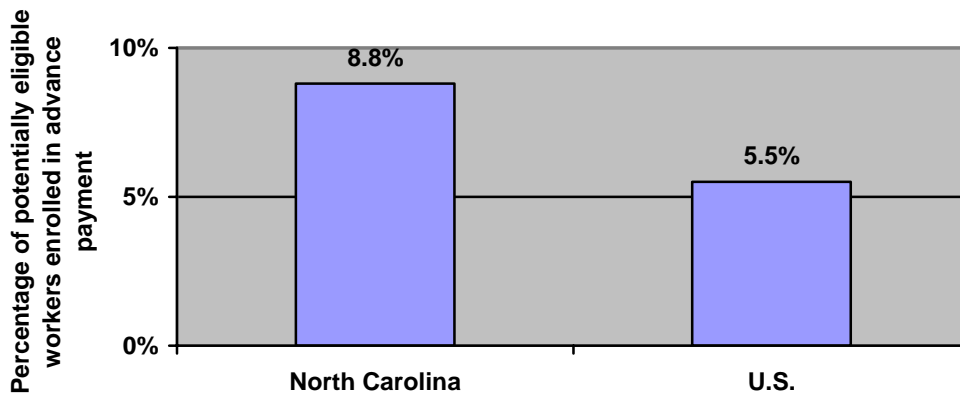
Figure 1. Basis for potential HCTC eligibility, North Carolina versus United States: May 2004



Source: U.S. Department of Treasury, June 22, 2004.¹² Calculations by ESRI, August 2004.

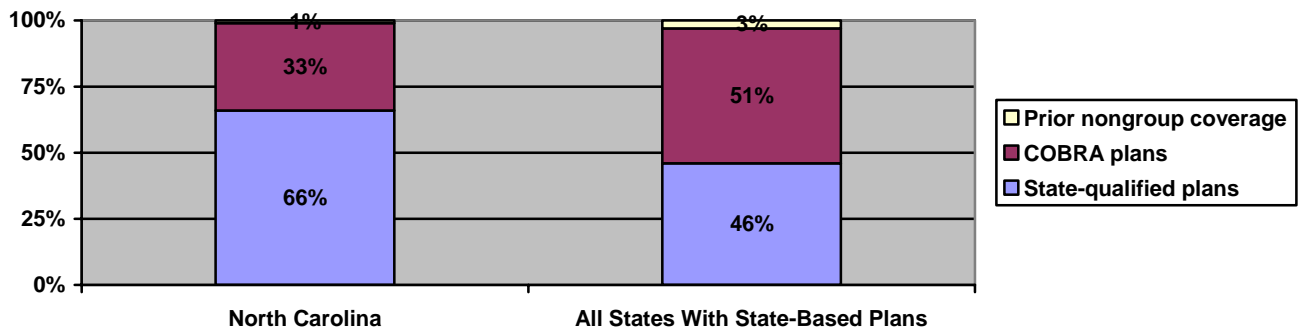
Of these 18,000 potentially eligible North Carolinians, no more than 1,606 – or 8.8 percent – had enrolled in HCTC advance payment by May 2004. Altogether, 66 percent of enrollees received state-qualified Blue Advantage coverage, rather than COBRA. By contrast, in the country as a whole, only 5.5 percent of potentially eligible individuals were then enrolled in advance payment; and in places where state-qualified plans were available, only 46 percent of advance payment participants were covered through such plans.

Figure 2. Enrollment into HCTC advance payment, North Carolina versus United States: May 2004



Source: U.S. Department of Treasury, June 2004. Calculations by ESRI, August 2004.

Figure 3. Advance Payment Enrollment into Types of Qualified Coverage, North Carolina versus All States with State-Qualified Plans: May 2004



Source: U.S. Department of Treasury, May 2004. Calculations by ESRI, August 2004. Note: the prior nongroup coverage shown in this chart was automatically qualified for HCTC, under federal law, because beneficiaries were enrolled in such coverage during at least the last 30 days before job loss.

Of course, these enrollment numbers portray a very early stage in program development, literally the eighth month during which advance payment was available in North Carolina. In addition, they do not include any North Carolinians who did not use advance payment but claimed HCTCs on their year-end tax forms for 2003. Participation is likely to grow as the program becomes more established.

In addition to the above data from the Treasury Department and its contractors, state and local officials have compiled information about the characteristics of workers laid off from Pillowtex. According to one survey in early August 2003 of over 700 displaced Pillowtex workers who attended community education events:¹³

- 35 percent had not completed high school, and only 8 percent had received any post-secondary education;
- Their average age was 46, but 40 percent were age 50 or older;
- Their median tenure at Pillowtex was 13.5 years;

- Previous hourly wages averaged \$11.44, and weekly wages ranged from \$220 to \$1140, averaging \$458;
- 85 percent were receiving unemployment benefits, which ranged from \$73 to \$408 a week and averaged \$275;
- More than three-fourths had depended on Pillowtex for all household income -- 62 percent were their households' sole earners, and 14 percent had spouses who also worked at Pillowtex;
- 59 percent were female;
- Nearly half (48 percent) had children, averaging 2.1 offspring per laid-off parent;
- Median indebtedness, excluding mortgages, was \$1,500, but 38 percent owed \$2,500 or more when they were laid off;
- By the first week of August, 43 percent reported being behind in rent or mortgage payments, and 11 percent had already received eviction or foreclosure notices;
- In the lowest income quartile, 50 percent were behind in their rent or mortgage, compared to 18 percent in the highest income quartile;
- Among workers receiving unemployment insurance who were not current on their housing payments, their average monthly UI income was \$1,108, their average monthly rent or mortgage was \$509, their average non-mortgage debt was \$6,653, and they had an average of 2.5 dependents;
- At least 68 percent were uninsured in August, immediately after the layoff; and
- Nearly three-fourths (74 percent) believed that they would have a problem or concern, in the next few months, paying for prescriptions (which had an average monthly cost of \$209 among survey respondents), and 75 percent believed they would have a problem or concern paying for doctor visits and hospital care.

Because of IRS concerns about confidentiality, state officials did not have access to information about the number of Pillowtex workers who ultimately enrolled into HCTC. State officials believed that about 20 percent of Pillowtex workers ultimately took advantage of HCTC, and that most of the remainder became uninsured. However, these officials were able to track with precision displaced workers' receipt of other benefits. They found that, while 65 percent of eligible displaced workers (3,115 out of 4,767) received UI or TAA income support, the new ATAA program reached only 5 percent (41 out of 814 eligibles) of re-employed, older workers who qualified for such assistance.¹⁴

Unavailable are comprehensive data about the characteristics of other HCTC-eligible North Carolinians. However, state officials collect layoff-by-layoff information about displaced workers. The following table displays some of this information for a number of recently announced layoffs.

