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Health Insurance
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Health insurance provides compensation for medical expenses incurred from illness or accident. Hospital confinement, surgery, medical care, and diagnostic examinations have been included in various health insurance plans. Most Americans have some health insurance.

While the quality, accessibility, and availability of health care and health insurance coverage have significantly improved over the years, a number of problems and issues remain--escalating medical care costs, groups with no protection against the basic costs of medical care, and limited access to health resources and services.

This Info Pack includes information on various health insurance programs, national health insurance, catastrophic health insurance, and provisions of Title X of the Consolidated Omnibus Budget Reconciliation Act (COBRA).

Members of Congress who want further information on this topic may contact CRS at 707-5700. Additional CRS Reports may be identified by looking in the current *Guide to CRS Products* (for congressional use only) under "Health Insurance" and in the latest *Update* under "Health."

Additional information, primarily in periodicals and newspapers, may be found at a local library through the use of such indexes as the *Readers' Guide to Periodical Literature*, Public Affairs Information Service *Bulletin* (PAIS), and various newspaper indexes.

We hope this information will be helpful.

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CRS Issue Brief

Mandated Employer Provided Health Insurance

Updated June 1, 1990

by
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CONTENTS

Mandated Employer Provided Health Insurance

SUMMARY

Between 31 and 37 million Americans under the age of 65 lack health insurance. Recent estimates have drawn special attention to the working uninsured: over 80% of the uninsured are employed or live in families of workers.

The increased number of uninsured has occurred when changes in reimbursement policy by private insurers and the Federal Government have made it harder for hospitals to shift the costs of treating the uninsured to privately insured patients. Consequently, access to health care for persons lacking insurance is a growing concern. These developments have led to new congressional interest in the problems of the medically uninsured. Faced with substantial Federal budget deficits and diminished interest in Government-financed solutions, Congress has begun to look to employers as a potential source of expanding access to health insurance coverage.

Under one approach gaining some support in Congress, the Federal Government would mandate that employers provide health insurance coverage and/or specific health benefits to their employees and to their employees' families. There is, however, substantial controversy over this approach. Proponents argue that providing health insurance is an employer's responsibility. They say that the costs of providing care to uninsured workers are being shifted by health care providers to those employers who provide and pay for health insurance. Opponents of mandated employer-provided insurance argue that it is not an employer's responsibility to provide health insurance. They say that many employers, especially smaller ones, cannot afford to offer insurance. Opponents also argue that the added costs of health insurance would reduce employers' ability to compete, harming the overall national economy.

As a result of past actions by Congress, employers who offer health insurance have to conform to specific requirements affecting the nature of their health insurance plans and the entitlement to those plans. Most larger employers have to offer their employees the option of becoming members of federally qualified Health Maintenance Organizations. Also, employers are prohibited from discriminating in employee benefit plans on the basis of disabilities arising on account of pregnancy. Certain employers have to offer Medicare-eligible workers and their spouses the option to elect the employer's health plan as their primary source of insurance. Finally, certain employers required to make available continued health insurance coverage to qualified employees and their families who would otherwise lose coverage as a result of specific events.

In the 101st Congress, bills have been introduced to expand access to health insurance by mandating that employers provide basic health insurance. One such bill, the "Basic Benefits for All Americans Act of 1989" (S. 768) has been voted out of Committee and is awaiting action by the Senate. Other proposals, placing new requirements on employers, may also be considered.

ISSUE DEFINITION

Most Americans have health insurance coverage through private group plans offered by their employer or through the two major Federal Government financed programs, Medicare and Medicaid. A much smaller number of Americans purchase individual policies through the private health insurance market. However, between 31 and 37 million Americans have no health insurance coverage. Moreover, the percentage of uninsured Americans has been climbing, increasing by some estimates by as much as 20% for the under age 65 population between 1979 and 1986. Recent U.S. Census Bureau estimates have drawn special attention to the working uninsured: over 80% of the uninsured are employed or live in families of workers. For these Americans, employment or connection to employment through a working family member has failed to result in coverage under a health insurance plan.

The increased uninsured population has occurred when changes in the reimbursement policies of private insurers and the Federal Government have made it more difficult for hospitals to shift the costs of treating the uninsured to privately insured patients. Consequently, there is growing congressional concern about decreased access to health care for persons lacking insurance. In search of a solution that will not result in major Federal spending, Congress has turned to employers as a potential source of expanding access to health insurance coverage. In past years, Congress has mandated that employers who offer health insurance to their workers must meet specific requirements affecting the nature of their health insurance plans and the entitlement to those plans. In the 101st Congress, legislation is being considered to mandate that employers provide basic health insurance to their employees and to require that employers provide specific health benefits in their insurance plans. The Pepper Commission has also recommended a "job-based" approach to increasing access to health insurance that includes a mandate on larger employers to provide health insurance or contribute a portion of payroll toward the cost of covering employees and dependents in a public insurance plan. (The Pepper Commission proposal is described in more detail in CRS Issue Brief 90005, Health Insurance, Janet Kline, Coordinator.) These proposals are stimulating substantial congressional debate.

BACKGROUND AND ANALYSIS

Uninsured Population

In 1987, between 31 and 37 million Americans did not have any health insurance. [Variations in estimates of the uninsured are explained by the different questions and methods of sampling used in the surveys.] Estimates from the March 1988 Current Population Survey (CPS) of the U.S. Census Bureau place the number at 31.3 million; estimates from the National Medical Expenditure Survey of the National Center for Health Research place the number at 37 million. In the late 1970s, between 13% and 14.5% of the under-65 population were uninsured. This number increased to 17.7% in 1984 and fell back to 17.5% in 1986. Estimates vary, and some studies report that the number of medically uninsured peaked during the economic recession of the early 1980s, and is now on a downward trend.

The effects on an individual of not having health insurance are not well documented. What is known is that the uninsured are less likely to use health services and are more likely to be in poorer health than the insured population. The 1986 National Access Survey (done for the Robert Wood Johnson Foundation) reports, for example, that the uninsured had approximately 40% fewer ambulatory visits and 19% fewer hospitalizations than the insured. Of those individuals surveyed who had chronic illnesses, 20% of the uninsured failed to see a physician or other provider over the course of a year, compared to 17% of the insured.

While data on the health consequences of lacking insurance are scarce, several studies do provide information on who make up the uninsured population. They indicate that low-income households are more likely to lack health insurance than those with middle or high incomes. They also indicate that the vast majority of uninsured are employed or live in families where the head of the household is employed. Most recent studies using Census Bureau data report that at least 80% of the uninsured live in families where someone is employed.

Working Uninsured

Largely as a result of labor union pressures for better employee benefits, and Federal tax incentives that allow employers to deduct the costs of providing health benefits to their employees, employer-related health insurance became increasingly commonplace after World War II. Today, after paid vacations, it is the most common fringe benefit offered by employers. For the nine out of ten Americans with private group insurance, that insurance is provided in the employment setting. As a result (and in contrast to other western nations where health and pension benefits are provided through public programs), workers in the United States have grown to rely on employer-provided benefits for these basic protections. However, as the following statistics reveal, not all employers offer health benefits and, when offered, not all employees accept them.

Some analysts argue that the decline in coverage is due to the shifting of our economy from jobs that carry health insurance to ones that do not. It is true that while civilian, nonagricultural jobs increased by about 7% between 1982 and 1985, the number of jobs with health insurance provided by an employer increased by less than 5%. However, more important may be changing demographics. For example, there appears to be an increase in the number of young adults without health insurance living in households in which the parents have insurance. In addition, dependent coverage has declined.

EBRI's May 1988 analysis of CPS data on the working uninsured reveal that in 1986, 18.1 million workers reported no coverage from an employer plan. Of that number, 10.9 million were the head of a family (meaning the family member with the greatest earnings or an individual without a family). Another 7.2 million were other family workers and not the head of the household. The majority of uncovered workers were low wage earners. In 1986, 74% of all uninsured workers earned less than $10,000; 93% earned less than $20,000. About 35% of all uninsured workers earned, on average, less than the Federal minimum wage in 1986; 50% of all uninsured workers earned less than 125% of the minimum wage. Most of these individuals worked full-time.

It is also useful to look at the working uninsured according to their primary source of employment. According to EBRI, workers in certain employment sectors are much more likely to lack health insurance coverage than the average American worker under age 65. These include workers in agriculture; retail trade; services (business, repair, entertainment and personal); and construction. Also included in this category are the self-employed. Workers in other employment sectors (including manufacturing, finance, transportation, and wholesale trade) lack insurance coverage only one-third to one-half as often as workers in the above employment sectors.

