Issue BRIEF

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# The Trade Act Health Insurance Subsidy: An Update from the States

The Trade Adjustment Assistance Reform Act of 2002 (TAARA), signed into law on August 8, 2002, offers a substantial subsidy towards the purchase of particular types of health insurance coverage for certain workers or retirees who have lost their employer-sponsored health coverage. Although few individuals who have lost health insurance are currently eligible for the TAARA health insurance subsidy, an expanded program built on this model could help many more unemployed and uninsured individuals buy health insurance.

The TAARA subsidy is new, but some of its strengths and weaknesses are already evident. This Issue Brief analyzes the implementation of this new subsidy and suggests changes that might strengthen the existing program. It also answers the following questions:

1. What is the TAARA health insurance subsidy?
2. What types of health insurance coverage can the TAARA subsidy help purchase?
3. What types of plans have states designated?
4. What is the cost of health coverage in state-designated plans?
5. What types of health benefits do the designated plans provide?
6. Why have some states not yet designated a plan?
7. What consumer protections are offered in state-designated plans?
8. How are the types of coverage that automatically qualify—such as COBRA, spousal coverage, and continuation of individual coverage—working so far?
9. Are eligible individuals aware of this new program?
10. Are people enrolling in this new program?
11. What types of changes could be made to improve the TAARA health insurance subsidy program?

Note: In this report, we refer to the TAARA Health Insurance Tax Credit as the "TAARA health insurance subsidy" or simply as the "TAARA subsidy." The three federal agencies that administer this program—the Department of Labor, the Department of the Treasury, and the Department of Health and Human Services—refer to it as the "Health Coverage Tax Credit" or "HCTC." A more detailed description of the TAARA health insurance subsidy can be found in the Families USA Issue Brief, *The Health Insurance Tax Credit in the Trade Adjustment Assistance Reform Act of 2002*, which is available online at (http://www.familiesusa.org/site/DocServer/TAARA_brief_final.pdf).

FamiliesUSA
The Voice for Health Care Consumers

## 1. What is the TAARA health insurance subsidy?

TAARA offers a 65 percent subsidy towards the purchase of certain types of health insurance coverage for three groups of people and their spouses and dependents:

1. trade-displaced workers (Trade Adjustment Assistance [TAA] workers);
2. alternative trade-displaced older workers (Alternative Trade Adjustment Assistance [Alternative TAA] workers); and
3. Pension Benefit Guaranty Corporation (PBGC) retirees.[1]

Trade-displaced workers qualify for the TAARA subsidy as long as they are eligible for trade assistance cash benefits, which can last for up to three years. Alternative trade displaced workers can receive the TAARA subsidy for up to two years. PBGC retirees can receive the TAARA subsidy for up to 10 years.

This subsidy is delivered through the federal personal income tax system. Eligible beneficiaries can receive the TAARA subsidy either when they file their personal income tax return (as a tax credit) or have it sent directly each month to their health insurance providers (as an "advanceable" tax credit). If the individual chooses the "advanceable" option, he or she need only pay 35 percent of the premium cost each month. Even if the beneficiary owes little or no personal income taxes, he or she will still receive the full subsidy (called a "refundable" tax credit).

Estimates of how many people are eligible for the TAARA subsidy have fallen. In February 2003, three federal agencies estimated that 260,600 individuals nationwide were eligible for the TAARA subsidy.[2] In July 2003, the Department of Treasury estimated that 182,100 individuals nationwide were eligible.[3] When the February 2003 numbers were gathered, states relied on the numbers of individuals who had filed a Trade Adjustment Assistance (TAA) application. When the July 2003 numbers were gathered, states instead relied on the subset of individuals who were actually eligible for a Trade Readjustment Allowance (which requires that individuals are in training or receive a waiver of the training requirement).[4] However, none of these estimates includes spouses and dependents who are covered by the tax credit, so the actual number of eligible individuals is larger than the estimates.

Table 1: Estimated Number of Workers and Retirees Eligible for the TAARA Subsidy, by State[5]

| State | Total Eligibles, July 2003[6] | Total Eligibles, February 2002[7] | TAA Workers, February 2002 | PBGC Retirees, February 2002 |
|---|---|---|---|---|
| Pennsylvania | 17,800 | 20,000 | 8,400 | 11,600 |
| Ohio | 12,100 | 19,600 | 5,200 | 14,400 |
| Florida | 10,000 | 13,000 | 1,700 | 11,300 |
| Indiana | 9,600 | 9,700 | 5,100 | 4,600 |
| New York | 9,300 | 11,900 | 4,200 | 7,700 |
| North Carolina | 8,800 | 14,600 | 9,900 | 4,700 |
| Illinois | 8,200 | 11,900 | 4,800 | 7,100 |
| Texas | 7,300 | 15,500 | 10,700 | 4,800 |
| Massachusetts | 7,100 | 3,900 | 2,000 | 1,900 |
| Michigan | 7,000 | 7,500 | 4,000 | 3,500 |
| California | 6,000 | 14,300 | 7,100 | 7,200 |
| Georgia | 6,000 | 10,700 | 4,700 | 6,000 |
| Missouri | 5,700 | 6,500 | 1,300 | 5,200 |
| Alabama | 5,000 | 8,100 | 5,500 | 2,600 |
| Mississippi | 5,000 | 3,100 | 2,300 | 800 |
| Virginia | 4,900 | 6,700 | 3,800 | 2,900 |
| Tennessee | 4,700 | 9,000 | 4,700 | 4,300 |
| Wisconsin | 4,600 | 5,300 | 3,300 | 2,000 |
| New Jersey | 4,300 | 5,900 | 1,200 | 4,700 |
| Maryland | 3,900 | 1,200 | 100 | 1,100 |
| Minnesota | 3,300 | 4,900 | 2,800 | 2,100 |
| Arizona | 2,500 | 2,500 | 1,000 | 1,500 |
| Colorado | 2,400 | 1,800 | 500 | 1,300 |
| West Virginia | 2,400 | 1,700 | 700 | 1,000 |
| Kentucky | 2,300 | 4,200 | 2,900 | 1,300 |
| Washington | 2,200 | 11,600 | 10,300 | 1,300 |
| Connecticut | 2,100 | 2,600 | 1,100 | 1,500 |
| Oregon | 2,000 | 5,100 | 4,500 | 600 |
| Oklahoma | 1,800 | 3,400 | 2,400 | 1,000 |
| South Carolina | 1,800 | 5,200 | 3,400 | 1,800 |
| Iowa | 1,700 | 1,900 | 600 | 1,300 |
| Idaho | 1,500 | 1,100 | 800 | 300 |
| Arkansas | 1,300 | 3,000 | 1,700 | 1,300 |
| Maine | 1,000 | 1,600 | 1,300 | 300 |
| Utah | 900 | 600 | 300 | 300 |
| Kansas | 800 | 3,600 | 2,600 | 1,000 |
| Louisiana | 700 | 1,400 | 400 | 1,000 |
| New Hampshire | 700 | 1,300 | 800 | 500 |
| Nevada | 600 | 900 | 200 | 700 |
| Delaware | 400 | 200 | 0 | 200 |
| Hawaii | 400 | 600 | 0 | 600 |
| New Mexico | 400 | 600 | 300 | 300 |
| Rhode Island | 400 | 500 | 200 | 300 |
| Nebraska | 300 | 500 | 200 | 300 |
| Vermont | 300 | 500 | 300 | 200 |
| Montana | 200 | 100 | 0 | 100 |
| Alaska | 100 | 200 | 100 | 100 |
| North Dakota | 100 | 100 | 0 | 100 |
| South Dakota | 100 | 200 | 100 | 100 |
| Wyoming | 100 | 200 | 100 | 100 |
| Washington, D.C. | 0 | 100 | 0 | 100 |
| **TOTALS** | **182,100** | **260,600** | **129,600** | **131,000** |

## 2. What types of health insurance coverage can the TAARA subsidy help purchase?

Individuals who are eligible for the TAARA subsidy can purchase one of several particular types of health insurance. The following three types of coverage are automatically qualified for the TAARA subsidy:

1. coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) continuation provision,
2. certain coverage under a group plan available through the employment of the eligible individual's spouse, and
3. coverage under individual health insurance if the individual was covered during the entire 30-day period that ended on the day he or she became separated from employment.