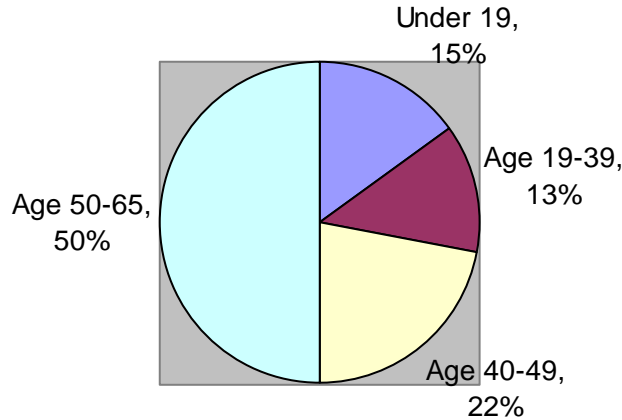
Table 3. Characteristics of displaced workers in North Carolina affected by various trade-related layoffs, February and March 2004

	Employer announcing trade-related layoffs			
	Schrader-Bridgeport	Americal	Temple-Inland	Chicago-Rawhide
Number of affected workers	130	96	85	133
Industry	Fuel sealing and conducting	Shoes and related products	Paper products	Rolling bearings and seals
Average age	48	46	Over 40	47
Average tenure at company (in years)	20+	17	n/a	12
Percentage with H.S. degree	100%	95%	n/a	97%
Percentage with a 2- or 4-year college degree	17%	10%	n/a	3%
Percentage paid hourly	75%	74%	72%	78%
Average wage and corresponding weekly income (in pretax dollars) for hourly workers	\$13.50 an hour \$540 a week	\$9.98 an hour \$399 a week	n/a	\$12.60 an hour \$504 a week
Percentage who are women	42%	68%	15%	37%
COBRA offered	Yes	Yes	Yes	Yes
COBRA subsidized	No	No	Unclear	No

Source: North Carolina Department of Commerce, Division of Employment and Training, March 2004.¹⁵ Calculations by ESRI, June 2004. Notes: (1) These employers met with the Governor's Rapid Response team in February or March 2004. At that time, layoffs were expected to occur between April and December 2004. (2) Temple-Inland furnished state officials with incomplete survey results. Items marked "n/a" were not provided. (3) The estimates of weekly, pre-tax income assume a 40-hour work week.

Along similar (but not identical) lines, information from BCBSNC shows that, among HCTC enrollees in Blue Advantage, 56 percent were women; nearly three-fourths (72 percent) were age 40 or older; and fully half (50 percent) were age 50 or older, as shown in the following chart.

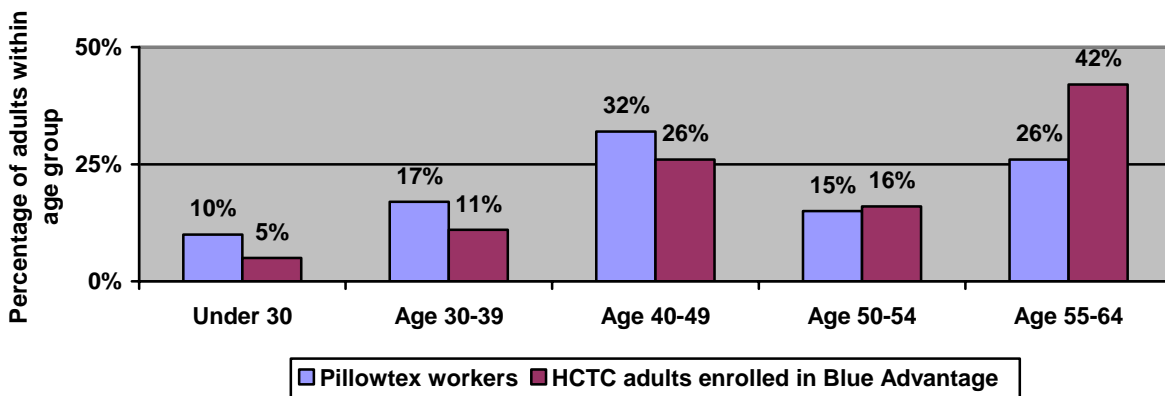
Figure 4. Enrollment into North Carolina’s State-Qualified HCTC Coverage by Age of Primary Insured: February 2004



Source: Blue Cross Blue Shield of North Carolina, May 2004. Calculations by ESRI, June 2004

A comparison of laid-off Pillowtex workers, who comprised a large share of HCTC-eligible workers, and actual enrollees into Blue Advantage suggests that older workers may have been somewhat more likely than younger workers to take advantage of these tax credits, as illustrated in the following chart.

Figure 5. Displaced Pillowtex workers potentially eligible for HCTC versus actual HCTC enrollees into Blue Advantage: age distribution, 2003-2004



How to read this chart: 10% of all displaced Pillowtex workers were under age 30; 5% of all HCTC adults enrolled in Blue Advantage were under age 30; 17% of all displaced Pillowtex workers were ages 30-39; 11% of all HCTC adults enrolled in Blue Advantage were ages 30-39; etc.

Sources: Blue Cross Blue Shield of North Carolina, May 2004; Paul C. Friday, September 2003. Calculations by ESRI, June 2004.

To summarize, the typical North Carolinian enrolled in HCTC is middle-aged or older; worked at a low-wage job for the same employer for many years before termination; had, at most, a high school degree; and had access to at least some COBRA coverage, but enrolled instead in a Blue Advantage plan. The implications of this profile and other aspects of the HCTC program in the state are explored in the following section.

Policy issues and lessons learned

The following discussion focuses on two broad subjects: factors facilitating or discouraging eligible workers' enrollment into HCTC; and the type of health coverage offered to HCTC beneficiaries in North Carolina.

Factors affecting enrollment

Problems that did not materialize

In the past, the author of this paper expressed several concerns about potential obstacles to enrollment that, in North Carolina, did not materialize.¹⁶ To date, the application of TAA training requirements to HCTC has not posed a major problem. HCTC applicants typically request and obtain training waivers, so training program closures and other limitations on the availability of TAA training have not prevented the receipt of HCTC. However, state workforce agency staff must renew training waivers each month, which increases administrative costs and creates some risk to HCTC coverage if an error takes place during monthly renewals. Moreover, for the second year of an eligible worker's TAA cash assistance (hence for HCTC coverage), participation in training programs is required, and waivers are not permitted. At that point, limitations on TAA training could deny HCTCs to some otherwise-eligible individuals.

Second, contrary to the author's earlier fears, ESC used effective procedures to reach UI recipients who qualified for HCTC because they met all requirements for TAA other than exhaustion of UI. Officials reported that, the vast majority of the time, state officials know in advance about firms making mass layoffs that are potentially trade-related; that TAA petitions are filed for the vast majority of such firms (by state officials, if necessary); and that these employers almost always provide lists of recently laid-off worker who potentially qualify for UI and HCTCs. State officials mail such workers information about events at which potential benefits (including HCTC) are discussed, and workers apply for HCTC by completing an application for TAA training or training waivers.

Difficulty affording the worker's 35 percent premium share

Whether from Blue Cross/Blue Shield, state agencies, private volunteers, unions, or other organizations, our interviewees agreed with virtual unanimity that far and away the most important factor limiting HCTC enrollment is that most eligible workers simply lack the money to pay the 35 percent of premium that is not covered by the credit. As one official from BCBSNC explained, "Affordability is the first, second, and third reason why so few eligible workers enroll." Across the board, informants agreed that, unless HCTC is increased substantially (in the opinion of one BCBSNC official, to cover at least 80 percent of premium costs), participation will remain quite low, no matter what other changes are made to the program.