Move Toward Mandated Health Benefits

Since the early years of this century, national health insurance has been a hotly debated issue in the United States. While in the late 1960s and 1970s, the debate revolved around whether to enact a program of universal national health coverage, in the 1980s the emphasis has been on incremental expansions of health insurance coverage. Proposals have focused on expanding coverage for specific segments of the population (such as laid-off workers, low-income elderly, and children) and for people who, because of a major pre-existing health condition, are unable to obtain health insurance through the private market. Faced with substantial Federal budget deficits and an apparent diminished interest in Government-financed solutions, Congress has begun to look to employers as a potential source of expanding access to health insurance coverage.

One approach gaining some support in Congress falls under the general heading of employer mandates. Under this approach, the Federal Government would mandate that employers (private employers as well as State and local governments) provide insurance coverage and/or specific health benefits to their employees and, in some cases, also to their employees' families. This approach is consistent with the current reality that in the United States, health insurance for all but the old, disabled, and very poor, is primarily obtained through an employer's group plan.

In the 99th Congress, legislation was enacted that required certain employers to offer continued health insurance coverage to their employees who would otherwise lose coverage for certain reasons. Also, certain employers were required to offer their Medicare-eligible disabled workers primary coverage under the employers' health insurance plans. In the 100th Congress, legislation was considered to mandate that employers provide basic and/or catastrophic health insurance coverage. These proposals are being considered again in the 101st Congress.

Issues Related to Mandating Employer-Provided Health Insurance

The debate over mandating that employers provide health insurance raises philosophical issues such as the nature of an employer's obligation to his or her employees, and whether it is appropriate for the Federal government to require that employers offer insurance. In addition, it raises questions about the potential economic effects of mandates on employers as well as on the health of the national economy.

Question of Employer Responsibility

Proponents of mandatory employer-provided health insurance argue that employers have a basic obligation to ensure that their employees have access to health insurance just as they have an obligation to provide a liveable wage. They assert that a minimum health benefits law should be established in the same manner as the Federal Government has established a minimum wage law. They say that it will ultimately lower the Nation's health bill because more people will have access to health care. In addition, they argue that requiring employers to provide coverage is in keeping with the Nation's heavy reliance on employment-related insurance. They further assert that relying on private rather than government-provided insurance builds upon our Nation's tradition of leaving health insurance to the competitive market place.

Proponents also argue that this approach will increase equity across employers and taxpayers. Currently, health insurance premiums are priced to include not only the direct cost of providing health care services to the employer's workers, but also other costs borne by the providers of health care for uninsured or underinsured individuals, a substantial portion of which are uninsured workers. Employers who are paying for health care coverage for their employees are thus subsidizing those employers who are not paying for coverage.

Finally, proponents argue that employers who provide health benefits are also subsidizing other employers by insuring many of the latter's workers through family coverage. According to a CRS analysis (based on March 1987 CPS data), 23.6 million working Americans receive coverage through employers for whom they are not directly working. Moreover, individuals who are not offered insurance by their employers are paying some of the $37 billion in taxes that are used to subsidize (through tax expenditures) health insurance for other, generally higher-paid workers.

The opponents of mandatory employer-provided health insurance counter by arguing that employers have no inherent obligation to provide health benefits. They assert that the individual has a responsibility to purchase insurance in the private market. For those individuals who cannot afford to pay for health insurance, then the public sector should provide a minimum level of health care. Moreover, opponents argue that an employer's decision to provide insurance or to provide a specific set of health benefits should not be dictated by the Government. Rather, it is labor-management negotiations or free-market competition among insurers vying for employers' business that should determine whether employers provide insurance and if so what health services should be covered under the policy. Such reliance on the marketplace will also ensure greater efficiencies in the supply and demand of health coverage and services, thus helping to hold down costs.

There are also those who reject mandates because they would, in their view, undermine the voluntary nature of employer-provided health insurance. They argue that the majority of employers already provide coverage; it is a benefit that these employers have privately chosen to provide in a form that is most appropriate to their own employees. Some employers who already insure their employees argue that a Federal law mandating that employers provide insurance (particularly if that law were to require a basic minimum level of benefits) would result in higher employee benefit costs and new administrative burdens.

Critics of mandated employer-provided coverage also argue that such a policy might increase the costs of labor to the point where companies, especially smaller ones, would reduce their labor force or reduce wages. Health insurance is a relatively expensive benefit. The Small Business Administration (SBA) reports average employer health care costs totalled $1,500 (roughly 75 cents per hour) per worker in 1986. For the 35% of uninsured workers who are paid less than the minimum wage ($3.35 in 1987), the added hourly cost of a health insurance benefit could be prohibitive, even if the employee were required to pay a share of the premium. Although a mandated insurance package might be less comprehensive and therefore less expensive than the average policy cited by the SBA, it could still produce reductions in the employment of low wage workers as employers attempt to adjust to higher labor costs.

Mandated Employer-Provided Insurance and Competitiveness

In addition to the debate about employer responsibility, there is a different set of issues relating to the potential effects of mandating benefits on employers' ability to compete in domestic and world markets. Much of the analyses of these effects is speculative; however, the basic arguments tend to be articulated as follows.

Opponents of mandated employer-provided health coverage say that mandated insurance would drive up the cost of doing business and reduce the ability of firms to compete, both in the domestic and world markets. Industries that compete against foreign manufacturers (especially those from certain Third World nations) are competing against employers who do not as a rule provide health and other fringe benefits. This helps foreign manufacturers to hold their prices down. Small employers, especially, believe that mandating health insurance coverage might cause them to lose whatever competitive edge they may have since they would have to offset the cost of the new benefits by raising their prices. While many smaller firms do not directly engage in international trade, some proportion of them are suppliers to large companies that do compete internationally. Higher costs for a supplier affect the costs of the purchasing firms: if health insurance coverage were required, small employers might pass the cost of the coverage onto their clients. This reasoning is also extended to domestic competition.

Proponents of mandated benefits dismiss the competitiveness argument as invalid or not compelling. In their eyes, it is not a real issue because the companies that are struggling to maintain their competitive edge (such as the auto manufacturers) are the very companies that already provide health insurance. The majority of the working uninsured are not found in the transportation and manufacturing industries but in the service and retail trade industries, which are comparatively unaffected by foreign competition. It is these latter industries that have experienced the most growth since 1979: the services industry is projected by the Bureau of Labor Statistics to increase from about 21% of total U.S. jobs in 1979 to over 26% in 1995; the retail trade industry is projected to increase from 22% to 23% over the same period. Manufacturing and transportation, which have traditionally covered most of their workers, are predicted to decline. These statistics noted, mandated benefits proponents conclude that there are more critical variables, such as exchange rates, undermining American competitiveness than the cost to American firms of their employee benefit packages.

Small Employers and Mandated Employer-Provided Health Insurance

It is often assumed that smaller employers are less likely to offer health benefits because of the high costs of premiums, administrative burdens and the perception that workers prefer cash wages to benefits. Estimates place the costs of insurance for small employers at anywhere from 10% to 40% higher than for large employers. The SBA reports that very small firms that do not offer health benefits spend about 7% of payroll on fringe benefits. Those which do offer coverage spend 10%.

According to the SBA, in 1986, 46% of firms with fewer than 10 workers offered health benefits, compared to 78% with 10 to 24 workers, 92% of firms with 25 to 99, 98% of firms with 100 to 499, and 100% of firms with 500 or more workers. 84% of all workers who worked for employers without health plans worked in firms with less than 25 employees.

Based on surveys and other studies, the SBA has concluded that smaller employers tend not to offer health insurance because they (1) face higher per worker premiums since the risk for insurers is spread over fewer persons; (2) do not benefit to the same extent as larger firms from the tax advantages associated with offering health insurance; (3) experience higher fixed costs in choosing and administering a health plan; (4) have relatively higher worker turnover rates and a greater use of part-time and seasonal employees which increase their administrative fees relative to the fees charged for larger firms; and (5) tend to have narrower profit margins from which to pay relatively higher premiums.

Associations representing small employers use such findings to argue that forcing small employers to offer health insurance will result in higher prices, lower wages, more business failures and fewer jobs. They contend that small firms simply cannot spend more of their receipts on employee benefits.

Another argument used against mandated coverage for small employers is that low-wage workers prefer to receive cash benefits or are already covered indirectly through a family member's insurance policy, and should not be forced to accept reduced earnings. However, an SBA survey of employers found that 14% of eligible workers in small firms (less that 10 employees) which offer coverage turn it down, compared to the 13% average across all firms.