In addition, states may designate another type of coverage for tax credit users who cannot enroll in any of the three types listed above. The following six types of health insurance coverage can be designated by states for TAARA subsidy purposes:

1. state-based continuation coverage;
2. coverage offered through a qualified state high-risk pool;
3. coverage under a health insurance program offered for state employees;
4. coverage under a state-based health insurance program that is comparable to the health insurance program for state employees;
5. coverage through an arrangement entered into by a state and a group health plan, an issuer of health insurance coverage, an administrator, or an employer; and
6. coverage offered through a state arrangement with a private sector health care coverage purchasing pool.

## 3. What types of plans have states designated?

As of early November 2003, more than half the states had designated plans. All 10 states with the highest number of eligible individuals will have designated plans for the TAARA health insurance subsidy by fall 2003.[8] States with low numbers of eligible individuals are also designating plans, even though this issue must compete for attention with other pressing health care issues. (Table 2 on page 20 provides a detailed snapshot of state-designated plans.)

**Four states—Florida, Maine, Michigan, and Pennsylvania—have designated coverage through an arrangement with a group health plan.**[9] All of these group plans are provided by Blue Cross and Blue Shield. Maine's group plan is administered by the State of Maine

Employee Health and Benefits Department, but it is a separate risk pool and provides a less costly benefits package than that of the state employees.

**Eight states—Indiana, Ohio, New York, North Carolina, Tennessee, Vermont, Virginia, and West Virginia—have designated coverage through an arrangement with an individual health plan.** Four of these states—Indiana, North Carolina, Ohio and Virginia—offer medically underwritten plans that charge individuals more because of health status. (Medical underwriting is the process insurance companies use to determine whether to accept an applicant for coverage and what the terms of the coverage will be, including the premium.) Vermont's individual plans are capped at a 20 percent rate increase per year and are also community rated, which means that health plan premiums do not vary based on age, gender, health status, or occupation.[10] New York's plans—two of which are provided through the Healthy New York program and two of which are provided through standard individual insurance polices—are all community rated.[11]

**Eleven states—Alaska, Arkansas, Colorado, Illinois, Maryland, Minnesota, Montana, New Hampshire, North Dakota, South Carolina, and Texas—have designated the state's high-risk pool.** These high-risk pools generally combine those who are eligible for the TAARA subsidy with other residents of the state who have a difficult time obtaining health insurance—mostly individuals with preexisting conditions that make them unattractive to conventional insurers because of the high costs associated with their health care. However, in some states, the high-risk pools are subdivided into different groups, which can be problematic. For example, in Illinois, the risk pool is divided into three separate plans: 1) the plan for TAARA-eligibles, 2) the plan for those eligible for insurance portability protection under HIPAA,[12] and 3) a plan for uninsurable people. Only the first plan has been designated for TAARA-eligibles, and it is available on a guaranteed issue basis with no preexisting condition exclusions. If TAARA-eligibles lose their TAARA consumer protections (because they have gone without health care coverage for more than 63 days), they are no longer eligible for the Illinois risk pool. If the TAARA-eligibles do not have COBRA or one of the other automatic options available, they will lose the ability to use the TAARA subsidy.[13]

**Four states—Nebraska, New Jersey, New York, and Ohio—have designated state-based, COBRA-type continuation coverage.** The federal COBRA law only applies to companies with 20 or more employees,

but 38 states have enacted so-called mini-COBRA coverage for workers in companies with fewer than 20 employees. The specific rules and regulations regarding the eligibility and length of state mini-COBRA coverage vary from state to state. These state provisions may help eligible individuals who worked in smaller firms and who thus are not eligible for federal COBRA.

## 4. What is the cost of health coverage in state-designated plans?

The affordability of plans depends on many factors. Some states have designated several plans through an insurer, and frequently one plan offers a more comprehensive benefit structure but has a higher monthly premium or a different deductible amount. Some of these plans base costs on factors such as the subscriber's age and whether the subscriber is single or is purchasing insurance for a spouse or children. Some plans' premiums also vary by county. (For more details, see Table 2 on page 20.)

States can modify the cost to the individual by altering the benefit structures of the designated plan. For example, in Maine, the cost of the plan was $479 a month for a single enrollee under the age of 40.[14] Because of a limited enrollment rate and ongoing discussions with eligible individuals about affordability, the state is in the process of modifying the plan—mostly by raising the deductible—so that it will be less expensive. The new monthly premium for TAARA-eligible individuals will be $273.[15]

On average, the new group plans that states have designated for the TAARA health insurance subsidy are more affordable than high-risk pool plans.[16] The group plans average about $417 a month for an individual before the TAARA health insurance subsidy and $146 after the TAARA health insurance subsidy kicks in.[17] The average monthly premium for 10 of the 11 states offering a high-risk pool plan is $680 before the tax credit.[18] Even with the advanceable credit, this still requires a monthly premium payment of $238. Even non-group plans can be more affordable than the high-risk pools. An average cost of the small number of individual market plans that do not medically underwrite is $420 a month for an individual before the TAARA subsidy and $147 after the subsidy.[19]

As mentioned above, in four states—Indiana, North Carolina, Ohio, and Virginia—the designated plans are underwritten based on health risk factors. The prices of these plans will depend, therefore, on the enrollees' health status and can be two or even three times higher if individuals have any serious health problems or a history of high

health care bills paid for by previous insurers. In some cases, the premium may even go up again when it comes time for the individual to renew the plan. These costs can be prohibitive for some individuals in less than perfect health.

**a. Some state-designated plans provide additional subsidies**

Some states have provided additional subsidies for qualified plans on top of the 65 percent federal subsidy. For example, in New York, the Healthy New York Plan is provided at a lower cost to low-income individuals who meet certain income requirements. The premiums are less costly because the state pays for 90 percent of claims when individuals have claims that cost between $5,000 and $75,000 in a given calendar year. Those meeting the Healthy New York income requirements may enroll in Healthy New York and receive the state subsidy and the federal subsidy towards its cost.[20] The cost of Healthy New York varies by county and by HMO, but it averages approximately $130 per month.

The Maryland Health Insurance Plan (MHIP), the state's high-risk pool, is subsidized by the state and costs substantially less than other risk pools. The cost of MHIP is $287 per month for a 55-year-old individual. This low cost is due in part to MHIP's funding base. MHIP is funded by hospital assessments, one of the broadest funding mechanisms of all the risk pools, because it is a tax on all hospital fees, including fees paid by fully insured, self-insured, government, and personal payers.[21] Many other risk pools are funded by assessments on insurance carriers, which do not constitute as broad an assessment base.