Paying premiums while waiting for advance payment to start

Our interviewees likewise agreed that without something like the state's bridge program, a requirement to pay one or more months of premiums in full, before the start of advance payment, would prevent the vast majority of HCTC-eligible workers from enrolling. Even if HCTC refunds for the first few months' premium payments were furnished very quickly, that would not suffice, according to our informants, who were convinced that the vast majority of HCTC-eligible individuals lacked the resources to "front" full premium payments, even if they knew that a refund would soon become available.

While the state's bridge program went a long way towards solving this problem, the program had some glitches. For example, following the first month of bridge coverage, the beneficiary was required to bring each month's health plan invoice to the local One Stop Center to trigger the next bridge payment. This could be cumbersome and time-consuming, particularly considering workers' time spent in One Stop Center waiting rooms. This process also creates monthly opportunities for human error to cause unintended termination of health coverage.

In response to individual delays and confusion, state officials showed greatly flexibility in keeping people insured. When required, officials would take such steps as express-mailing a bridge payment to avoid a stoppage of health insurance or making out a 65 percent check to a worker who, by mistake, already paid the insurer a full month's premium. Such deviations from standard procedures provided another example of the laudable commitment by state officials to helping displaced workers retain health coverage. They did increase administrative costs, however. Administrative costs were also increased by the absence of an electronic system of transmitting information from IRS to state officials indicating when HCTC started for a particular beneficiary, triggering the transition off bridge coverage. Individualized intervention was required to obtain that information, at some cost to the state.

A different kind of glitch also happened during the transition from bridge coverage to HCTC advance payment. The two subsidy systems used different due dates for beneficiary contributions. Under the bridge program, beneficiaries typically paid their 35 percent share after the start of a given month of coverage. By contrast, for HCTC advance payment, beneficiaries made their 35 percent payments at least eight days before the start of a given month of coverage. Accordingly, during the final month of bridge coverage, a beneficiary was required to make two 35 percent premium payments – one for that month's bridge coverage and another for the following month's HCTC advance payment. Some HCTC beneficiaries without the necessary discretionary income to make both payments may have dropped coverage.

Finally, state officials were hamstrung by DOL's delays in approving extensions of the \$7.6 million NEG grant that funded the bridge program. DOL extended until the end of June 2004 the state's permission to spend the grant, which originally ran through the end of December 2003. As of late April, the state had spent only \$1.5 million, and, for several months, had not received an answer from DOL in response to its request for an extension permitting unspent NEG funds to be used for the bridge program after June 2004. This complicated the state's efforts to plan future strategies to enroll HCTC-eligible workers.

Cumbersome methods to start and modify advance payment and to solve problems

The following sections describe key procedural challenges to gaining and retaining coverage.

Beginning advance payment

Under national HCTC policy, IRS does not determine an individual's eligibility for advance payment of HCTC until two things happen: first, PBGC or an SWA must send IRS the individual's name electronically; and second, the person must apply for HCTC, attaching a copy of an invoice from the individual's qualified health plan (typically BCBSNC, in North Carolina).

Generally, this means that the individual must enroll in a qualified health plan and obtain an invoice before applying for HCTC advance payment. And in North Carolina, before the state sends the individual's name to IRS as potentially eligible for HCTC based on TAA eligibility, the worker must apply for TAA training or a TAA training waiver. If the worker wants to apply for bridge program coverage, the worker must complete an application for that program as well. The latter two applications take place via the local One Stop Center.

In addition, BCBSNC may need to know whether an individual is potentially eligible for HCTC in order to provide the right premium quote. That is because more favorable rating rules apply to high-risk HCTC beneficiaries than to other high-risk applicants for Blue Advantage coverage, as explained above. However, IRS does not provide information about particular individuals' HCTC status to BCBSNC electronically, because of concerns about confidentiality as well as an understandable preference for uniform national payment arrangements. Accordingly, many HCTC applicants must provide BCBSNC with documentation from IRS showing potential eligibility for HCTC.

In short, HCTC eligibility is not determined until a displaced worker has applied in three places: the SWA, the health plan, and IRS. The worker must also show some of these agencies the appropriate documents issued by other agencies, keeping straight who needs which pieces of paper. It is surely not surprising that many affected workers find this confusing.

This confusion is exacerbated both by the limited education of many workers and the situation facing workers shortly after job loss. While they cope with the shock and financial difficulties of unemployment, they are bombarded by myriad messages about options and benefits such as unemployment insurance, pension rights, job search assistance, job training, stress management strategies, SCHIP coverage for children, etc. In addition, most workers formerly receiving employer-sponsored insurance are unfamiliar with health insurance premium issues, because they are used to their employer working out necessary premium arrangements. All of these factors make it difficult for HCTC-eligible workers to absorb and act effectively on complex messages about how to navigate the HCTC enrollment process.

On a nationwide basis, IRS employed several strategies to address consumers' need for information and assistance. First, the IRS mailed each potentially eligible beneficiary a 20-page HCTC Program Kit explaining the program. Second, private contractors with IRS ran a consumer call center to answer questions and take applications for advance payment.

Unfortunately, these measures did not meet the needs of many displaced workers in North Carolina. Our respondents reported, with virtual unanimity, that the HCTC Program Kit was far too complicated for most HCTC-eligible workers to understand. Intimidation rather than comprehension was the common response among the target audience.

Obviously, the Kit fell even farther short with workers with limited English proficiency. In North Carolina, this included both Latinos and speakers of Asian languages. The Kit was available in

Spanish, but it is not clear how the HCTC program made sure that Spanish speakers were mailed the Spanish language version.

Respondents agreed that the consumer call center improved considerably during the initial months of program operation. The center was also lauded for the rapid access it provided to live humans, rather than multiple menus of recorded messages. However, most HCTC-eligible workers were intimidated by their experiences with the call center's staff, even after those improvements. A number of state officials called the line themselves to see how workers would be treated, and they found that many customer service staff did not take the time needed to walk workers patiently through the application process, step by step. In addition, staff at the call center typically did not use the kind of language that most displaced workers understood. Without substantial, additional assistance, it became clear to state officials that most workers would be unlikely to complete their applications for HCTC.

As a result of these factors, UNITE, local One Stop Centers, community volunteers, and health plan representatives all were deeply involved providing intensive, one-on-one assistance to potential HCTC beneficiaries, which allowed many otherwise befuddled workers to enroll. Even routine cases consumed considerable time, as displaced workers often did not understand group presentations but wanted a more private setting in which to ask questions. Frequently, application forms had to be filled out by expert helpers from the union, the state, BCBSNC, or private volunteer groups. Not infrequently, many hours had to be spent to straighten out problems with a particular worker's application.