Many proponents of mandated coverage agree that small employers might be adversely affected if they were required to offer (as well as pay some portion of) health insurance. They suggest, however, that potential problems for small employers could be reduced through mechanisms designed to lower both the costs and the administrative burdens of offering health insurance. These mechanisms are generally designed to pool large numbers of small employers in one large group, enabling them to obtain health insurance at lower costs. For example, the Council of Smaller Enterprises (COSE) in Cleveland, Ohio, arranges with a number of insurance companies group health insurance for about 8300 firms, which in turn provide insurance to more than 120,000 employees. COSE is able to negotiate less expensive policies than would otherwise be available to these employers if they sought the insurance on their own.

Such pooling mechanisms have been employed with mixed success. Observers say that they are not as effective for the smallest employers, which are still subject to medical underwriting. They also tend not to attract those employers who have never offered coverage. In addition, their effectiveness in holding down premium rates is limited by the volatility of the small group insurance market. However these problems largely could be eliminated if employers were required to participate in the pool.

Underinsurance and Catastrophic Coverage

Some analysts advocate that an appropriate compromise between the two extremes of doing nothing and mandating that all employers offer health insurance is to require that all employers offer coverage under a catastrophic illness policy. These policies provide coverage for only very large medical expenses after the beneficiary has paid a large deductible; the premium cost of such coverage is, however, generally lower than for more comprehensive policies. A catastrophic illness policy would ensure protection of individuals against the devastating financial burdens of a major illness but would be less costly for employers to offer. On the other hand, such an approach would not address the need of the medically uninsured for basic health services.

History of Federal Employer Mandates

The Federal Government has traditionally left the regulation of insurance to the states. According to Blue Cross and Blue Shield Association, there are over 680 State-mandated benefit laws governing health insurance. They include specific services (e.g., maternity coverage and newborn care), the services of specific providers (e.g., dentists and chiropractors), as well as requirements that plans provide for continuation and conversion options. The States vary in the numbers and types of mandates. Some observers in the business and insurance communities contend that these mandated benefit laws are largely responsible for the high costs of health insurance. Advocates of State mandates say that they increase access to needed health services and encourage greater freedom of choice of providers, which in turn promotes competition and lowers health care costs.

While the business of insurance has been left largely to the States to regulate, employee welfare benefit plans are governed by the Employee Retirement Income Security Act (ERISA), a Federal law enacted in 1974. (Hawaii is an exception. ERISA was amended to allow Hawaii to continue its law requiring employers to provide health insurance coverage.) Included under employee welfare benefit plans are self-insured health plans, where the employer assumes the risk for paying claims, instead of paying premiums to an insurance company which in turn assumes the risk. Thus, while traditionally insured companies are affected by State mandates, self-insured companies are regulated by ERISA. ERISA regulates such aspects of welfare benefit plans as plan disclosure, but until recently, employers under ERISA were relatively free to structure plans as they desired or, if their employees were represented by a union, through the collective bargaining process. As discussed below, this changed with the enactment of Title X of the Consolidated Omnibus Budget Reconciliation Act (COBRA, P.L. 99-272).

In the 1970s, changes were made in Federal law to mandate that employers offering health insurance meet specific requirements. For example, the Health Maintenance Organization Act of 1973 (P.L. 93-222) requires that certain employers with 25 or more employees offer a health maintenance organization (HMO) option in their health plan if a qualified HMO exists in their area. In 1978, Congress amended the Civil Rights Act to extend the prohibition against sex discrimination in employment to include discrimination on the basis of pregnancy, child birth, or related medical conditions (P.L. 95-555). As a result, larger employer health plans must treat women affected by these conditions similarly to other employees, based on their ability or inability to work.

Federal proposals mandating employers to provide coverage date back to the Nixon Administration. More recently, the Carter Administration developed legislation to require employers to provide basic health insurance as an employee benefit. The Carter proposal would have also expanded Federal programs to include those who remain uncovered under employer plans. It was criticized by representatives of small business who argued that requiring them to provide insurance would add significantly to their labor costs and threaten their viability. It also fell victim to the absence of consensus among other health policy actors.

Federal mandates on employers who provide health coverage have continued into the 1980s. In addition, new efforts have been made to broaden the scope of the mandates to those employers who do not already offer health insurance.

Title X of COBRA

The passage of Title X of the Consolidated Omnibus Budget Reconciliation Act (COBRA) in April 1986, marked a major departure in Federal law and regulation of employers' welfare benefit plans. It was the first time that the Federal Government mandated a specific benefit in employee welfare benefit plans. While COBRA does not mandate that employers provide health insurance, it does require that employers with 20 or more employees who do provide health benefits offer qualified employees and their families the option of continued health insurance at group rates when faced with loss of their coverage because of certain qualifying events. The qualifying events include termination or reduction in hours of employment, death, divorce, eligibility for Medicare, or the end of a child's dependency under a parent's health insurance policy. When a covered employee experiences termination or reduction of hours of employment, then the coverage of the employee and any qualified beneficiaries must continue for 18 months. For all the other qualifying events, the coverage for the qualified beneficiaries must be continued for 36 months. The employer's health plan may require the employee or beneficiary to pay the premium for the continuation coverage, but the premium may not exceed 102% of the otherwise applicable premium for that period. (See also CRS Issue Brief 87182, Private Health Insurance Continuation Coverage, by Beth C. Fuchs.)

In the Tax Reform Act of 1986 (P.L. 99-514), Congress included a number of technical corrections to Title X of COBRA. In the Omnibus Budget Reconciliation Act of 1986 (P.L. 99-509), Title X was expanded to require continuation coverage for retirees in cases where the employer files for bankruptcy. The Technical and Miscellaneous Revenue Act of 1988 (P.L. 100-647) made major changes in the penalties, and the Omnibus Budget Reconciliation Act of 1989 (P.L. 101-239) extended

continuation of coverage from 18 to 29 months for certain disabled workers and their families. (See CRS Issue Brief 87182.)

Medicare Working Aged and Working Disabled Secondary Payer Requirements

A different type of employer mandate was legislated through changes in the Medicare program and amendments to the Age Discrimination in Employment Act of 1967. Prior to 1982, employers generally used Medicare coverage as the basic health insurance for their Medicare-eligible employees supplemented by an employer-provided policy which filled in gaps in the Medicare coverage. This tended to ensure that health care costs for their older workers were confined to supplemental as opposed to basic health care coverage. In 1982, as part of the Tax Equity and Fiscal Responsibility Act (TEFRA, P.L. 97-248), Congress adopted a proposal by the Reagan Administration to require that private employers with 20 or more employees offer their employees and their employees' spouses, age 65-69, their health insurance plan, which would be the primary payer for all claims. This provision was adopted to reduce Medicare expenditures by shifting the health care costs of older workers onto employers. The "working aged" or "secondary payer" requirement was expanded through subsequent laws. The Deficit Reduction Act of 1984 (DEFRA, P.L. 98-369) expanded the spousal coverage to include all beneficiaries 65-69 with working spouses under age 65. COBRA, (P.L. 99-272) made Medicare benefits secondary to those payable under employer group plans for employed individuals age 65 or over, and the spouses age 65 or older, of any employed individual regardless of age. OBRA of 1986 (P.L. 99-509) included a Reagan Administration proposal requiring employers with 100 employees or more to offer their disabled workers and their spouses the option of coverage under their employers' health plan as the primary insurance policy.

Bowen Catastrophic Proposal

In November 1986, Otis Bowen, Secretary of Health and Human Services, released a report to President Reagan on catastrophic illness expenses. This report was in response to the President's directive in his Feb. 6, 1986, State of the Union address that the Secretary report to him with recommendations on "how the private sector and Government can work together to address the problems of affordable insurance for those whose life savings would otherwise be threatened when catastrophic illness strikes."

While the Bowen report discussed options to encourage employers to provide catastrophic coverage, it recommended that States require that such coverage be offered in all employment-related plans. It specified that employers should not be required to finance such coverage, and also recommended the extension of full tax deductions for health insurance to the self-employed and unincorporated businesses (currently at 25%) as long as coverage is included for catastrophic expenses.

Although the Reagan Administration promoted Secretary Bowen's proposals for restructuring Medicare to cover catastrophic illness expenses, it did not endorse the recommendations in the Secretary's report for mandating catastrophic illness insurance under employer-provided health benefit plans. Some of these options were incorporated in legislation introduced in the 100th Congress, such as H.R. 2300

(Gradison), which would have denied the tax deduction for employer-provided health insurance to employers who failed to provide catastrophic coverage.

Types of Mandated Coverage Proposals

A variety of approaches to mandating coverage are incorporated in legislation that has been introduced in recent years. While most are aimed at expanding access to basic health insurance by mandating that employers provide health coverage, others seek also to define the nature of the benefits to be offered. There are also proposals that require employers to provide their existing benefit packages to employees, laid-off employees, retirees and/or dependents who experience a change in job or family status. Finally, other proposals require employers who already offer insurance to offer specific benefits, such as well-baby care.