**b. Affordability of designated plans**

Experience thus far in many states has shown that it is very difficult for individuals to pay the full cost of premiums up front and wait for a tax refund at the end of the tax year. Therefore, the advanceable credit is critical to making the tax credit affordable. For example, few individuals in Maine were enrolling in the designated plan. Results from an informal focus group of eligible individuals revealed that the plan was too expensive: It cost $168 for an individual, $265 for an individual and a spouse, $351 for families, and $219 for an individual and children *with the TAARA subsidy*.[22] Individuals said that their family budget allowed them to spend only $100 a month on *family* health coverage with the TAARA subsidy.[23]

The Bethlehem Steel retirees in Maryland are a good example of the difficulty some retirees will have affording health insurance even with

the TAARA subsidy. Half of the Bethlehem Steel PBGC enrollees received pensions of between $6,000 and $10,780 a year.[24] However, very few PBGC enrollees in MHIP had incomes in this low range. For example, three-quarters (74 percent) of the PBGC enrollees in MHIP had annual incomes between $12,120 and $45,000, and only 5 percent had annual incomes in the range of half the Bethlehem Steel PBGC retirees ($6,000-$10,780).[25] For a worker with an annual pension of only $6,000 and no other income, the MHIP premium of $300 a month would be out of reach, even with a TAARA subsidy of $195 (65 percent of the cost). For such a worker, the $105 share of the premium would consume more than 20 percent of his or her annual income, leaving only $4,740 a year for housing, food, and all other expenses.

Unfortunately, the lead time required to be eligible for the advanceable credit has also been a barrier to many eligible individuals. Because of the 27-day lead time it takes to set up the advanceable payment mechanism, individuals generally have to pay 100 percent of the health insurance premium in the first month that they become eligible.[26] Many TAARA-eligibles cannot afford to pay a whole month's premium up front and therefore delay enrolling in health care.

States have been looking for solutions to this problematic delay, and some states have found creative solutions.

- North Carolina received a National Emergency Grant (NEG) to pay 65 percent of the first month's premium for eligible individuals and has recently extended this to two months for those who require more time to enroll in the advanceable tax credit.[27] NEG grants are available from the U.S. Department of Labor to provide health insurance coverage assistance and support services to eligible trade-affected workers and other eligible individuals, as specified in TAARA law.[28]
- Maine is considering approaching a local foundation to set up a revolving fund for individuals who would later refund the money when they received their tax refund.[29]

## 5. What types of health benefits do the designated plans provide?

Many of the plans offer comprehensive coverage and benefit packages.[30] Every plan, whether an individual or group plan or a high-risk pool, includes inpatient and outpatient care. The majority of plans also offer coverage for substance abuse, mental health care, home health services, and prescription drugs. However some plans don't cover important preventive, substance abuse, mental health, and maternity care, and some plans have problematic spending caps. In

addition, very few plans cover non-accidental dental and vision services. (For more information, see Table 3 on page 22.)

**Some of the designated plans do not offer some critical preventive services**. Of 11 high-risk pools, three—those in Alaska, Minnesota,[31] and South Carolina—do not offer preventive services like immunizations, gynecological exams, and periodic screenings for cancer. One of the designated plans in Michigan also does not cover some preventive services. Failure to provide coverage for these services could, in fact, result in increased state health expenditures in the future because diagnosis occurs at a later point in the disease process when more drastic and costly health measures must be taken.

**Some plans do not cover substance abuse and mental health treatment**. The high-risk pool in Montana does not cover treatments for substance abuse and chemical dependency and only covers treatment for certain mental illnesses. The low-income Healthy New York plan does not cover mental health or substance abuse treatment.[32]

**Several states' designated plans do not cover maternity care**. In Indiana, optional coverage for maternity services can only be elected at initial enrollment and not at renewal. In North Carolina and Ohio, coverage for maternity care is an option, but it costs extra.

**Some plans have also instituted problematic spending caps that could inhibit patients from receiving all the care they need**. The low-income Healthy New York plan has a $3,000 annual prescription drug cap.[33] Lifetime spending caps generally range from $1 million in Alaska and other states to a $5 million limit in Florida, North Carolina, and others. These caps are generous enough that most enrollees never reach their spending limit. However, some individuals with particularly costly conditions like hemophilia can reach their spending cap relatively quickly. Once this occurs, the plan will no longer pay for care, and the individual must find another resource.

Also, one designated plan in Ohio has enacted a "per cause" spending cap that severely limits the amount of money the insurer will pay each time the patient gets sick. The per-cause cap in this plan is $1,000 per illness and $2,500 per injury. This is problematic because if an individual enrolled in this plan breaks her hip, for example, the patient would be left with a bill that could run as high as $22,500, the remainder of both the inpatient and outpatient costs after the $2,500 benefit has been paid.[34]

## 6. Why have some states not yet designated a plan?

Many states with a low number of eligible individuals have not yet designated plans. Some states may have only recently turned their attention to designating a plan because recent layoffs and bankruptcies have rapidly increased the number of eligible individuals. Another reason for states' lack of response is that some states need to pass authorizing legislation in order to designate a plan, and many legislatures have been out of session in recent months when more information about the TAARA health insurance subsidy became available. Furthermore, this issue must compete for attention with the Medicaid budget crisis and other urgent health care issues facing governors and legislators.

In states where changes in the private health insurance market were already taking place, it was easier to designate a plan quickly. For example, Maryland was able to designate MHIP quickly because it was a new plan and it was easy to make changes to MHIP's consumer protections and other rules to comply with the federal TAARA guidelines. However, in North Carolina, a lengthier process was required to make changes to an already existing Blue Cross Blue Shield product, because Blue Cross had to change an existing computer system, educate its staff, and re-file the changes to the plan with the insurance department.

## 7. What consumer protections are offered in state-designated plans?

Under the federal TAARA law, four consumer protection requirements must be met when designating a plan: 1) guaranteed issue; 2) no exclusions for preexisting conditions; 3) nondiscrimination in premiums; and 4) nondiscrimination in benefits.[35] These consumer protections must be provided to all individuals who have *three months of prior creditable coverage without a substantial gap in coverage (63 days) at the time they seek to enroll in the designated plan*.[36] States may choose to strengthen these consumer protections by only designating as qualified those plans that provide better protection from discrimination in premiums and benefits.

Unfortunately, however, four states have already interpreted the consumer protection requirements in the TAARA law to mean that they can use medically underwritten individual market plans. Although some members of Congress believed that TAARA law would prevent states from designating these types of plans, the actual TAARA statute says that the premiums or benefits must be the same as those provided to a "similarly situated individual who is not a qualifying individual."[37] (This means that if you are eligible for TAARA, you cannot

be charged more than someone in the plan who is not TAARA-eligible who has the same medical status and history, age, etc.)

The disadvantage of using medically underwritten plans in the individual market is that affordable, comprehensive plans are usually only available to those who are young and in perfect health. Older beneficiaries, like many PBGC retirees, or those with even minor health problems must often pay very high premiums for plans that provide skimpy coverage. The cost of these medically underwritten plans could be two or even three times higher for an individual who has any serious health problems or a history of high health care bills paid for by previous insurers than for a healthier person.