All of this work was made more difficult by IRS policies concerning confidentiality. Even if an HCTC applicant gave permission for otherwise confidential information to be shared with a state worker, health plan staff, or volunteer so that person could help solve the applicant's problem, IRS and its contractors typically would not share information with anyone but the applicant. Staff at the One-Stop Center in Kannapolis sometimes had to have beneficiaries come to the office and participate on three-way calls that included the HCTC applicant, the One-Stop Center, and the HCTC program to diagnose and solve problems that could have been solved much more efficiently through a direct conversation between state outreach workers and HCTC program staff.

Changing advance payment

When circumstances affecting HCTC change, the worker is responsible for properly calculating the results and communicating them to IRS no later than the due date for the worker's 35 percent payment (that is, eight days before the start of the coverage month). If the worker does not discharge this duty properly, and the advance HCTC payment to the insurer is lower than it should be, the insurer must collect the balance from the worker, who receives no reimbursement until claiming the HCTC on year-end tax forms.

For example, if an HCTC beneficiary adds a newborn to the worker's health policy, the premium may go up. If the beneficiary does not inform IRS of the new premium amount sufficiently in advance of the next monthly HCTC disbursement, IRS bills the worker for 35 percent of the former premium amount (without the newborn on the policy), adds a credit equal to 65 percent of the old premium amount, and pays the insurer 100 percent of the former premium. To collect the difference between the old and new premiums, the insurer must bill the beneficiary directly.

In important ways, this approach represented a tremendous improvement, in both increasing coverage and limiting administrative costs, compared to IRS' initial policies for 35 percent premium payments that turned out to be too low. In such cases, IRS originally planned to terminate the beneficiary's advance payment option for the remainder of the calendar year. IRS then shifted to a system whereby advance payment ended if the 35 percent payment was too low, but the worker could re-enroll in advance payment during the same calendar year. By contrast, the approach in place by the time of our site visit kept advance payment in force while the insurer and beneficiary addressed premium shortfalls.

In January 2004, every HCTC beneficiary enrolled in BCBSNC experienced a premium change when the insurer implemented its annual, across-the-board premium increase for Blue Advantage. This increase averaged approximately 7 percent, but the precise numbers varied based on the enrollee's coverage option and individual characteristics. BCBSNC offered to inform IRS and its contractors about each beneficiary's new premium amount electronically. That way, IRS could follow its normal timeline and bill each beneficiary in early December for the new 35 percent share of premiums appropriate for January's insurance coverage. IRS and its contractors declined this offer, making clear that the plan should inform beneficiaries of new premium levels, and the beneficiaries in turn would be responsible for providing IRS with timely and accurate notice of the new premium amounts. Apparently, one reason for this decision was the understandable desire for uniform, nationwide procedures, which did not include this kind of accommodation to a particular state-qualified plan.

To help HCTC beneficiaries address this situation, from mid-November through mid-January BCBSNC dedicated eight specially trained customer service representatives to work with the company's HCTC members both proactively and in response to calls and complaints from consumers; most of their work fell into the latter category. In December, five BCBSNC customer service employees worked full-time to help HCTC beneficiaries address the changed premium amount and to fix emerging problems. Union staff, local One Stop community education workers, and community volunteers all were recruited as well to help HCTC beneficiaries deal with this annual change in premiums, answer consumers' questions, and prevent disruptions in coverage. Despite this intensive assistance, approximately 20 percent of previous HCTC beneficiaries dropped out of coverage at the time of the premium increase.

General problem-solving

Problems can surface in many ways, including simple errors and snafus. For example, advance payment could not be established for one HCTC beneficiary because his health insurance policy was in the name of his wife. In another case, advance payment ended because the insurer and HCTC had different understandings about the month for which a particular HCTC payment was intended.

In addition to such inevitable individual problems, several more global issues presented ongoing challenges. For example, as a matter of national policy, consumers enrolled in advance payment received two invoices for each month: one from both the health plan requesting payment of the full premium amount; and another from IRS requesting payment of the beneficiary's 35 percent share. Despite repeated communications from IRS and BCBSNC, many consumers failed to understand that, once advance payment began, they were required to pay the invoice from IRS but not the invoice from the plan. Some paid the plan's invoice alone and were terminated from

HCTC advance payment, at least temporarily. Others simply dropped out of the system in confusion after receiving multiple invoices for the same month.

Similarly, HCTC invoices have typically stated the date on which payment was due, without showing that the invoice was for the following month of coverage. As a result, some consumers mistakenly thought that these invoices were for the month of coverage in which they were due. This led some to not pay them, since they had already paid for that particular month's coverage. As a result, some were disenrolled.

Federal officials worked hard to prevent or solve such problems. Our informants reported that such officials, both at IRS and its contractors, were remarkably helpful and flexible. Many were willing to devote large amounts of time to helping individual beneficiaries enroll or remain in advance payment.

More systematically, to address problems created by agencies that certify eligibility, the HCTC program initiated a national, monthly audit process to ensure that eligible individuals were not wrongfully dropped from coverage. Under that procedure, if information from an SWA or PBGC seemed to show that a previously eligible individual no longer qualified, the national HCTC program initiated a discussion with the SWA or PBGC to see whether, in fact, the individual was eligible. This led to detection and correction of a number of erroneous terminations of HCTC.

However, when advance payment was disrupted for other reasons, IRS confidentiality requirements complicated efforts to solve problems. Rather than permit beneficiaries to authorize health plan or state staff or experienced volunteers to communicate with IRS on their behalf, beneficiaries were often required to diagnose problems on their own and obtain help, if necessary, by querying local experts or staff at the consumer call center. In many cases, this slowed the process of problem solving; increased administrative costs; or even caused losses in health coverage.

Implications of these cumbersome procedures

Given the structure of the current system, many HCTC-eligible individuals require substantial, one-on-one help enrolling in advance payment and staying current. This means that administrative costs per enrollee are likely to be quite high, on an ongoing basis. This could make it difficult to enlarge the HCTC model in its current form so that it can efficiently serve significantly larger numbers of beneficiaries.

Because of the burden the current system imposes on health plan staff, some BCBSNC officials indicated that they would prefer to receive a 65 percent HCTC from IRS and to bill beneficiaries for their 35 percent premium share. According to these officials, the resulting increase in administrative costs tracking separate payments would be far outweighed by the reduced costs of working through enrollees to diagnose and solve problems that emerge with the national HCTC office.

In addition, enrollment will remain low in places that, for whatever reason, do not devote the resources to enrollment assistance that were mustered in North Carolina. Even in North Carolina, not all HCTC beneficiaries benefited from the extraordinary services that many Pillowtex workers received in Kannapolis. A number of informants observed that the quality and extent of help furnished by One Stop Centers varied enormously from county to county. Other informants wondered whether, in response to layoffs much smaller in scale than the Pillowtex closure, the same kind of assistance would be available to affected workers. If not, take-up could be lower.

More globally, many health policy experts¹⁷ have noted that take-up of health coverage can be dramatically affected by the presence or absence of streamlined procedures for obtaining and retaining coverage. Some have pointed to remarkably different utilization rates of identical tax-sheltered retirement accounts depending on whether individuals must sign up on their own, can sign up at the workplace, or are automatically enrolled at their workplace unless they affirmatively opt out. In terms of health coverage, these analysts have noted that more than 95 percent of eligible seniors enroll in Medicare Part B because, unless they affirmatively opt out, they are placed in Part B and their premiums are automatically deducted from their social security checks. To summarize this research in a phrase, enrollment declines as effort is required. Unless the HCTC program is reformed to make enrollment and retention procedures much easier for beneficiaries to navigate, take-up is likely to remain low.