Defining the Application, Nature and Scope of Mandated Health Benefits

One of the controversies in providing for any Federal mandate is whether or not it should apply to all employers, and if not, where the limits should be drawn. The Medicare working aged and COBRA Title X provisions exempt employers with fewer than 20 employees, although the Medicare working disabled provisions enacted in OBRA of 1986 (P.L. 99-509) apply to only those employers with 100 or more employees. Congress has been wary of applying mandates to smaller employers largely because of concerns that they are not as easily absorbed by such firms and could create economic hardships. Congress has also excluded the Federal Government and religious organizations from certain provisions.

The debate over mandated benefits is influenced by concerns about the lack of coverage as well as about concerns that working Americans are not adequately protected against the costs of a catastrophic illness. Consequently, there are proposals to require that employers provide basic hospital and medical insurance as well as those that would mandate only catastrophic illness protection. A more complex issue is whether the mandate should specify the nature of health benefits to be offered by employers. Again, the proposals vary in their approach. Some, such as the Kennedy-Waxman proposal in the 101st Congress (S. 786, H.R. 1845), require a minimum level of benefits in the health insurance package. However, an actuarial equivalency provision allows employers to offer different mixes of benefits and employee cost-sharing requirements. Other bills have left the nature of the benefit package unspecified. There have also been narrowly defined proposals that mandate that employers who already provide health insurance include within their benefit package specific services, such as coverage for pediatric preventive health care. (See S. 968 and H.R. 1449, in the 100th Congress.)

Defining the Population to be Covered and the Duration of Coverage

Whichever approach is pursued, it is necessary to define the beneficiaries who would receive the mandated health coverage. The employer's responsibility could be limited to active full time employees, or expanded to include any or all of the following: part-time employees, seasonal employees, retired employees, spouses, widowed and/or divorced spouses, dependent family members, and employees who

have terminated their employment, either voluntarily or involuntarily. Title X of COBRA and its subsequent amendments provide an example of a broad definition of beneficiaries.

In the same vein, some proposals are directed at ensuring that employers offer health benefits beyond the point at which the employee (and his/her dependents) has an immediate connection with the employer. In the past, Congress has considered proposals to require that employers pay for the continued group coverage of laid-off employees for a defined period of time. In this case, the benefit package may or may not be defined. Such continuation of coverage mandates may extend to laid-off or otherwise terminated employees, retirees of the firm and dependent spouses and dependents of such employees.

Defining the Liability of Employers and Employees

The proposals to mandate employer-provided insurance also generally define the limits of the employer's financial obligation to pay for those benefits. In Title X of COBRA, Congress authorized employers to require the employee to pay for the continued health coverage, plus a small fee to cover the employer's administrative costs. In other proposals, the focus is to keep the employee's costs for coverage low by requiring employers to pay a large portion of the premium. The Kennedy-Waxman plan in the 101st Congress (S. 768, H.R. 1845), for example, requires that the employer pay 80% of the employee's insurance premium (and 100% for low-income employees) which in turn is deductible from the employer's taxes as a cost of doing business. H.R. 2563, in the 101st Congress, prohibits employers from reducing their premium shares for certain part-time workers.

LEGISLATION

H.R. 43 (Clay)

Requires that certain contracts between the U.S. and private contractors contain provisions requiring the contractor to provide certain pension and health benefits to its employees. Introduced Jan. 3, 1989; referred to Committee on Education and Labor.

H.R. 1845 (Waxman)

Basic Health Benefits for All Americans Act. Amends the Public Health Service Act, Fair Labor Standards Act, Title XIX of the Social Security Act, and Employee Retirement Income Security Act to require that employers enroll employees in a health plan that covers specified health services and provides protection against catastrophic illness expenses. Also requires that State Medicaid programs provide health benefits on a phased-in basis to people in poverty and near poverty, and to all other individuals not covered by employer plans. Requirements for employer-based plans similar to S. 768 (see below). Introduced Apr. 12, 1989; referred to Committees on Education and Labor and on Energy and Commerce.

H.R. 2563 (Schroeder)

Part-time Temporary Workers Protection Act of 1989. Amends the Employee Retirement Income Security Act to prohibit a reduction in employer-provided premiums for employees solely because the employee works less than full-time with

less than 30 hours per week, allows employer to reduce the premium contribution to not less than a ratable portion of the premium ordinarily provided in the case of an employee who completes 30 hours of service per week. Introduced June 6, 1989; referred to Committee on Education and Labor.

H.R. 4070 (Grandy)

Universal Health Benefits Empowerment and partnership Act of 1990. Amends ERISA, the Internal Revenue Code, and the Public Health Service Act to provide for universal and more affordable coverage under group, State, or alternative health benefit systems. Requires employers to offer coverage for eligible individuals under basic group health plans or group health payroll deduction plans. Introduced Feb. 22, 1990; referred to Committees on Education and Labor, Ways and Means, and Energy and Commerce.

S. 768 (Kennedy)

Basic Health Benefits for All Americans Act. Amends the Public Health Service Act, the Fair Labor Standards Act, and ERISA to require that employers enroll employees in a plan that covers specified health services and provides protection against catastrophic illness expenses. Also requires that States establish programs to provide health benefits on a phased-in basis to people in poverty and near poverty, and to all other individuals not covered by employer plans. Failure of an employer to provide insurance would result in eligibility loss for grants, contracts, loans or loan guarantees under the Public Health Service Act or civil penalties under the Fair Labor Standards Act. Provides that an individual may sue in Federal court for injunctive relief. Under employer plans, limits the deductible to $250 per person ($500 per family) and copayments to 20% of the cost of any service (excluding certain services for which copayments are prohibited and other services for which different copayments are specified). Except part-time employees, limits the employee's share of the premium to 20% of the cost of coverage, and requires the employer to cover the full cost of at least one health plan for low wage workers. Provides that employers may provide benefits that are equivalent on an actuarial basis to those specified, and that new employers with 10 or fewer employees may provide a "tailored" plan, i.e., a plan that has one-half the actuarial value of benefits of a health benefit plan. Certain part-time employees may waive enrollment in the employer's plan, but the employer must pay what he/she otherwise would have paid for the employee's health plan to the State or Federal entity providing coverage to non-working persons. Employers without a plan meeting the minimum benefit standards are required to join regional insurance pools to be established by the Secretary of Health and Human Services that provide health benefits at community rates. Provides for a Federal subsidy for small businesses where compliance costs exceed 5% of gross revenues. Provides for Federal and State financing of the State programs, and specifies benefit package and cost-sharing. Introduced Apr. 12, 1989; referred to Committee on Labor and Human Resources. Hearings held May 1 and June 23, 1989. On July 12, 1989, the Committee voted to report an amended version of S. 768 to the Senate.

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50th Anniversary

Fifty years of U.S. health care policy

When *Hospitals* replaced the old *Bulletin of the American Hospital Association* in January 1936, three events had recently occurred that would influence much of the next 50 years of U.S.health care:

- The Social Security Act passed in 1935, inaugurating a new era of federal involvement in the welfare of at least some U.S. citizens. Although the Social Security Commission recommended that health care for the elderly be part of the package, it was not included.
- The age of private hospitalization insurance began, through the work of C. Rufus Rorem, Ph.D., the Committee on the Cost of Medical Care, the American Hospital Association, and the many other pioneering entities that made what would be known as "Blue Cross plans" a reality. Insurance for physicians' services would follow a similar track.
- Largely (but not exclusively) as a result of the work of Sidney Garfield, M.D., in designing health services for migrant construction crews in the West, the idea of health maintenance organizations (or HMOs) was born, soon to be adopted by industrialist Henry J. Kaiser.

weaving influences, these three trends foreshadowed much of what would follow. The period from 1936 to 1945 was marked by growth of Blue Cross and Blue Shield on the one hand and the Kaiser-Permanente model on the other. If Blue Cross and Blue Shield were creatures of the Depression, Kaiser was a creature of World War II and the health care needs of industrial workers.

Government, preoccupied with depression and war, was not very active in health care during this period, although one hallmark event did take place. In 1943, Congress passed the Emergency Maternal and Infant Care Act in order to ensure that health care was available to dependents of low-ranking servicemen. And in the background, there were stirrings of interest in national health insurance (NHI).

The United States began the decade between 1946 and 1955 with a new—and only marginally popular—president, the end of a devastating world war, and the beginning of a period of unparalleled prosperity. It was a golden era for prepaid health insurance. During the war, Congress exempted health-insurance benefits from the wartime freeze on wages; the continued tax benefits of employer-provided health insurance helped Blue Cross, Blue Shield, and indemnity plans increase their coverage of the U.S. population. National contracts became a reality as the Blue Cross and Blue Shield plans organized as associations.