In contrast, in order to improve access to health coverage, some states are providing consumer protections that are more generous than those required by federal law. For example:

- In Pennsylvania, the Blue Cross Blue Shield plans are offered on a guaranteed issue basis to all TAARA subsidy eligible individuals regardless of prior health coverage.[38]
- In Maryland, all eligible individuals, regardless of length of prior health coverage or gaps in coverage, were able to enter the state-designated plan until October 1, 2003 with no preexisting condition exclusion.[39] After October 1, a six-month preexisting condition exclusion was instituted for those who do not have three months of prior creditable coverage or have a gap in coverage of greater than 63 days.[40]
- In Maine, the state employee plan manages a TAARA-subsidy plan through Anthem. The plan policy paralleled the consumer protections available under TAARA, but Anthem has made exceptions on an ad hoc basis and provided coverage on a guaranteed issue basis with no preexisting condition exclusion for individuals who had long waits to get TAA benefits.[41]
- In Illinois, additional consumer protections were provided until October 1, 2003. Eligible individuals who had coverage in a qualified plan on December 1, 2002 (generally employer-sponsored coverage or COBRA)—regardless of gaps in coverage—were able to enter the state-designated plan with no preexisting condition exclusions.

- In Colorado, if the individual has been insured for at least six continuous months within 90 days of application to the designated plan, the preexisting condition period will be waived.[42] These longer enrollment periods are especially important for lower-income beneficiaries who need to complete the requirements to have the subsidy sent directly to health insurance providers each month.
- In Minnesota, the preexisting conditions of all TAARA-eligible individuals will be waived as long as they enroll in the plan *within 90 days* of termination of prior coverage, which is more generous than the federal 63-day maximum gap in coverage. This policy provides almost a month of extra time to individuals who need three weeks of lead time to enroll in the advanceable tax credit.[43]

## 8. How are the automatic types of coverage—such as COBRA, spousal coverage, and continuation of individual coverage—working so far?

**COBRA**

Federal COBRA legislation requires many employers to allow former workers to remain in the employer's group health plan for a fixed period of time—if the workers are able to pay the full cost of coverage. Workers laid off from firms with 20 or more employees can get 18 months of COBRA coverage for themselves and their family members. For certain TAARA-eligible individuals, the TAARA law extends the eligibility window for electing COBRA. Under this provision, if the TAA- or Alternative TAA-eligible individual did not elect COBRA coverage during the regular COBRA election period (60 days from notice), he or she may elect COBRA within the 60-day period that starts on the first day of the month when he or she is determined to be an eligible trade assistance recipient.[44] (However, such election may not be made later than six months after the day the worker lost health insurance coverage as a result of separation from employment that resulted in his or her becoming an eligible trade assistance cash benefits recipient.)

COBRA generally provides individuals who have lost their job or retiree health benefits with a generous benefit package in a plan that they already understand. However, COBRA can be costly even with the subsidy, it is not available to all TAARA-eligible individuals and, in some cases, it may be difficult to get COBRA administrators to participate in the advanceable tax credit.

Although COBRA is generally a costly option, the TAARA health insurance subsidy provides substantial help in making it affordable. The

average employer-based health insurance premium for family coverage, plus a 2 percent administrative fee, is $771 per month.[45] Thirty-five percent of that amount—the portion that would be paid by a TAARA health insurance subsidy recipient—is $270 a month. A monthly trade readjustment allowance (TRA—a cash benefit that mirrors unemployment insurance, which covers any living expenses, including health coverage) averages only about $1,040.[46] Therefore, unemployed workers who rely entirely on their trade readjustment allowance would spend slightly more than ***one-quarter*** of their income on health insurance. However, without the TAARA health insurance subsidy, the average unemployed worker would be paying ***three-quarters*** of his or her income on health insurance. In this context, the TAARA health insurance subsidy makes a large difference. However, for unemployed workers with a lower TRA benefit or a very modest pension, the cost of COBRA coverage can quickly become prohibitive.

Another problem with COBRA is that, when former employers go bankrupt, COBRA is generally not available to employees, or it is only available for a very short time. For example, in North Carolina, where Pillowtex went bankrupt, COBRA was available for only two months. National Steelworkers and retirees were offered COBRA for three to five months (from August 1, 2003 until October 31, 2003 for salaried [non-union] employees and from August 1, 2003 until December 31, 2003 for hourly [union] employees). When COBRA ends, such workers will need to have state-designated plans where they can use the TAARA health insurance subsidy.[47]

Furthermore, the advanceable tax credit option for COBRA is dependent on cooperation between COBRA administrators and the Internal Revenue Service. Many COBRA administrators have been helpful in setting up these arrangements. However, employers may discourage their COBRA administrators from participating. Employers generally think they lose money on COBRA because they believe that only sicker employees take up COBRA, which causes their insurance costs to rise. However, the TAARA tax credit might lessen these effects. The 65 percent TAARA subsidy may encourage more individuals—even healthier individuals—to take up COBRA, especially in states where they do not yet have any other options or do not have less expensive options.

**Spousal Coverage**

The TAARA subsidy may also be available to a worker or retiree through insurance provided by a spouse's employer, but only if the spouse's employer contributes less than 50 percent of the monthly premiums.[48] Unfortunately, few workers or retirees will be able to take advantage of this option, for two reasons. First, few employer plans pay less than 50 percent of the premium—the average percent of total premiums that employers paid in 2003 was 73 percent for family coverage.[49] Second, the TAARA subsidy for spouse's plans is not available on an advanceable basis, and few individuals can afford to wait until taxes are filed.

**Continuation of Individual Coverage**

The TAARA subsidy is available on an advanceable basis for those who had individual health insurance during the entire 30-day period that ends on the date that they became separated from employment.[50] The few individuals who had an individual policy rather than employer-sponsored coverage when they became unemployed are able to use the TAARA subsidy towards their individual coverage.[51]

## 9. Are eligible individuals aware of this new program?

Partnerships between federal agencies, state governments, labor unions, and nonprofit organizations have been critical in implementing, publicizing, and educating individuals about the TAARA health insurance subsidy.

- In Maryland, federal agencies in combination with MHIP, the Maryland Senior Health Insurance Program, and the Steelworkers and other unions have continued to hold many enrollment and outreach events. MHIP has also provided information to eligible individuals by mail and has advertised in all major Maryland newspapers for six weeks.
- In North Carolina, the "2-1-1" information system run by the United Way is being used get information out in affected localities. "2-1-1" is the national abbreviated dialing code for free access to health and human services information and referral services. The union also ran a call center where individuals could get information about health insurance options. In addition, forums have been held where representatives from the Health Coverage Tax Credit (HCTC—the entity that administers the program on a federal level), the designated Blue Cross Blue Shield plan, and others are available to help individuals enroll in the plans on the spot.[52]

- Pennsylvania, the state with the highest number of eligible individuals, provides an excellent model for providing outreach to workers and retirees. The Pennsylvania Department of Labor and Industry (PADOLI), the Pennsylvania Insurance Department, the Pennsylvania APPRISE program (a health insurance assistance program for seniors and people with disabilities), labor unions, and representatives from HCTC partnered to provide many outreach activities. The Pennsylvania Insurance Department worked to designate group plans for the tax credit. The APPRISE program joined with the insurance department, labor unions, and others at community forums to educate eligible individuals about their health insurance options. PADOLI and HCTC repeatedly sent information packets to all eligible individuals.[53] PADOLI and HCTC are also able to electronically compare the names in their respective databases to resolve any inconsistencies.[54] Finally, PADOLI has a rapid response team, so that when there is a trade act certification, they can advise individuals about the trade act. Individuals can apply for TRA and get training or receive an individual waiver so they can get cash benefits if training is not available or is not appropriate because the individual already has marketable skills.[55]

## 10. Are people enrolling in this program?

Since the advanceable tax credit has only been available in most states since August, it is difficult to determine the level of enrollment at this time. The federal agencies responsible for running the TAARA subsidy program do not yet have reportable data about how many people are electing the advanceable credit nationwide, and it will not be until after next tax season (April) that we will know how many people filed for the refundable tax credit in 2002. However, the HCTC call center is receiving many calls and tracking many hits to its Web site.[56] The HCTC team is beginning to put together data for public use, and some early data should be available late in 2003. The take-up rate is expected to be slow at first because of the many steps involved in enrolling individuals. Individuals must first learn about the program, then communicate with HCTC, make choices about their health plan, and fill out the relevant paperwork.