Inadequate resources for individual assistance

As the previous section made clear, enrolling North Carolinians into HCTC advance payment has been quite costly, per covered individual. Unfortunately, available federal resources have apparently paid only a small fraction of these costs. The HCTC statute authorized two types of NEG funding from DOL: infrastructure grants and bridge grants. North Carolina received a \$141,000 infrastructure grant that primarily served to fund the establishment of data systems that processed HCTC information. DOL has taken the position that, as a general rule, no more than 10 percent of actual bridge grant spending may cover administrative costs.¹⁸ By late April 2004, \$1.5 million of the bridge NEG had been spent on premiums, permitting roughly \$150,000 to be used for One Stop Center enrollment assistance and other administrative costs; actual administrative costs were, in all likelihood, much greater. Since September of 2003, the state has been asking DOL for permission to fund enrollment assistance either with unused bridge grant funds or through a new NEG grant. So far, DOL has not responded to these requests, leaving the state to use funds from other sources (including the general fund) to pay for enrollment assistance and case management needed for HCTC to function at even a basic level.

As is discussed above, North Carolinians outside state government have also devoted substantial resources to help laid-off workers navigate HCTC and obtain coverage. Such contributors include BCBSNC and UNITE as well as a number of philanthropists and volunteers. Plainly, a health coverage system that depends on such voluntary private donations as well as unreimbursed state general fund contributions to enroll eligible individuals into a federal income tax credit will have difficulty reaching its objectives.

Reactive approaches to enrollment

Except where unions or civic volunteers intervened, displaced workers were generally responsible, on their own initiative, to seek out necessary information and assistance from state officials or the HCTC call center. Some stakeholders viewed this as an appropriate allocation of individual responsibility. Others expressed the concern that this somewhat reactive approach to enrollment was unrealistic, given the financial and emotional stresses of job displacement, many workers' low level of education, and most workers' history of passively relying on their employer to take care of health benefits issues. Some stakeholders recommended that the state shift to more of a proactive, database-driven, customer service model, akin to marketing practices at many private sector companies. When such a company's database shows that a particular customer is not taking advantage of a potentially useful product or service, the company's sales staff takes the initiative to contact the consumer (via phone, mail, in-person

visit, or email) and encourage the customer to obtain the available product or service. Given the complex array of services intended for displaced workers, such a proactive approach may be the only viable method of assuring delivery, not just of HCTCs, but also of other TAA and related services, according to some stakeholders.

Obviously, such an approach for state agencies would increase administrative costs substantially. Nevertheless, it may be worth considering as an alternative to more automated enrollment strategies discussed above.

Coverage offered to HCTC beneficiaries in North Carolina

To ensure that workers laid-off by Pillowtex could quickly gain access to health coverage, state officials worked with BCBSNC to make existing Blue Advantage coverage available to HCTC beneficiaries, with relatively small modifications, none of which required state legislation. This section of the paper explores some of the advantages and disadvantages of the coverage offered by BCBSNC.

General commitment of BCBSNC

At every level, Blue Cross and Blue Shield of North Carolina was deeply involved in making the HCTC program as effective as possible for displaced workers and early retirees. The company's CEO quickly decided to develop state-qualified coverage, in response to a request from Governor Easley. As noted above, the company sought to help laid-off workers avoid coverage gaps by offering short-term coverage on terms that were certain to cost the company money – namely, a combination of community rating and guaranteed issue. Only a few hundred workers enrolled, but presumably they knew they needed services that cost more than the insurance premiums, in a classic adverse selection scenario that BCBSNC chose to endure for a short time. The company's offer of free prescription drug discount cards provided a valuable service to many more laid-off workers, most of whom expressed a need for prescriptions, with a monthly average cost above \$200. Also, the company's decision to eliminate the top two premium tiers for HCTC beneficiaries made coverage considerably less costly for these affected workers.

The CEO, other high-level officials, and mid-level staff made dozens of presentations to displaced workers explaining about Blue Advantage coverage and HCTC enrollment, often joining state officials at outreach events and enrolling workers into coverage on the spot. To supplement outreach efforts of state and federal officials, BCBSNC developed its own outreach brochures and mailed them to all Pillowtex workers. To ensure that Pillowtex workers retained continuous coverage, key-data-entry workers at BCBSNC volunteered to work evenings and weekends, including Sundays, which was virtually unprecedented. Customer service staff devoted large amounts of time to HCTC beneficiaries, far out of proportion to their representation among BCBSNC members. Other stakeholders repeatedly praised the company for its remarkable flexibility and creativity in addressing emerging problems. To give just one example, even though premium payments are normally due before the start of a coverage month, to make the bridge program work, BCBSNC agreed to accept, on a routine basis, premium payments during the middle of a coverage month and to provide coverage retroactively to the first of the month. Not only did BCBSNC train and dedicate staff to work specifically on the HCTC program, the company even revised its phone menu to give HCTC beneficiaries rapid access to these trained staff specialists.

In sum, Blue Cross and Blue Shield of North Carolina did a remarkable job helping vulnerable North Carolinians in a time of crisis.

Access to both comprehensive and catastrophic benefits, with most workers choosing broader coverage

HCTC enrollees were presented with sixteen coverage options. After the basic choice between Plans A and B, consumers could choose between four deductibles. In addition, women enrolling could choose whether to purchase maternity benefits. See Table 1, above.