A 25-year battle for NHI. Yet concurrent with the triumph of private insurance, Harry S. Truman became the first president to endorse NHI. It was the first shot in what would be a 25-year legislative battle. The concept had been around since the 19th century, but Truman's call indicated a new level of support for it. Like all NHI proponents to date, Truman would be frustrated in his efforts.

Other federal health care proposals would be more successful. The Hospital Survey and Construction Act, more popularly known as the Hill-Burton legislation, passed in 1948, providing funds for hospital construction in return for guarantees of care for the poor. In 1950, in an action that drew little notice at the time, Congress also amended the Social Security Act to allow federal matching funds for state vendor payments for health care services for the elderly.

By 1956, the ground swell of support for NHI became noticeable, with special interest manifested in some kind of relief for the elderly. But the victory of Medicare and Medicaid in 1965 is most easily seen as the logical product of a unique decade.

The day of the underdog. "America will always go for the underdog in the long run, even if it created the underdog in the first place," observes Henrik Blum, M.D., emeritus professor at the University of California School of Public Health. During the mid-1960s,

the underdog had its day.

John F. Kennedy, to a great degree, and Lyndon B. Johnson, to an unprecedented degree, believed in the federal government's right to involve itself in matters traditionally viewed as the business of the states. Furthermore, the national desire to make sense out of Kennedy's assassination strengthened Johnson's already formidable legislative hand. Johnsonian democracy, the growing pressure for health care enfranchisement of the vulnerable, and the accession of Rep. Wilbur Mills (D-AR) to chairmanship of the powerful House Ways and Means Committee made passage of Medicare and Medicaid only a matter of time.

Congress, meanwhile, had been sneaking into more health care enfranchisement anyway—by expanding matching funds for state health care programs for the elderly, extending health care benefits to military dependents, and approving state-federal funding of health care for the medically indigent. The final enabling event was passage of the Civil Rights Act of 1964, which permanently changed the relationship between the federal government and the states. By the time that Medicare was passed, almost everyone was in favor of the program's philosophy—if not its content—save for the American Medical Association, which inflicted significant political harm upon itself with its continued opposition.

The economic fruits ripen. From 1966 to 1975, one of the greatest turnarounds began in what is normally (at best) a mercurial health care economy. First, the economic fruits of Medicaid and Medicare appeared. The medical cost component of the Consumer Price Index increased from 2.1 percent in 1965 to 6.5 percent in 1967. By then, Congress already was amending Medicaid to reduce cost overruns.

Hospitals were singled out for special attention from 1971 to 1974 during the Economic Stabilization Program. Congress also approved funding for HMOs as a means of controlling health care costs, as well as national health planning.

Despite the 1968 Republican victory, NHI proponents made their biggest congressional push in the early 1970s, culminating in the 1974 failure (by only one vote) of the Kennedy-Mills NHI proposal in the House Ways and Means Committee. After a battle lasting more than a quarter of a century, the massive escalation in health care costs would overwhelm the appeal of NHI after 1974.

Disenchantment leads to DRGs. Of the three watershed factors in health care between 1976 and 1985, two had nothing to do with government health policy.

First was the recession of 1981-82 and its repercussions, including greater awareness among employers of health-benefits costs and greater awareness among state governments of Medicaid costs. That awareness was intensified by federal cutbacks in overall health care funding.

Second, the election of Ronald Reagan signaled a

Highlights from 50 years of American health care

1936-45

"*Hospitals* will endeavor to develop a service to all hospitals, and to all the friends of hospitals, that will aid them in making their institutions better, their patients happier and more efficiently taken care of, and their publics more interested and more generous with their moral and material support."

—From the lead editorial in the first issue of Hospitals, *January 1936*

1936: A federal government report claims that 90 percent of Americans are receiving inadequate medical care.

1937: The Group Health Association HMO is founded in Washington, DC.

1938: The American Hospital Association develops a seal of approval for prepaid insurance plans; the seal is a blue cross.

Work begins on mass production of penicillin, discovered in 1928 by Alexander Fleming, M.D.

Kaiser Permanente

Kaiser and Garfield

1939: Sen. Robert Wagner (D-NY) introduces a national health insurance bill, but like its many successors, it will not pass.

1942: The Kaiser Permanente HMO is founded.

1943: Congress adopts the Emergency Maternal and Infant Care Act to provide medical benefits for dependents of low-income servicemen.

1944: The Social Security Board's annual report recommends mandatory state health insurance.

1945: California Governor Earl Warren calls for mandatory state health insurance; the resulting bill is defeated.

national disenchantment with government solutions for intractable problems; private-sector solutions to the health care cost dilemma became the order of the day. They worked, too, as private employers rushed in where government had feared, or had been unable, to tread.

Third, threats to the fiscal survival of Social Security and Medicare overwhelmed ideological niceties. In what many observers thought was the last gasp of federal cost-control efforts, Jimmy Carter's hospital cost-containment bill went down to congressional defeat twice in the late 1970s. But less than five years later, Congress enacted a Medicare prospective pricing system that set prices based on DRGs.

Prospective pricing is every bit as much of a government cost-control program, but because of the new system's use of market language and dynamics, it became politically acceptable. The question of whether government should intervene was settled in the 1960s; today, it is only a question of how.

Inspired by (and, in turn, inspiring) employer and payer activism, Medicare's new stance was that market economics—not government policy—should control the future of health care. The pendulum had swung again.

Policy forged by social tensions. Many years ago, Mohandas K. Gandhi, when asked what he thought of western civilization, replied, "I think it would be a very good idea." One is tempted to say the same of U.S. health policy: We don't have one. Rather, the structure and financing of American health care is determined by the tensions within and among a series of opposing forces that alternate in dominance at any given time. These forces are:

- **Indecisiveness.** Our inability as a nation to determine whether we believe that health care is a market commodity, a social good, or both, depending on the situation. If a nation cannot make this basic determination, it is not surprising that health policy implemented in its absence tends to be quirky.
- **Fiscal ambivalence.** Although the U.S. public has declared—in its political expressions, in opinion polls, and by custom—that it believes health care is a right, it has shown a marked unwillingness to come up with the money necessary to make that statement operational. As a result, the United States and South Africa are alone among developed nations in not having formally declared access to health services as a right of citizenship.
- **Infighting.** This nation's love/hate relationship be-

Highlights

1946-55

"President Truman's recent endorsement of a national health program . . . challenges the American health professions and agencies to bring their services to the public in a manner which will best remove the present uneven distribution of services and costs."

—*C. Rufus Rorem, Ph.D., in* Hospitals, *January 1946*

Fishbein

1946: President Harry Truman announces his call for a program of compulsory national health insurance.

The Hospital Survey and Construction Act (the "Hill-Burton Act") passes.

1948: The Association of University Programs in Hospital Administration holds its first meeting.

1949: The Blue Cross Association is chartered in Illinois.

Morris Fishbein, M.D., controversial editor of the *Journal of the American Medical Association* and the most famous health care spokesman in the United States, is removed from his position.

1950: In amendments to the Social Security Act, Congress approves provision of federal matching funds to states that subsidize health care for the elderly through vendor payments.

1952: The Joint Commission on Accreditation of Hospitals is established.

1954: Jonas Salk's vaccine against poliomyelitis is developed.

March of Dimes

Salk

tween its public and private sectors is probably more intense and more convoluted than in any other country. Again and again, government, which clearly holds responsibility for public health, has supported private providers while neglecting its own. Medicare and Medicaid were designed specifically to preserve freedom of choice of provider—a philosophical underpinning only recently undone by the cost-containment imperative—and over and over, Congress defeated government health-insurance schemes in favor of making private insurance more available through tax incentives and other means.

- **Quality vs. cost.** The merry-go-round interrelationships among the cost of, quality of, access to, and effectiveness of health care is not a new phenomenon bred by the use of market incentives. Even a cursory look at the legislation, studies, and reports of any decade in this century reveals that the pendulum of policy constantly swings toward spending to improve quality and access, and then toward controlling of the expenses thus engendered; toward efficiency and cost control, and then toward rectification of the inequities, maldistribution of care, and mortality and morbidity thus engendered. And it always swings back again.
- **Power shifts.** Who wields power in health care continues to bedevil all the parties involved, particularly those that do not hold power at the moment. At various times, dominant power has been in the hands of state and local governments, the federal government, physicians, providers in general, Congress, voters, insurers, and employers. Rarely is any of these interests without power; but the pattern is that a disproportionate amount of power is invested in the hands of one, then another, then another as we become disappointed by the performance of each in turn. Thus, the debate over competition versus regulation is, in fact, a false one; American health care has never been without either. The debate is really over who will be regulated, and who will benefit from competition.
- **Structure vs. financing.** As Professor Odin Anderson, of the University of Chicago and the University of Wisconsin, points out: The United States never came to grips with the fact that its health care *structure* developed almost entirely independent of its health care *financing*. The era of third-party payment—public and private—came well after the system's main elements were in place. In fact, perhaps the only really new trend of the 1980s is the attempt to interrelate

Highlights

1956-65

"The total operating expenses of general hospitals in 1954 were slightly more than half their total capital assets. The problem of providing hospital care is an annual problem, and the problem only starts after the capital funds are raised."