Some preliminary data are available at the state level. In Pennsylvania, more than 1,500 people took advantage of the advanceable credit in August 2003.[57] In Maryland, as of December 1, 2003, 494

TAARA-eligible individuals had enrolled in MHIP.[58] However, when many Bethlehem Steel retirees lost their health insurance in March 2003, many chose COBRA, which was immediately available. MHIP did not become available until July. In Maine, only about 100 people have enrolled in the TAARA plan, but this may grow substantially as the plan is modified and the costs are reduced.[59]

## 11. What types of changes could be made to improve the TAARA health insurance subsidy program?

As is, the TAARA health insurance subsidy is already helping many laid-off workers and retirees who have lost health insurance. However, many more people could be helped by the TAARA subsidy if the current TAARA law was amended. The following changes could help expand the availability of this program:

**a. The consumer protections should be strengthened to prevent health risk factor (medical) underwriting.**

Many states have interpreted TAARA law as allowing states to designate plans in the individual market as alternatives for the TAARA tax credit. As mentioned above, four states have already designated individual market plans that charge higher premiums for older individuals or individuals in less-than-perfect health. Few states regulate premium rates in the individual market, so these premiums can be very high; the cost of these plans may be two or even three times higher if the individual has any serious health problems or has had a history of high health care bills paid for by previous insurers. The premium may even go up again when it comes time for the individual to renew the plan.

Language in the TAARA statute should be strengthened to clearly prohibit states from designating individual market plans with premiums that vary based on health status so that health insurance coverage remains affordable for the must vulnerable unemployed workers.

**b. The 65 percent subsidy should be increased to help many unemployed and uninsured individuals.**

Even with a 65 percent subsidy, health insurance premiums remain too high for many low-income people to afford. A family receiving the subsidy would still have to pay about $270 per month, on average, for family coverage through COBRA. This amounts to more than one-fourth of an average unemployment insurance payment of $1,040 a month. As we know from the informal focus group in Maine and the income-based enrollment information from MHIP, low-income families coping with the additional financial strain of losing a job will find it very difficult to come up with the extra resources to take advantage of the health insurance subsidy.

A more generous subsidy would make it feasible for more workers and retirees to take advantage of the subsidy. Raising the subsidy to at least 75 percent would significantly increase the purchase of COBRA coverage by all workers, including low-income workers. A 2002 survey of COBRA-eligible workers found that 59 percent of all workers, and 37 percent of low-income workers, said they would be "very likely" to buy COBRA coverage if they received a subsidy in the range of 75 percent.[60]

Another approach might be to provide a variable subsidy level based on income. This would allow more help to be targeted to the people who most need assistance with the costs of health insurance.

**c. Individuals should receive assistance in the first month that they become eligible.**

As discussed above, there is a gap in time from when a worker becomes eligible for the TAARA tax credit to when the advance payments begin. The initial month of eligibility often requires the worker or retiree to pay 100 percent of the cost (and not recoup that expense until they get a tax refund at the end of the tax year) and wait until the second month to receive the advanceable tax credit.[61] This causes two problems. First, many individuals cannot afford to pay the entire monthly payment out of pocket. Second, if the individual cannot afford this monthly payment, he or she risks losing valuable consumer protections that can only be provided if he or she has a gap in coverage of less than 63 days when applying for benefits.

In the meantime, states have developed temporary solutions to this problem. For example, North Carolina applied for an NEG grant to allow the state to cover the 65 percent TAARA subsidy in the first month so that individuals will only have to pay 35 percent right away.[62] In Maine, officials are considering approaching a local foundation to set up a revolving fund that would pay the 65 percent for individuals up front. Individuals would later refund the money to the foundation when they received their tax refund.[63]

However, as a long-term solution to this problem, changes should be made on the federal level. First, the federal law could be changed so that the consumer protections would be provided to all individuals who have three months of prior creditable coverage (continuous coverage with no break of more than 63 days) *at the time they lose their job or retiree health insurance coverage* and not *at the time that they seek to enroll* in the designated plan (see d. on the next page for more information).

Second, the TAARA law could allow states to pay the first month's coverage (through an NEG grant or other source), and the federal government could refund the money directly to the state at the end of the tax year. Third, the Department of Treasury could provide a quick retroactive refund in the second month for the first month's payment.

**d. Eligible individuals should be allowed more time to enroll in health plans.**

The TAARA law has been interpreted to mean that the consumer protections must be provided to all individuals who have three months of prior creditable coverage (continuous coverage with no break of more than 63 days) *at the time they seek to enroll in the designated plan*. However, it often takes more than 63 days from the time an individual loses employment or retiree health benefits to learn about the TAARA subsidy, receive trade readjustment benefits, and enroll in the TAARA health insurance subsidy program. Also, most individuals eligible for the TAARA subsidy have been insured through work for long periods of time, and the only gap in coverage begins when they lose their job or retiree coverage. Therefore, the TAARA statute should be amended so that the consumer protections will be provided to all individuals who have three months of prior creditable coverage *at the time they lose their job or retiree health insurance coverage*, regardless of any gaps in coverage after that point. This change would allow more time for eligible individuals to enroll in plans that provide consumer protections.

**e. Younger spouses of Medicare-eligible individuals should be able to receive the TAARA subsidy.**

One problem with the current TAARA law is that spousal and dependent eligibility for the TAARA subsidy comes through the worker or retiree. When TAARA-eligible workers or retirees become eligible for Medicare, their younger spouses are not able to receive a TAARA subsidy. (Ironically, if an eligible PBGC retiree were deceased, then the pension would pass to the spouse, who would then be eligible for the TAARA subsidy). However, if the PBGC retiree is eligible for Medicare and alive, then the spouse is not eligible.[64] Many families are hurt by this limitation. For example, in Pennsylvania, a spouse of a Bethlehem Steel retiree took many medications, but her husband was of Medicare age, so she was not eligible for the TAARA subsidy. The couple had to sell their house to be able to afford health insurance coverage.[65]

The TAARA law should be amended to allow uninsured spouses and dependents of workers and retires who are eligible for Medicare to continue to receive the subsidy. This is of particular concern because, in some cases, pensions are reduced by PBGC, and the family also has to pay more for health insurance.

**f. Workers and retirees should be better able to use the TAARA subsidy to enroll in their spouse's employer's plan**.

The TAARA subsidy can be applied to insurance provided by a spouse's employer if the spouse's employer contributes less than 50 percent of the monthly premiums.[66] Unfortunately, few workers or retirees will be able to take advantage of this option for two reasons. First, few employer plans will meet this test, because the average percent of total premiums that employers paid in 2003 was 73 percent for family coverage.[67] Second, the TAARA subsidy for spouse's plans is not available on an advanceable basis, and few individuals can afford to wait for the annual refundable credit. In order to make this option more useful to individuals, the TAARA subsidy should also be available in cases where the spouse's employer contributes more than 50 percent. If not, the federal government will ultimately be paying more (65 percent of the cost of the more expensive share of the employer plan) when the employer would have instead assumed more of the cost for the individual. Spousal coverage should also be available on an advanceable basis in order to make it more affordable for families.