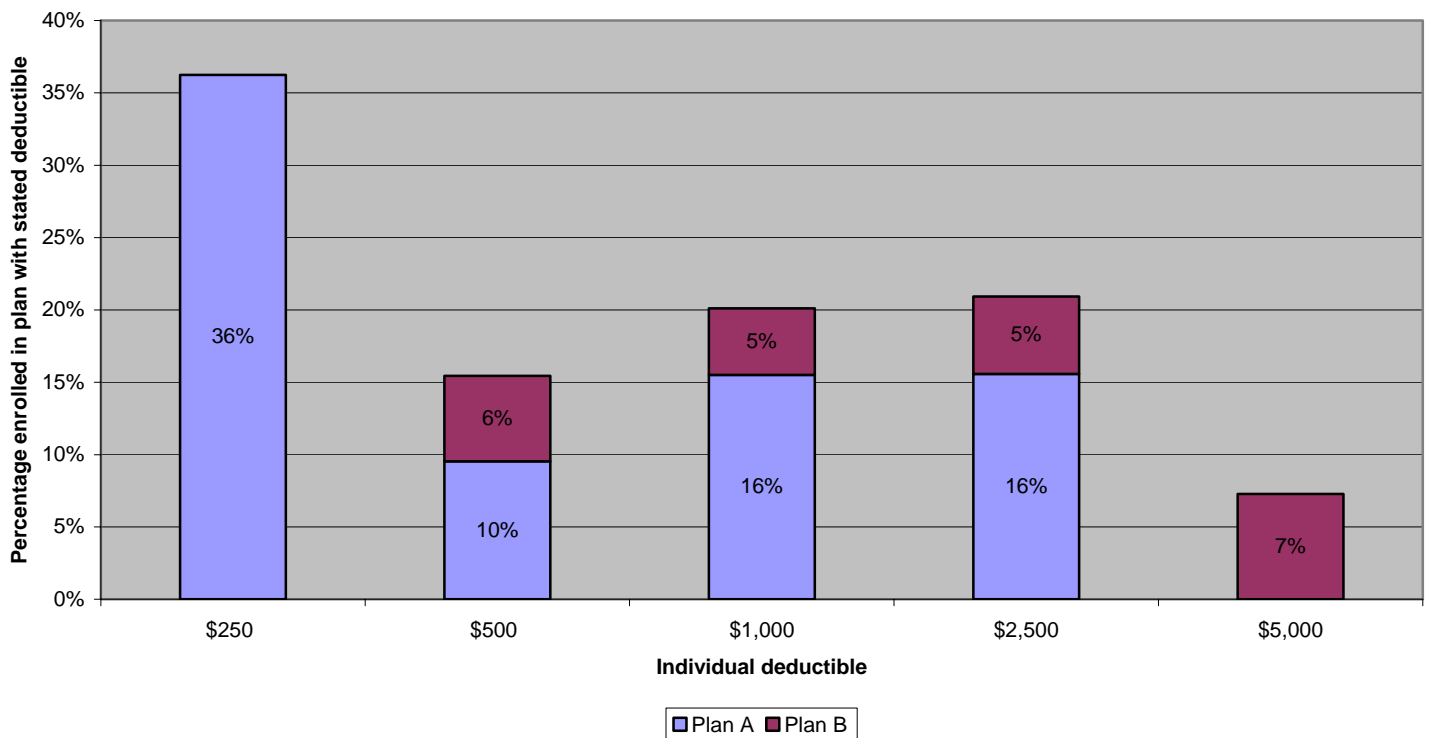
At one end of the continuum, Plan A's low-deductible options were quite comprehensive, with limited out-of-pocket cost-sharing. The main areas in which coverage departed significantly from average employer-sponsored insurance¹⁹ were maternity care, for which an additional premium was charged; mental health care, which had 50 percent coinsurance and an annual benefit cap of \$2,000 person; and prescription drugs, which likewise had a \$2,000 annual cap on benefits. Of course, these more comprehensive options had higher premiums attached, compared to other Blue Advantage choices.

At the coverage continuum's other end, the plans with the lowest premiums involved individual deductibles of \$2,500 or \$5,000; an additional \$200 deductible for prescription drugs; copayments and coinsurance of \$25-\$50 and 30 percent for in-network care and 30 to 40 percent for non-network care; and annual limits on out-of-pocket consumer spending of \$3,000 per individual and \$6,000 per family.

Presented with these diverse choices, workers could buy fairly comprehensive coverage that provided good access to most necessary health care (provided enrollees were willing and able to pay their share of premiums); but other consumers interested in health insurance primarily to protect their assets could do so, with considerable savings on premiums. For the median differential among the six enrollee profiles we surveyed (55-year-old and 25-year-old men, women buying maternity coverage, and women not buying such coverage), the most comprehensive plan cost 78 percent more than the least comprehensive plan. See Table 2, above.

Most HCTC beneficiaries chose more generous coverage, despite resulting higher premiums. Altogether, 77 percent enrolled in Plan A, and only 23 percent in Plan B. Between both plans, 52 percent of HCTC beneficiaries selected plans with \$250 or \$500 deductibles, as the following Chart shows.

Figure 6. Distribution of HCTC enrollees among Blue Advantage plans, February 2004.



How to read this chart: 36% of all HCTC enrollees in Blue Advantage were covered through Plan A with a \$250 deductible; 6% of such enrollees were in Plan B with a \$500 deductible; 10% were in Plan A with a \$500 deductible; etc.

Source: Blue Cross Blue Shield of North Carolina, May 2004. Calculations by ESRI, June 2004.

Before they learned the results of medical underwriting, an even larger percentage of HCTC beneficiaries requested the most comprehensive plans. Once BCBSNC provided actual premium quotes based on medical underwriting, many workers stopped pursuing coverage entirely, and others shifted to less generous plans.

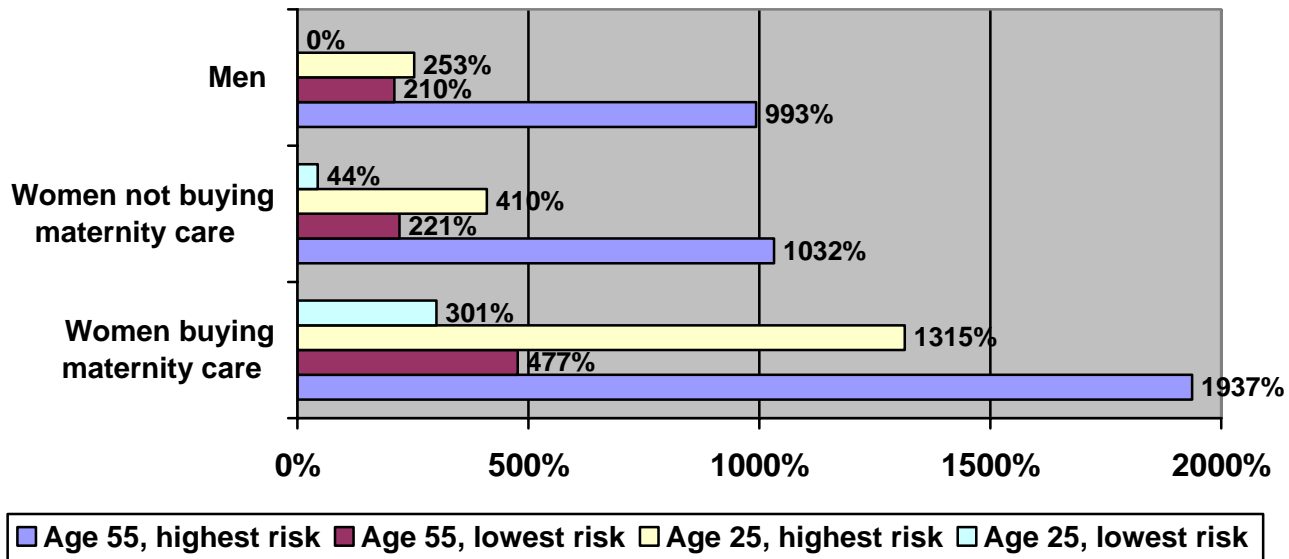
A number of workers interviewed for this report expressed strong dissatisfaction with the less comprehensive plans in which they ultimately enrolled because of premium costs. Until deductibles were satisfied, these plans did not cover any medical expenses. As a result, the workers we interviewed who enrolled in low-premium coverage went without some necessary health care because of its unreimbursed cost. For example, some adults with chronic illness did not refill maintenance medication that had been prescribed to prevent their conditions from worsening. Ultimately, some of these workers perceived their high-deductible coverage as so useless that they disenrolled.