—AHA President Ray E. Brown in Hospitals, *January 1956*

1956: Federal health care benefits are extended to military dependents.

Congress expands support of state health benefits for the elderly.

The AFL-CIO endorses the idea of national health insurance.

1957: Rep. Wilbur Mills (D-AR) becomes chairman of the powerful House Ways and Means Committee.

Rep. Aimé Forand (D-RI) proposes federal funding of care for the elderly; his bill fails.

1958: The AHA officially acknowledges the possible need for federally supported health insurance for some populations.

1960: Hearings by the Senate Subcommittee on Problems of the Aged and Aging find wide support for health coverage for the elderly.

President Johnson signs the 1964 Civil Rights Act.

Congress passes the Kerr-Mills bill, providing joint federal-state assistance for the medically indigent.

The Eisenhower Administration presents a bill creating a "Medicare Program for the Aged" to Congress; although the legislation does not pass, the name sticks.

1961: The Task Force on Health and Social Security for the American People endorses health care benefits for the elderly through the Social Security program.

1963: Congress passes the Health Professions Educational Assistance Act, which provides federal funds to encourage training of various health professionals, including physicians.

1964: The Civil Rights Act of 1964 passes.

1965: The Social Security Amendments of 1965 (P.L. 89-97) are passed, creating the Medicare and Medicaid programs.

structure and financing—in the public sector (Medicaid and Medicare incentives to use HMOs and outpatient care), the provider sector (provider insurance and HMO formulations), and the private-payment sector (employers' and insurers' increasing role as providers, through HMOs or more directly). However, even here, predictions of revolution prove overenthusiastic.

Americans: surprised by results. Finally, in health care as in many things, Americans continue to be surprised by the logical results of their policy decisions. The legal definition of competence is the ability to understand and accept the consequences of one's own actions; yet a significant amount of American health care policymaking consists of efforts to cope with the effects of *previous* U.S. health care policies.

Medicare and Medicaid brought federal, state, and sometimes local governments into funding health care for some 50 million people. Yet when the programs proved expensive, everyone seems to have been taken unaware. When cost-based reimbursement fueled the enormous growth in hospital capacity, the intensity of health care, and the development of health technology, providers were blamed as though they somehow had reacted inappropriately. Medicare and Social Security alike simply did not take into account the fact that most of the 75 million people born between 1946 and 1964 eventually would grow old.

The Johnsonian programs of the 1960s doubled production of physicians from 7,574 medical school graduates in 1966 to 15,728 in 1983; but the first major statement that a physician oversupply might be in the works came in 1980.

Highlights

1966-75

"If the medical community and hospitals reflect their professional concerns in the various mechanisms they themselves develop, then I think it can be predicted that our administrative concern will rarely *not* be met."

—Arthur Hess, director of the Social Security Administration's Bureau of Health Insurance, talking about the new Medicare program in Hospitals, *January 1966*

William Pittman

DeBakey

1966: Medicare and Medicaid become operational.

Congress passes the Comprehensive Health Planning and Public Health Service Amendments (P.L. 89-749).

Michael DeBakey, M.D., uses plastic arteries and a temporary artificial heart during cardiac valve replacement surgery.

The federal government declares that hospitals participating in Medicare are subject to the provisions of the Civil Rights Act.

1967: The medical care component of the Consumer Price Index, which totaled 2.1 percent in 1965 and 2.9 percent in 1966, jumps to 6.5 percent.

Christiaan Barnard, M.D., conducts the first human heart transplant operation.

1968: Walter Reuther, director of the United Auto Workers, announces that he will form a "Committee of 100" to press for comprehensive national health insurance.

1969: The Department of Health, Education, and Welfare Task Force on Medicaid and Related Programs is created.

1970: The Health Security Act, a national health insurance plan, is introduced in Congress; it and many others like it will fail in the 1970s.

1971: The Economic Stabilization Program is inaugurated.

1972: Congress passes the Social Security Amendments of 1972, which create the Professional Standards Review Organization program, fund dialysis and transplants for victims of end-stage renal disease, and give the federal government more cost-containment authority.

1973: The Health Maintenance Act is passed, greatly increasing federal financial support for HMOs.

1974: Economic Stabilization Program controls end.

The Kennedy-Mills bill dies in a House committee, ending the high point for national health insurance.

Hawaii passes the Prepaid Health Care Act, thus becoming the first (and still the only) state to mandate employer-provided health insurance for all employees.

1975: The National Health Planning and Resources Development Act is passed.

A New Jersey court allows Karen Ann Quinlan's parents to withdraw life support from their permanently comatose daughter.

And almost the entire policymaking structure is still resisting the idea that when public and private programs are cut back, that when hospital margins are narrowed, that when care of the poor is concentrated in a minority of institutions, the result is a massive increase in the number of medically indigent patients, and fiscal calamities for institutions that care for them.

Fifty years of no policy. The past 50 years of American health care nonpolicy have been marked by fits and starts, recurring tensions, reactions and overreactions—a pendulum that ceaselessly swings from one extreme to the other, always leaving its mark, but also always retreating back to a more moderate position before it goes off in yet another direction to leave another mark.

There is talk once again of national health insurance, as the holes in private and public health care sponsorship become more apparent. Questions are being raised about quality. As the effectiveness and the distribution of health care once again come under scrutiny, voices are heard asking whether government needs to step in and moderate the excesses of a private sector whose interests may not be in step with those of the population as a whole.

"Americans," Winston Churchill once remarked, "can always be counted on to do the right thing—once they have exhausted all the possible alternatives." In the search for either a national health policy or an acceptable substitute, many options remain unexplored. And despite the eccentric, sometimes frightening, and sometimes hilarious record of that search during the past 50 years, it is impossible to doubt the sincerity and commitment of those individuals engaged in the quest.

So who knows? Perhaps down one of those darkened pathways that still beckons, we will yet find the right thing to do.—*Emily Friedman* H

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Highlights

1976-85

"Ironically, the strings that hold back our imaginations are the same ones that hamstring the hospital field now—rising costs, limited budgets, and finite resources. It is probably safe to say that these three problems will lead to an inevitable redefinition of the health provider's philosophy of care and to reevaluation of the provider's commitments."

—Donald Phillips, field editor, in Hospitals, *January 1976*

1977: President Jimmy Carter proposes the Hospital Cost Containment Act.

The AHA and fellow organizations launch the Voluntary Effort to Contain Health Care Costs.

1978: Carter's hospital cost-containment legislation fails in Congress.

In Great Britain, the first baby conceived outside the human womb is born.

1979: Carter's hospital cost-containment bill fails again.

The Carter Administration submits a national health insurance bill to Congress; it doesn't pass, either.

1980: Per capita U.S. health care expenditures reach $1,075, an increase of more than 300 percent since 1970.

The Graduate Medical Education National Advisory Committee issues a report predicting an oversupply of U.S. physicians by the 1990s.

Carter

New Jersey institutes a prospective pricing system that uses DRGs.

1981: Congress passes the Omnibus Budget Reconciliation Act.

The worst recession since the 1930s hits the United States.

The AHA, the AMA, the Blue Cross and Blue Shield Association, the AFL-CIO, the Business Roundtable, and the Health Insurance Association of America endorse private-sector initiatives to control health care costs.

1982: Congress passes the Tax Equity and Fiscal Responsibility Act.

1983: Congress passes legislation establishing Medicare's DRG-based prospective pricing system.

1984: Per capita U.S. health care expenditures reach $1,632, an increase of more than 50 percent since 1980.

1985: In December, *Hospitals* concludes 50 years of publishing.

[EXCERPT FROM]

CATASTROPHIC ILLNESS EXPENSES

Department of Health and Human Services Report to the President

DEPARTMENT OF HEALTH & HUMAN SERVICES

November 1986

EXECUTIVE SUMMARY

The American health care system provides substantial benefits to most Americans. Even so, many Americans run the risk of financial ruin when catastrophic illness strikes. The President, in his 1986 State of the Union address, requested a study of how the private sector and government can work together to address this problem.