## Conclusion

The TAARA health insurance subsidy makes health insurance coverage much more affordable for the limited number of uninsured workers and retirees who are eligible for the program. However, an expanded program built on this model could help many more unemployed and uninsured individuals stay insured during a difficult time in their lives. The suggestions discussed above provide ideas about how the TAARA subsidy can be improved if it is expanded. For more information on how this program could be expanded, see *A Shelter in the Storm, How a Subsidy Could Help Unemployed Workers Get Health Insurance*, available online at (http://www.familiesusa.org/site/DocServer/TAARA_expansion.pdf?docID=2161).

Table 2: Types of Designated Plans as of November 4, 2003

| State | Type of Plan | Description of Plan | Monthly Premium (based on a 55- to 59-year-old male, non-smoker, individual plan, $1,000 deductible) | Factors Causing Premium Variations |
|---|---|---|---|---|
| **Alaska** | State High-Risk Pool | Alaska Comprehensive Health Insurance Association | $ 1, 022.00 | Age |
| **Arkansas** | State High-Risk Pool | Arkansas Comprehensive Health Insurance Pool | $ 786.67 | Age |
| **Colorado** | State High-Risk Pool | CoverColorado | Varies by county | Age, Gender, County, Smoker |
| **Connecticut** | TBA | Coming soon and expected to be the Connecticut Health Reinsurance Association (high-risk pool)[a] | n/a | n/a |
| **Florida** | Group Health Plan | Blue Cross/Blue Shield | Varies by county;[b] $660 in Miami, $492 in Hillsborough | Age, Gender, County |
| **Illinois** | State High-Risk Pool | Illinois Comprehensive Health Insurance Plan | $819.00 | Age, Gender |
| **Indiana** | Individual Health Plan | Blue Cross/Blue Shield | n/a | Health Status[c] |
| **Maine** | Group Health Plan | Anthem Blue Cross Blue Shield | $473 (current); $273 (new)[d] | Age |
| **Maryland** | State High-Risk Pool | Maryland Health Insurance Plan | $287.00 | Age |
| **Massachusetts** | TBA | Coming soon | n/a | n/a |
| **Michigan** | Group Health Plan | Blue Cross/Blue Shield | $407.04; Value Plan $307.60[e] | None |
| **Minnesota** | State High-Risk Pool | Minnesota Comprehensive Health Association | $340.48 | Age |
| **Montana** | State High-Risk Pool | Montana Comprehensive Health Association Plan | $610.00 | Age |
| **Nebraska** | State Continuation Coverage | Plan of former employer | n/a | n/a |
| **New Hampshire** | State High-Risk Pool | New Hampshire Health Plan | $560[f] | Age, Smoker |
| **New Jersey** | State Continuation Coverage | Plan of former employer | n/a | n/a |
| **New York** | State Continuation Coverage | Plan of former employer | n/a | n/a |
| | Individual Health Plans | 2 standardized individual plans offered by all NY state HMOs | n/a[g] | County |
| | | HCTC Healthy NY | $367.26 (Healthy NY, NY county) | County |
| | | Healthy NY (low-income) | $186.80 | County |
| **North Carolina** | Individual Health Plan[h] | Blue Cross/Blue Shield | n/a | Health Status |
| **North Dakota** | State High-Risk Pool | Comprehensive Health Association of North Dakota | $411.60 | Age |
| **Ohio** | Individual Health Plan | Kaiser | | Health Status[i] |
| | | Anthem | | Health Status |
| | | Aegis | | Health Status |
| | State Continuation Cov. | Plan of former employer | | n/a |

Table 2: Types of Designated Plans as of November 4, 2003 (continued)

| State | Type of Plan | Description of Plan | Monthly Premium (based on a 55- to 59-year-old male, non-smoker, individual plan, $1,000 deductible) | Factors Causing Premium Variations |
|---|---|---|---|---|
| **Pennsylvania** | Group Health Plan | Blue Cross/Blue Shield (regional plans) | $367.49 (average of regional options 1 and 2) | Region |
| **South Carolina** | State High-Risk Pool | South Carolina Health Insurance Pool | $1,072.42[i] | Age, Gender |
| **Tennessee** | Individual Health Plan | Blue Cross/Blue Shield | $687.71 | Age, Gender, Smoker |
| **Texas** | State High-Risk Pool | Texas Health Insurance Risk Pool | $822.08 | Age, Gender, County, Smoker |
| **Vermont** | Individual Health Plan | MVPHealth Plan | $443.10[k] | None[l] |
| **Virginia** | Individual Health Plan | Anthem Blue Cross/ Blue Shield | n/a | Health Status[m] |
| **West Virginia** | Individual Health Plan | Blue Cross/Blue Shield | $416.32 | None |

[a] Information from National Association of State High Risk Pools conference, October 2003.

[b] Florida's plan has a $500 deductible.

[c] In Indiana, when a policy is renewed, the premium increases will be based on the claim experience of the pool of people who bought the same policy. This means that rates will depend on the health of the entire pool of people with the policy, not the individual's health alone. www.healthinsuranceinfo.net, accessed on October 30, 2003.

[d] Maine's premium rate is for those under 40.

[e] Michigan's plan 1 has a $250 deductible, and the Blue Value plan has no deductible.

[f] New Hampshire's plan is based on a $1,500 deductible.

[g] The cost of these plans varies both by insurer and by county, so we did not provide the average.

[h] In North Carolina, when individuals renew individual coverage, premiums can increase substantially with age or as health declines.

[i] According to an official in the Insurance Department in Ohio, there is no reunderwriting at renewal.

[j] The South Carolina plan has a $500 deductible.

[k] Based on Vermont MVP Comp Care plan premium.

[l] All individual market products in Vermont are community rated. In Vermont, there is a maximum renewal increase of 20 percent. Conversation with Faye Mooney, State of Vermont Insurance Department, October 3, 2003.

[m] Conversation with a representative of the Virginia Department of Insurance, October 8, 2003. Virginia's dental coverage is optional and costs extra.

Table 3: Covered Benefits in Designated Plans[a]

| | Preventive Services | Maternity | Substance Abuse & Mental Health | Dental & Vision | Rx Drugs | Hospital Charges | Home Health | Outpatient |
|---|---|---|---|---|---|---|---|---|
| **High-Risk Pools (10)** | AR, CO, IL, MD, MT, NH, ND, TX, | AR, CO, MD, MN, MT, NH,[b] ND, SC, TX | AK, AR, CO, IL, MD, MN, NH, ND, SC, TX | ND | AK, AR, CO, IL, MD, MN, MT, NH, ND, SC, TX | AK, AR, CO, IL, MD, MN, MT, NH, ND, SC, TX | AK, AR, CO, IL, MD, MN, MT, NH, ND, SC, TX | AK, AR, CO, IL, MD, MN, MT, NH, ND, SC, TX |
| **Group Plans (4)** | FL, ME, MI,[c] PA | FL, ME, MI, PA | FL, ME, MI, PA | | FL, ME, MI | FL, ME, MI, PA | FL, ME, MI, PA | FL, ME, MI, PA |
| **Individual Plans (8)** | IN, NY, NC, OH,[d] VA, VT, WV | NY, OH,[e] VT, WV | IN, NY,[f] NC, OH, TN, VT, VA, WV | OH,[g] VA[h] | IN, NY, NC, OH, TN, VT, WV | IN, NY, NC, OH, TN, VT, VA, WV | IN, NY,[i] NC, OH,[j] TN, VT, WV | IN, NY, NC, OH, TN, VT, VA, WV |

**Notes:**

**High-Risk Pools**: Alaska, Arkansas, Colorado, Illinois, Maryland, Minnesota, Montana, New Hampshire, North Dakota, South Carolina, Texas

**Group Plans**: Florida, Maine, Michigan, Pennsylvania

**Individual Plans**: Indiana, New York, North Carolina, Ohio, Tennessee, Vermont, Virginia, West Virginia

**State-Based Continuation Coverage**: Nebraska, New Jersey, New York. We could not analyze the covered benefits in these state continuation coverage plans because they vary by employer. Therefore, we did not include them in the chart.