Of course, we did not conduct any kind of random survey to analyze the extent of such dissatisfaction. Rather, this finding reflects a small number of interviews; more research is needed to see whether most HCTC beneficiaries who enrolled in less comprehensive plans shared these concerns.

Premiums that varied according to age, gender, and individual medical risk

As the following chart shows, premiums for the identical policy could vary greatly depending on age, gender, and an individual’s risk level as determined through medical underwriting.[†]

Figure 7. Compared to premiums for a 25-year-old man in the best risk tier, the increase in premiums resulting from differences in age, gender, and risk level: Average of all Blue Advantage options, June 2004



How to read this chart: Compared to premiums for a 25-year-old man in the lowest risk category, premiums for identical coverage were (on average for all Blue Advantage plans) 253 percent higher for a 25-year-old man in the highest risk category; 210 percent higher for a 55-year-old man in the lowest risk category; 993 percent higher for a 55-year-old man in the highest risk category; 44 percent higher for a 25-year-old woman in the lowest risk category not buying coverage for maternity care; 410 percent higher for a 25-year-old woman in the highest risk category not buying coverage for maternity care; etc.

Source: Source: Blue Cross and Blue Shield of North Carolina web site, June 28, 2004. Calculations by ESRI, July 2004, based on quoted Tier 2 premiums for residents of Wake County and BCBSNC information about risk tiers.

According to virtually all stakeholders, these differentials created tremendous dissatisfaction, especially those related to medical underwriting. It seemed unfair that health insurance was least affordable to those who needed it the most, particularly after a lifetime of hard work in the mills.

Resentment of these differentials was exacerbated, to some degree, by workers’ previous inexperience with employer-paid premium amounts and by the timing of BCBSNC rate quotes. As with all subscribers, HCTC applicants for Blue Advantage initially received premium estimates based on the company’s second-best risk tier, with warnings that actual premiums could vary, depending on the results of medical underwriting. Generally, 55 percent of purchasers in the nongroup market are in the two best tiers, according to BCBSNC officials. As noted above, most HCTC applicants were placed in the insurers’ highest risk tiers, resulting in serious “sticker shock” upon learning the actual, medically underwritten premiums. To be sure, this shock was much reduced by the company’s decision to abolish, for HCTC beneficiaries only, the top two premium tiers. Nevertheless, many displaced workers were quoted monthly

[†] Premiums also varied based on area of residence. We did not investigate this source of variation, however, as all our premium quotes were for the County that includes the state capital of Raleigh.

premiums that exceeded \$1,000 or even \$2,000 for a one-person policy and that many viewed as shockingly unaffordable, even with a 65 percent health insurance tax credit.

As the following Table indicates, 69 percent of HCTC workers who applied for Blue Advantage coverage dropped out of the application process after they received medically underwritten premium quotes, with the highest percentage of drop-outs among those placed in the highest risk category.

Table 4. Risk Levels of HCTC Applicants for and Enrollees into Blue Advantage Plans, October 2003- February 2004

Tier	Premium increase above lowest tier	Applicants		Enrollees	
		Number	Percentage of all applicants	Number	Percentage of applicants in tier
Preferred Plus	0%	333	10%	129	39%
Preferred	18%	943	29%	237	25%
Standard	53%	579	18%	242	42%
Basic – 4	135%	355	11%	140	39%
Basic – 5	253%	429	13%	228	23%
Basic – 6	n/a	92	3%	n/a	n/a
Basic – 7	n/a	466	15%	n/a	n/a
Total:		3,197	100%	976	31%

Notes: (1) Before enrollment began, the top two risk tiers (Basic-6 and Basic-7) were eliminated for HCTC beneficiaries. Applicants placed in those tiers were moved to Basic Tier 5 and given corresponding premium quotes. (2) Before starting medical underwriting, BCBSNC provided workers with premium estimates based on the Preferred tier, making clear that the actual premium could vary from the estimate, depending on the result of medical underwriting.

Source: Blue Cross Blue Shield of North Carolina, May 2004. Calculations by ESRI, June 2004

Continuous coverage and federal consumer protections

Interviewees reported that very few HCTC enrollees experienced gaps in coverage that placed them outside federal consumer protections. BCBSNC’s willingness to guarantee coverage starting on October 1, 2003 (if necessary, effective retroactively) played a critical role in achieving this result for Pillowtex workers. It is unclear whether similarly positive results have taken place with other lay-offs, however. Most informants agreed that, for both PBGC and TAA beneficiaries, more than 63 days typically pass between loss of job or pension and the start of HCTC advance payment. Obviously, the state’s bridge program prevents many workers from developing such coverage gaps.

One private sector policy that helped HCTC beneficiaries in North Carolina was BCBSNC’s decision to guarantee issue of Blue Advantage, for all applicants. The need for consumer safeguards, whether established by insurers or the government, was illustrated by BCBSNC’s conclusion that at least 40 percent of HCTC beneficiaries in North Carolina (compared to 15 percent of traditional applicants) would have been denied coverage on the basis of medical underwriting, were it not for the company’s decision to guarantee issue.²⁰

Fraudulent marketing by other insurers

A number of interviewees confirmed that, when public and private officials were conducting large outreach events for displaced Pillowtex employees, a number of insurers tried to market

non-qualified products to potential HCTC beneficiaries, misrepresenting the impact of HCTCs on those products. Insurance representatives stated falsely that, if HCTC beneficiaries would make initial premium payments of hundreds of dollars per month, writing the first month's check on the spot, HCTC would eventually reimburse 65 percent of those costs, and advance payment would ultimately become available to help pay ongoing premiums. These misrepresentations persuaded a number of displaced workers to part with scarce dollars, ultimately not receiving HCTC-reimbursable coverage. The amount of such fraudulent marketing appeared limited, and officials were apparently able to stop it, given the tight, centralized control over enrollment into state HCTC plans.

Conclusion

North Carolina's experience with HCTCs provides valuable lessons to guide the design of broader reforms. That experience strongly suggests that, for most low-income households to take up health insurance tax credits, such credits must cover significantly more than 65 percent of premiums. The opinions of North Carolina stakeholders and officials further suggest that such households cannot feasibly be asked to pay health insurance premiums in full while their eligibility for advance payment is being determined. Furthermore, much simpler, more highly automated application and troubleshooting procedures may be needed for a scaled-up advance payment program to have affordable administrative costs enrolling and retaining eligible households. Finally, risk-rated coverage can result in surprisingly wide discrepancies in premiums, based on factors like age and gender over which individuals have no control.

Much less clear are the implications of nongroup health insurance, with medically underwritten premiums, as a coverage vehicle for the uninsured. This analysis of North Carolina's program found wide agreement among policymakers and stakeholders that such coverage was problematic and generated great resentment, with some evidence that the underwriting of premiums cut enrollment substantially. Our limited interviews also suggested that individuals who, because of cost, selected the least expensive plans with large deductibles in fact went without some essential care because of those deductibles. On the other hand, using existing nongroup plans permitted state-qualified coverage to be offered rapidly enough to help workers affected by the state's largest layoff in history; the nongroup insurer (Blue Cross and Blue Shield of North Carolina) went to extraordinary lengths to help laid-off workers retain health coverage; and enrolling workers were presented with a broad choice of quite diverse health coverage options. In any event, additional empirical research is needed to understand what happens when, through the HCTC program, fully advanceable health coverage tax credits are used to buy nongroup coverage with medically underwritten premiums.