No single policy approach provides protection for all groups of people and for all types of health expenses; but a combination of options can help reduce the financial risks for many people. Options are available to redirect government health financing programs, to encourage private saving and the purchase of private insurance, and to stimulate development of innovative methods of providing health care services by the private sector.

Current Coverage and Risk Patterns

Almost all Americans have some health insurance -- virtually all of the elderly (with Medicare and two-thirds with supplementary Medigap insurance as well), and nine out of ten members of the general population. In addition, a wide variety of subsidized or free health services are provided to individuals through public and private hospitals, clinics, and other health care programs. Some of these are sponsored by State and local governments, some by private nonprofit organizations like the Red Cross, some by private charity. The remainder are provided as

uncompensated care, in the form of bad debt. Even so, the problem of catastrophic illness expense exists. The reasons for the problem are very different for the elderly than for the general population.

Unfortunately, no immediate resolution of this problem is possible without the infusion of large sums of Federal monies. Given current budget constraints this is not a feasible solution. Longer term private sector partial solutions are feasible. However, decisive action is needed now if we are to have these mechanisms in place in time to address the enormous public policy crisis that the baby boom generation will present when they become the elder boom in the ensuing decades. The catastrophic problem for the general population, in contrast, is not that people lack available insurance possibilities, but that they fail to acquire insurance protection for themselves and their families. About 30 million individuals are currently uninsured, of whom over 20 million are without coverage all year. About 10 million others (most with employment-related insurance) have insurance which is inadequate to protect them from risk of catastrophic illness expense.

The uninsured or inadequately insured are not typically out of the labor force; nor are they typically poor. Most of them work or are dependents of workers, often in small businesses. They are often part-time or part-year workers, and earn relatively low wages.

The recommendations selected for the President's consideration recognize the dangers of fiscal expansion to increase coverage of catastrophic health care expenditures. The recommendations, therefore, involve at most moderate increases in public outlays or reductions in Federal receipts. The strategy also recognizes that much of what needs to be done can most appropriately be done through encouraging development of private financing mechanisms and increasing flexibility at the State and local levels. The recommendations address three major parts of the catastrophic illness coverage problem:

- o acute care catastrophic protection for the elderly;
- o long term care protection alternatives;
- o catastrophic protection for the general population.

RECOMMENDATIONS FOR IMPROVING ACUTE CARE CATASTROPHIC EXPENSE PROTECTION FOR THE ELDERLY

The Medicare program now has coverage gaps that leave the elderly with acute care needs vulnerable to catastrophic out-of-pocket expenses. A restructured Medicare program can promote equity among beneficiaries in a way that relieves the worries of the elderly about acute care expenses, while simultaneously reducing the out-of-pocket expenses of the majority who now purchase limited insurance coverage. At the same time, we can ensure that the elderly fully pay for this increased security, rather than depending on younger generations to finance it. Restructuring is consistent with efforts to increase competition and encourage

capitated health care delivery. The recommendations presented here are also consistent with the cost-containment objectives of the President's 1988 budget.

We recommend that Medicare be restructured to provide catastrophic protection with an actuarially sound additional premium.

Medicare Part A is for inpatient and home health services and covers all Medicare-eligible persons. Medicare Part B is for physician and outpatient services; coverage depends on a premium payment which is voluntary.

The recommendation would place an annual limit on each beneficiary's out-of-pocket expenses for all Part A and Part B deductibles and coinsurance. Part A coinsurance and lifetime limits would be removed, and the maximum number of hospital deductibles would be limited to two per year. Part B cost sharing arrangements would remain unchanged. Catastrophic coverage with a $2,000 annual limit (which corresponds to an annual health care expenditure of over $10,000) would require an additional premium of $4.92 a month. That additional cost would be included in the Part B premium, which would remain voluntary. This approach would provide the elderly with a budgetable, predictable expenditure pattern for securing catastrophic acute care protection and a known out-of-pocket limit for such coverage at the beginning of each year, and would provide them with peace of mind.

This recommendation requires that the benefit be fully funded by the premium, which would be indexed annually (up or down) to insure budget neutrality. The $2000 out-of-pocket cap would also be indexed each year to account for health care inflation. Indexing assures that the tax burden of the working age population is not increased, and that those who receive the benefit pay their fair share of the cost.

Alternatively: We recommend that Medicare be restructured to provide catastrophic protection through increased cost sharing related to income.

Alternatively: We recommend that Medicare be restructured to provide catastrophic protection through increased cost sharing unrelated to income.

These alternative recommendations would finance catastrophic protection under Medicare by shifting coverage away from modest and predictable health care costs to pay for extremely high costs incurred in any year. One approach would spread the additional cost over the cost sharing contributions of all beneficiaries. The other would keep the Part B coinsurance the same for the beneficiaries whose incomes are below a certain threshold and charge higher-income beneficiaries additional copayments calculated to cover the total cost of the increased coverage.

The strength of financing catastrophic coverage by cost sharing is that it provides catastrophic coverage to all Medicare beneficiaries, not just to those who participate in Part B.

Unlike the premium approach, however, the cost sharing approach can be viewed as a tax on sickness since only those persons who use Medicare services (25% of the Medicare beneficiaries hospitalized in any given year) are made to bear the full cost of the catastrophic protection. The cost sharing burden on those who use the system, moreover, could be burdensome for significant numbers of elderly. This is the first time that cost sharing related to income has been recommended for the Medicare program. However, it is not an unprecedented change for those on Social Security, because income differentials via the tax system were introduced into the OASDI program in 1983.

RECOMMENDATIONS TO IMPROVE LONG TERM CARE PROTECTION ALTERNATIVE

Long term care is the most likely catastrophic illness risk faced by individuals and families. There are several reasons for this. Foremost among them is lack of comprehension on the part of many people about the financial risk they run in the event that they need long term care. The result is a lack of demand for long term care risk protection, and consequently only modest progress in developing alternatives for effective private sector long term care financing and service provision.

Our strategy for addressing the long term care problem is guided by four considerations. First, Americans should be encouraged to make adequate plans for their own care in old age. Second, the financing of long term care should not inhibit

maximum choice regarding the types and level of care. Third, the elderly prefer and should be able to receive the least restrictive care possible. Thus, approaches should be emphasized that allow people to remain in their own homes, or in facilities that meet multiple personal and medical needs, such as church homes and Continuing Care Retirement Communities. Fourth, the public sector is already paying half the costs of formal long term care services through Medicaid, with the remainder being paid out-of-pocket by older persons or their families. Only 1.4% of nursing home costs are paid by long term care insurance. In any given year, as many as 500,000 elderly persons may exhaust their assets and have to spend down to Medicaid while they are in nursing homes.

We recommend that the Federal government work with the private sector to educate the public about the risks, costs, and financing options available for long term care, as well as the limitations of coverage for such services under Medicare and Medigap supplemental insurance.

The elements of a campaign might include:

- Use of radio, television, and printed material targeted to both the elderly and their families, providing information regarding risks, costs, and financial protection measures.
- Continued use of currently planned official mailings to Social Security and Medicare beneficiaries to clarify current program coverage for long term care services.
- National coordination of, and assistance for, State-led efforts to assist consumers in understanding and selecting financial protection for long term care services.

- Educational and promotional efforts on private financing of long term care directed toward long term care insurers and providers.

This recommendation would have far-reaching impact on the nation's elderly and their families and their ability to plan for the needs of old age.

We recommend that the Federal government encourage personal savings for long term care through a tax-favored Individual Medical Account (IMA) combined with insurance, and amend Individual Retirement Account (IRA) provisions to permit tax-free withdrawal of funds for any long term care expense.

The first part of this recommendation uses tax-favored individual savings to encourage personal responsibility to pay for long term care expenditures. Establishing an IMA is designed to promote private financing of long term care expenses through tax-favored savings combined with long term care insurance. Individuals would be permitted to deposit a certain amount of money (e.g. $1,000 maximum) each year into a savings account restricted for use on long term care expenses. Interest accumulations would be tax free and withdrawals would not be taxed or penalized as long as their use was for nursing home care. The principal and half the interest could be used by the individual to pay for nursing home expenses incurred after age 65; if unused it would remain in the individual's estate. The remainder of the interest would purchase additional nursing home care or long term care insurance for IMA holders after the balance in their personal accounts had been exhausted.

The major strengths of this part of the recommendation are that it encourages personal responsibility for long term care needs and enhances private sector involvement in financing those needs. This strategy offers participants more months of protection than savings-only plans because of the cost sharing feature of the insurance financed by half the interest on their savings. This option is preferable to a pure long term care insurance option in that individuals would have an added incentive to participate, because if they did not require long term care services, the funds would accrue to their spouses or their estates.