[a] In cases where more than one plan is designated in a state, unless otherwise noted, all of the plans offer coverage for the particular service.

[b] New Hampshire's maternity coverage is optional and costs extra.

[c] Only one of Michigan's Blue Cross Plans offer coverage—the Community Blue PPO Plan 3.

[d] Kaiser and Anthem only.

[e] Kaiser does not offer maternity coverage. Aegis offers maternity coverage. Anthem offers a maternity enrollment option that costs $328 per month.

[f] HCTC Healthy NY and the standard individual plans.

[g] Kaiser only.

[h] Virginia's dental coverage is optional and costs extra.

[i] HCTC Healthy NY and the standard individual plans.

[j] Kaiser and Anthem only.

## Glossary of Selected Terms

| | |
|---|---|
| **Alternative Trade Adjustment Assistance (Alternative TAA) workers** | Trade-displaced older workers who are at least 50 years old and who obtain other employment at a lower wage than earned in the adversely affected employment. |
| **COBRA** | The federal Consolidated Omnibus Budget Reconciliation Act of 1985. COBRA legislation requires many employers to allow former workers to remain in the employer's group health plan for a fixed pe riod of time if the workers are able to pay the full cost of coverage. Workers laid off from firms with 20 or more employees can generally get 18 months of COBRA continuation coverage for themselves and their family members. |
| **Guaranteed issue** | A requirement that insurers sell a policy to anyone who seeks one, regardless of preexisting conditions. |
| **Health Coverage Tax Credit (HCTC)**; see **TAARA Health Insurance Tax Credit** | The three federal agencies that administer this program—the Department of Labor, the Department of the Treasury, and the Department of Health and Human Services—use this term to refer to the health subsidy. |
| **High-risk pool** | An insurance pool of state residents who have a difficult time obtaining health insurance—mostly individuals with preexisting conditions that make them unattractive to conventional insurers because of the high costs associated with their health care. |
| **HIPAA** | The Health Insurance Portability and Accountability Act of 1996. This federal law is designed to help people buy and keep health insurance when they change jobs even if they have serious health conditions. The law limits the ability of health insurers to refuse to pay for preexisting conditions. An individual obtains HIPAA-eligible status once he or she has had 18 months of continuous creditable health coverage. In addition, he or she must not be eligible for Medicare or Medicaid, must not have other health insurance, and must apply for individual health insurance within 63 days of losing prior coverage. No matter where a person lives in the U.S., HIPAA-eligible individuals must be offered at least some type of individual health plan with no preexist ing condition provisions. |
| **Medical underwriting** | The process insurance companies use to determine whether to accept an applicant for coverage and what the terms of the coverage will be, including the premium. This process takes into account such factors as age, current health conditions, and medical history. |

| | |
|---|---|
| **Mini-COBRA coverage** | State programs that provide COBRA coverage to eligible individuals who work in firms with fewer than 20 employees and who thus are not eligible for federal COBRA. The federal COBRA law only applies to companies with 20 or more employees, but 38 states have enacted so-called mini-COBRA coverage. The specific rules and regulations regarding the eligibility and length of mini-COBRA coverage vary from state to state. |
| **National Emergency Grants** | Grants available from the U.S. Department of Labor that enable states to provide health insurance coverage assistance and support services to eligible trade-affected workers and other eligible individuals. |
| **Pension Benefit Guaranty Corporation (PBGC) retirees** | For the purposes of this Issue Brief, individuals who receive any portion of their pension benefits from the PBGC and who are age 55 or older. |
| **TAARA Health Insurance Tax Credit** | The subsidy that TAARA legislation provides to certain workers or retirees who have lost their employer-sponsored health coverage due to trade practices. Also known as the TAARA health insurance subsidy or simply as the TAARA subsidy. |
| **Trade Adjustment Assistance Reform Act of 2002 (TAARA)** | Signed into law on August 8, 2002, TAARA offers a substantial subsidy towards the purchase of particular types of health insurance coverage for certain workers or retirees who have lost their employer-sponsored health coverage due to increased imports or trade-related relocation. |
| **Trade Adjustment Assistance (TAA) Workers** | Trade-displaced workers who have worked for employers that are directly affected by increased imports or a shift in production to another country, as well as employees that are secondarily affected as suppliers or "downstream producers" (for example, parts suppliers or assembly plants) of directly affected employers. Such workers are eligible for trade assistance cash benefits, which can last for up to two years. |
| **Trade Readjustment Allowance** | A cash benefit available to trade-affected workers that mirrors unemployment insurance. To be eligible for a TRA, individuals must be in training or have received a waiver of the training requirement. |

## Endnotes

[1] Trade-displaced workers have worked for employers that are directly affected by increased imports or a shift in production to another country, as well as employees that are secondarily affected as suppliers or "downstream producers" (for example, parts suppliers or assembly plants) of directly affected employers. Such workers are eligible for trade assistance cash benefits, which can last for up to two years. Alternative trade-displaced workers are individuals who are at least 50 years old and who obtain other employment at a lower wage than earned in the adversely affected employment. PBGC retirees are individuals who receive any portion of their pension benefits from the PBGC and who are age 55 or older.

[2] See U.S. Department of Health and Human Services, U.S. Department of Labor, Internal Revenue Service, *Guidance for Elections of Qualified Health Insurance*, February 2003, on file with the authors.

[3] Department of the Treasury, Office of Public Affairs, *Potentially Eligible Populations Based on July 2003 Estimates*, July 31, 2003, available online at (http://www.ustreas.gov/press/releases/reports/js6231.pdf). The July 2003 data do not provide a TAA/PBGC breakdown.

[4] Conversation with Pete Cope and Ken Wright, Pennsylvania Department of Labor and Industry, September 23, 2003.

[5] These estimates do *not* include spouses and dependents who are covered by the tax credit, so the total number of eligible individuals is actually larger.

[6] Department of the Treasury, Office of Public Affairs, *Potentially Eligible Populations Based on July 2003 Estimates*, op. cit.

[7] U.S. Department of Health and Human Services, U.S. Department of Labor, Internal Revenue Service, *Guidance for Elections of Qualified Health Insurance*, op. cit.

[8] Based on July 2003 estimates provided by the U.S. Department of Treasury. Massachusetts's plan is likely to be designated in fall 2003. The delay most likely occurred because the population of TAARA subsidy eligible individuals in Massachusetts grew only recently.

[9] Note, some states offer more than one health plan option.

[10] Conversation with Faye Mooney, State of Vermont Insurance Department, October 3, 2003.

[11] Conversation with Patricia Swolak, New York Insurance Department, October 16, 2003.

[12] The Health Insurance Portability and Accountability Act (HIPAA) was passed in 1996 to help people buy and keep health insurance, even when they have serious health conditions. The law sets a national floor for health insurance reforms. An individual obtains HIPAA-eligible status once he or she has had 18 months of continuous creditable health coverage. To be HIPAA-eligible, an individual must have used up any COBRA or state continuation coverage, must not be eligible for Medicare or Medicaid, must not have other health insurance, and must apply for individual health insurance within 63 days of losing prior creditable coverage. No matter where a person lives in the U.S., HIPAA-eligible individuals must be offered at least some type of individual health plan with no pre-existing condition periods. In many states, this plan is the high-risk pool.