Of course, groups eligible for HCTCs – namely, displaced workers and early retirees – differ somewhat from other uninsured Americans. HCTC-eligible workers are more likely to be older, for example, and many (particularly among displaced workers) have suffered dramatic, short-term losses in income that may color decisions about whether and how to take up coverage. Nevertheless, certain aspects of designing health insurance tax credits, such as efficient and rapid mechanisms for advance payment, can benefit greatly from a careful analysis of HCTCs, which now provide the country's first experiment with fully advanceable federal income tax credits to cover uninsured Americans. And even such questions as the credit size needed for high take-up may benefit from studying the HCTC experience in states like North Carolina, where people moved mountains to help those in need, but accomplished much less than they had hoped for.

Notes

¹ 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>.

² Myra Beatty, Douglas Longman, and Van Tran. *Community Response to the Pillowtex Textile Kannapolis Closing: The "Rapid Response" Team as a Facilitative Device*. University of North Carolina, March 2004. http://www.unc.edu/depts/econ/PlantClosure/beatty_longman_tran.pdf.

³ Jim Cook, Director, Cabarrus County Division of Social Services. *Comments for the Joint Select Committee on Economic Growth and Development*. December 4, 2003. http://www.unc.edu/depts/econ/PlantClosure/cook_comments.pdf.

⁴ U.S. Department of Labor (DOL), Office of Public Affairs. *Labor Department Certifies Pillowtex Workers For Trade Adjustment Assistance*. September 9, 2003. <http://www.pillowtex.com/pr/pr030911.pdf>.

⁵ Emily Stover DeRocco. *Use of National Emergency Grant (NEG) Funds Under the Workforce Investment Act (WIA), as Amended, to Support Health Insurance Coverage Assistance for Trade-Impacted Workers*. Training and Employment Guidance Letter No. 20-02. DOL Employment and Training Administration, March 3, 2003. http://www.ows.doleta.gov/dmstree/tegl/tegl2k2/tegl_20-02.htm.

⁶ DOL. News Release: *Labor Secretary Elaine L. Chao Announces \$20.6 Million in Grants to Aid Pillowtex Workers in North Carolina*. August 15, 2003. <http://www.dol.gov/opa/media/press/eta/ETA2003436.htm>.

⁷ Blue Cross and Blue Shield of North Carolina. *BCBSNC, ScriptSave to Provide Pharmacy Discount Program for Pillowtex Workers*. August 28, 2003 News Release.

⁸ Blue Cross and Blue Shield of North Carolina. *BCBSNC Reduces Rates for Displaced Workers*. October 9, 2003 News Release.

⁹ Cook, op cit.

¹⁰ Deborah Chollet, Fabrice Smieliauskas, *Madeleine Konig. Mapping State Health Insurance Markets, 2001: Structure and Change*. Mathematica Policy Research, for AcademyHealth and The Robert Wood Johnson Foundation, September 2003.

¹¹ <http://www.bcbsnc.com/plans/blueadvantage/which.cfm>.

¹² HCTC Executive Scorecard for May 2004. June 22, 2004.

¹³ Paul C. Friday. *Long-Term Needs Assessment, Pillowtex Employees*. Prepared by Research and Training Specialists, Inc., for the Cabarrus County Community Development Corp. and The City Of Kannapolis. September 3, 2003.

¹⁴ Beatty, et al., op cit.

¹⁵ Memoranda from Russell Doles, Governor's Rapid Response Team Coordinator, to Steve Gold, Dislocated Worker Unit Supervisor, re Rapid Response with SKF USA, Inc., Franklin, North Carolina (Macon County) (dated February 6, 2004), Americal Corporation, Henderson, North Carolina (Vance County) (Dated February 20, 2004), Temple-Inland, Raleigh, North Carolina (Wake County) (dated March 22, 2004), and Schrader-Bridgeport, Monroe, North Carolina (Union County) (dated March 22, 2004).

¹⁶ See Stan Dorn and Todd Kutyla, *Health Coverage Tax Credits Under The Trade Act Of 2002: A Preliminary Analysis of Program Operation*, Economic and Social Research Institute, for The Commonwealth Fund and The Nathan Cummings Foundation, April 2004, http://www.cmwf.org/programs/insurance/dorn_tradeactfullrpt_725.pdf; and Stan Dorn, *How Can National Policymakers Improve Health Coverage Tax Credits Provided under the Trade Act of 2002?* Prepared by the Economic and Social Research Institute for The California HealthCare Foundation, May 2004, http://www.esresearch.org/newsletter/trade_act_options.pdf.

¹⁷ See, e.g., Dahlia K. Remler and Sherry A. Glied, "What Other Programs Can Teach Us: Increasing Participation in Health Insurance Programs," *American Journal of Public Health*, Vol 93, No. 1, January 2003, <http://www.ajph.org/cgi/content/abstract/93/1/67>; Lynn Etheredge, *Health Insurance Coverage At Transitions: What Works, What Doesn't Work*, Prepared for the Maryland Department of Health and Mental Health, State Planning Grant, April 11, 2003, <http://www.dhmmh.state.md.us/hrsa/pdf/LynnEtheredge.pdf>; James J. Choi, David Laibson, Brigitte Madrian, Andrew Metrick, *For Better or For Worse: Default Effects and 401(K) Savings Behavior*,

National Bureau of Economic Research Working Paper 8651, December 2001, <http://papers.nber.org/papers/w8651>. Calculations by ESRI, June 2002.

¹⁸ DeRocco, op cit.

¹⁹ Kaiser Family Foundation and Health Research and Educational Trust. *Employer Health Coverage: 2003 Annual Survey*. September 2003. (KFF/HRET 2003 Employer Survey) <http://www.kff.org/insurance/ehbs2003-1-set.cfm>.

According to this survey, employer-sponsored insurance (ESI) in 2003 had the following characteristic features:

- A deductible of \$275 for in-network and \$561 for nonnetwork care (average employer-sponsored PPO);
- No separate deductible for hospital care or prescription drugs (applicable to 56 and 92 percent, respectively, of workers with ESI);
- Prescription drug copayments of \$9 for generic drugs, \$19 for preferred name-brand drugs, and \$29 for nonpreferred name-brand drugs (average employer-sponsored PPO);
- Physician office visit copayment of \$15 or less (71 percent of workers with ESI);
- Coinsurance of 25 percent or less in network (91 percent of workers with PPO coverage through employers) and 39 percent or less out of network (65 percent of workers with such coverage);
- Annual coverage of at least 21 outpatient mental health visits (61 percent of workers with ESI);
- Annual coverage of at least 21 inpatient mental health days (71 percent of workers with ESI);
- Coverage of adult physicals (93 percent of workers with ESI), well-baby care (97 percent), maternity care (99 percent).

²⁰ Blue Cross and Blue Shield of North Carolina, October 9, 2003 release, op cit.