[13] Conversation with Illinois Comprehensive Health Insurance Plan staff, October 10, 2003.

[14] Conversation with Ellen Schneiter, Deputy Director, Governor's Office of Health Policy and Finance, September 24, 2003.

[15] Ibid.

[16] In order to best compare plans across states, whenever possible, the plan with a $1,000 deductible was used in this comparison. The monthly premium rate for a 55- to 59-year-old male purchasing health insurance only for himself was also used whenever possible. Most states offer a plan fitting these criteria, but a $750 deductible plan was used in Colorado and a $500 deductible plan was used in South Carolina because a $1,000 deductible plan was not offered. To make premiums more affordable, Maine recently changed its policy from a plan with a $1,000 deductible to one with a $5,000 deductible.

[17] Rates calculated from information provided on state Blue Cross/Blue Shield Web sites and a conversation with Richard Robleto, Chair of the Florida Bureau of Life and Health, Forms and Records, September 25, 2003.

[18] For a 55-year-old male with a deductible of $1,000. From states' high risk pool Web sites. We did not include Colorado because information was not available from the state in a compatible format.

[19] This cost is based on the average cost per individual of Healthy NY, HCTC Healthy NY, Blue Cross/Blue Shield in Tennessee, MVP Health Plan in Vermont, and Blue Cross/Blue Shield in West Virginia.

[20] New York State Insurance Department, *Information on Federal Health Coverage Tax Credit for TAA and PBGC Recipients, Introducing the Federal Health Coverage Tax Credit (HCTC)*, available online at (http://www.ins.state.ny.us/hnyfedtx.htm).

[21] Code of Maryland Regulations, 31.17.03.07. Presentation by Richard Popper, MHIP, at High Risk Pool Conference, October 9, 2003.

[22] Conversation with Ellen Schnieter, op. cit.

[23] Conversation with Ellen Schnieter, Deputy Director, Governor's Office of Health Policy and Finance, September 21, 2003.

[24] United Steelworkers of America chart of retirees by monthly pension benefit received.

[25] Maryland Health Insurance Plan enrollment as of October 15, 2003.

[26] The TAARA health insurance subsidy billing cycle can take up to 27 days before the payment date as it appears on the invoice from the health plan administrator. Health Coverage Tax Credit, *The August 1, 2003 Implementation: A Readiness Communication to the Health Plan Administrator Community* 2003 (Washington: U.S. Department of Treasury, August 2003).

[27] Conversation with Phil Telfer, North Carolina governor's office, September 17, 2003.

[28] U.S. Department of Labor Web site at (http://www.doleta.gov/tradeact/2002act_index.cfm).

[29] Conversation with Ellen Schnieter, Deputy Director, Governor's Office of Health Policy and Finance, September 24, 2003.

[30] This information was compiled by examining benefit summaries or by phone conversations with plans, unless otherwise indicated.

[31] Minnesota's high-risk pool does offer coverage for influenza and pneumococcal vaccines, as well as screenings for cancer, but not other preventive services.

[32] New York State Insurance Department, *Introducing the Federal Health Coverage Tax Credit (HCTC)*, op. cit.

[33] Ibid.

[34] Wright Medical Technology Web site (www.wmt.com), accessed on November 18, 2003.

[35] 26 USC 35 (e)(2).

[36] By contrast, the Health Insurance Portability and Accountability Act (HIPAA) provides slightly different consumer protections and often provides entry into a different type of health insurance program. To be eligible for HIPAA, an individual must have had 18 months of continuous creditable health coverage, used up any COBRA or state continuation coverage, be ineligible for Medicare or Medicaid, have no other health insurance, and must apply for individual health insurance within 63 days of losing prior creditable coverage.

[37] 26 USC 35 (e)(2)(A)(iii).

[38] Conversation with Geoff Dunaway, Pennsylvania Insurance Department, September 16, 2003.

[39] Conversation with Richard Popper, op. cit.

[40] Maryland is considering changing the six-month preexisting condition exclusion to three months for TAARA subsidy eligible individuals. Conversation with Richard Popper, Maryland Health Insurance Plan, September 17, 2003.

[41] Conversation with Ellen Schnieter, Deputy Directory, Governor's Office of Health Policy and Finance, September 24, 2003.

[42] Communicating for Agriculture, *Comprehensive Health Insurance for High Risk Individuals* (Fergus Falls, MN: Sixth Edition 2002/2003).

[43] Communicating for Agriculture, op. cit.

[44] 26 USCA 4980B(f)(5)(c) and 26 USCA 4980B(f)(5)(c)(IV)(II).

[45] The Henry J. Kaiser Family Foundation and Health Research and Educational Trust, *Employer Health Benefits, 2003 Annual Survey* (Menlo Park, CA: Henry J. Kaiser Family Foundation, 2003).

[46] Trade Readjustment Allowance benefits mirror unemployment insurance benefits. U.S. Department of Labor, Employment and Training Administration, State UI Program Data, U.S. Totals (for month ending July 31, 2003), available online at (http://workforcesecurity.doleta.gov/unemploy/claimssum_us.asp).

[47] Note, if individuals elect and exhaust the COBRA available to them, most will have guaranteed access to a HIPAA plan, but these plans are generally expensive and are not necessarily the plans that are designated for the TAARA health insurance subsidy.

[48] Definition of eligible coverage month 26 U.S.C. s35 (b) (2003). Definition of specified coverage 26 U.S.C. S. 35(f) (2003).

[49] The Henry J. Kaiser Family Foundation and Health Research and Educational Trust, *Employer Health Benefits, 2003 Annual Survey* (Menlo Park, CA: Henry J. Kaiser Family Foundation, 2003), p.83.

[50] 26 U.S.C. s 35(e)(1)(J) (2003).

[51] Conversation with Stephen Finan, Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services, September, 17, 2003.

[52] Conversation with Phil Telfer, op. cit.

[53] Conversation with Pete Cope and Ken Wright, Pennsylvania Department of Labor and Industry, September 17, 2003.

[54] Ibid.

[55] Ibid.

[56] Conversation with Stephen Finan, op. cit.

[57] Conversation with Geoff Dunaway, op. cit.

[58] Maryland Health Insurance Plan enrollment as of October 15, 2003.

[59] E-mail from Ellen Schnieter, Deputy Director, Governor's Office of Health Policy and Finance, September 30, 2003.

[60] Jennifer Edwards, Michelle M. Doty, and Cath Schoen, *The Erosion of Employer-Based Health Coverage and the Threat to Workers' Health Care: Findings from the Commonwealth Fund 2002 Workplace Health Insurance Survey* (New York: The Commonwealth Fund, August 2002).

[61] Conversation with Richard Popper, op. cit.

[62] Conversation with Phil Telfer, op. cit.

[63] Conversation with Ellen Schnieter, Deputy Director, Governor's Office of Health Policy and Finance, September 24, 2003.

[64] Conversation with Richard Popper, op. cit.

[65] Conversation with Geoff Dunaway, op. cit.

[66] Definition of eligible coverage month 26 U.S.C. s 35 (b) (2003). Definition of specified coverage 26 U.S.C. S. 35(f) (2003).

[67] The Henry J. Kaiser Family Foundation and Health Research and Educational Trust, *Employer Health Benefits, 2003 Annual Survey* (Menlo Park, CA: Henry J. Kaiser Family Foundation, 2003), p. 83.

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