The second part of the recommendation -- tax-free withdrawal of IRA funds for any long term care expense -- provides the opportunity to finance a full range of care that would allow individuals to remain in the least restrictive environment possible. A person saving $1,000 a year (indexed for inflation) from age 40 to 64 would cover 16 months of nursing home care.

The major strength of this part of the recommendation is that it builds on an existing tax-favored savings mechanism. It allows persons to save for long term care expenses, while offering substantial flexibility and choice in purchasing financial protection or services.

We recommend encouraging development of the private market for long term care insurance in three ways:

- establish a 50 percent refundable tax credit for long term care insurance premiums for persons over age 55 (up to an annual maximum of $1,000);
- provide the same favorable tax treatment for long term care insurance reserves as is now the case for life insurance;
- remove 1984 Deficit Reduction Act (DEFRA) barriers to prefunding long term care benefits provided by employers to retirees.

The major strength of this three-part recommendation is its potential for stimulating the supply of private long term care insurance options and for broadening the market for such policies -- including innovative products that combine income and health benefits for individuals in their retirement years, and individual freedom to receive the care they need in the least restrictive living environment. It is an important complement to the education campaign recommended above, which would increase awareness of the need for long term care insurance and stimulate demand for such insurance coverage.

The specific reason for establishing the refundable tax credit is to provide a direct incentive for potential buyers, (particularly lower-income families) stimulated by their increased awareness of the risks, to take action. The specific reason for the recommended treatment of reserves is that long term care insurance involves accumulation of reserves over a much longer period than is necessary for acute health care coverage. Providing favorable tax treatment would encourage development of

more affordable long term care insurance policies. Removal of the DEFRA barriers is a prerequisite for gradual development of employment-based group coverage of long term care.

The combination of incentives will encourage the development of more flexible private insurance coverage, including home care, case-managed social and medical services under capitation, and different types of protected living environments where the elderly can receive services appropriate to their needs.

We recommend that the Federal government act to set an example for private employers and care providers. One alternative would be to offer employee-paid long term care group insurance as an option under the Federal Employees Health Benefit Program.

The Federal government is the nation's largest employer. Its leadership role would be invaluable in demonstrating the effectiveness of using large groups as a vehicle for offering long term care coverage to retirees at lower cost, at group rates, and to younger employees. Retirees might be given a choice of either paying separately for long term care insurance, or trading some of the health insurance benefits currently offered for better long term care insurance coverage. Although long term care policies are not currently available extensively to persons in their middle years, it is possible that interest in creating such policies would be generated if a large pool of individuals, such as Federal employees, were available.

RECOMMENDATIONS FOR ACUTE CARE CATASTROPHIC PROTECTION FOR THE GENERAL POPULATION

The general population includes many specific groups with differing coverage availability and coverage needs. Most of the general population are employed or dependents of an employed worker. Their protection typically comes from employment-related insurance, whether self-financed or as part of a fringe benefit package. Employers must have new incentives to expand private sector benefits to include catastrophic coverage alternatives. Historically, coverage of the poor, the near poor, and the related problem of uncompensated care have been the responsibility of State and local governments. This should continue. However, such governments need increased flexibility to develop a wider choice of alternative ways of meeting these coverage needs.

We recommend that States require all employers who offer health insurance to offer a catastrophic coverage option.

State mandates that employers who offer coverage include (but not necessarily finance) a catastrophic coverage option would allow an opportunity for the underinsured to purchase catastrophic coverage for a modest insurance premium since catastrophic coverage per se is not very expensive.

We recommend that full tax deductions be extended for health insurance to the self-employed and unincorporated businesses, as long as the coverage includes catastrophic expenses.

Until the recent tax legislation, the self-employed and owners of unincorporated businesses could not deduct the premiums for their own health business plans. The self-employed can now deduct 25 percent of their premiums. While this will help, there is little justification for not allowing certain limited portions of the employed population the same tax subsidies available to the rest of working population. The extension of the full tax subsidy should require that the self-employed and unincorporated business owners offer comparable coverage to their employees and that the coverage include catastrophic expenses.

We recommend encouraging formation of State risk pools to subsidize insurance for those whose medical condition makes it impossible or prohibitively expensive to get catastrophic insurance.

Use of an insurance pool for high risk individuals can be an effective way of reaching this small but medically and financially very vulnerable population. The subsidy should be spread over a large group -- either taxpayers or the insurer/employer community.

We recommend State innovation and initiative in such areas as loan guarantees, high-deductible catastrophic health insurance requirements for motor vehicle registrations, and greater flexibility in managing State Medicaid programs.

The catastrophic health insurance needs of persons with employment-related coverage and persons who are medically uninsurable or insurable only at very high cost have already been addressed in our recommendations. Other groups in the population can be helped substantially by the States. State and local governments must be encouraged and enabled to foster catastrophic health insurance in innovative ways which target particularly vulnerable groups in their communities.

States could, for example, institute a loan guarantee program for persons incurring high health expenses. Loan guarantees would make credit available to individuals to spread the costs of an expensive medical episode over several years. Loan guarantees, coupled with possible State subsidies to broaden the program to lower-income families, would encourage the sharing of uncompensated care costs among providers, beneficiaries, and State governments.

Another approach is for States to target specific activities or groups of people for catastrophic health insurance coverage. States could, for example, require accident-related catastrophic health insurance for all motor vehicle registrations. Driving accidents can cause disabling injuries, and many of the victims receive substantial amounts of uncompensated care from hospitals and other providers.

Increased Medicaid program flexibility will assist States in developing programs tailored to meet local needs and preferences for dealing with catastrophic expenses. States have proven their ability to meet State and local health care needs in a cost-effective manner. Among the wide range of possibilities are inclusion of catastrophic benefits as a category of service; shifting coverage toward catastrophic expenses and away from optional services; waiving income determination rules to secure family contributions toward institutional care; and other modifications to State Medicaid programs. Several alternatives are now available to State governments.

* * *

The threat of catastrophic illness is very real. Now is time, after decades of debate, to forge a partnership between government and the private sector which will help provide coverage for catastrophic illness expense.

Risk of catastrophic illness expense faces persons and families in a wide variety of economic and personal circumstances. The range of public and private coverage that currently exists is already wide. This diversity suggests the need for a variety of approaches involving every segment of employers, providers, insurers, at all levels of government; and most importantly, individuals and their families. Approaches must address the preservation of individual choice and individual responsibility at the same time that they make provision for the affordable financing of needed services.

Private sector initiative and responsible government action can lead to a strengthened health care system and the ultimate resolution of this important problem. Failure to act now will not make the problem disappear. Indeed, delay may make it harder to solve as the population ages.

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CRS Issue Brief

Major Planning Issue

Health Insurance

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by
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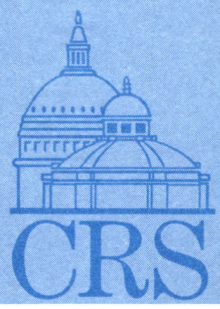

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Health Insurance

SUMMARY

Rising health care costs have created increasing pressures on public and private health care financing programs in a time of limited resources. Over the past 10 years, health care spending has grown faster than spending in the general economy. National health expenditures were $540 billion in 1988, over 11% of the gross national product. While payments by public and private health insurance programs account for a majority of payments (approximately three-fourths) for health care services, gaps in coverage and in the availability of insurance leave many persons at risk. Between 31 and 37 million people were uninsured in 1988. Generally, the uninsured are young (under age 24); they are poor; and they have ties to the work force (primarily in small firms, in industries with seasonal or temporary employment, and in firms with a lower skilled or less unionized work force). In the last decade, there was growth in the number and proportion of the uninsured population. Insurance status has implications for access to health services: the uninsured use fewer health care services and have poorer health status than the insured.

Even persons who are insured can face substantial health care costs if their insurance does not adequately cover their medical expenses. In 1986, the Department of Health and Human Services estimated that about 10 million persons (in addition to the number of uninsured) had insurance that was inadequate to protect them from risk of catastrophic illness expense. Private sector health plans and public programs such as Medicare and Medicaid all, to some degree, leave their enrollees underinsured because of cost-sharing requirements (i.e., enrollee deductible and coinsurance payments), limits on payment to providers, or uncovered services. A key coverage issue, particularly for the elderly, is that most health care plans (except Medicaid) either do not cover, or have only limited benefits for, long-term care services, including both nursing home care and home and community-based care.

Several issues for the future will continue to affect the numbers of uninsured and underinsured individuals. The rising cost of health care will put increasing pressures on public budgets, employer costs, and individuals' out-of-pocket expenses for medical care. A continuing focus of our public and private health care systems will be attempts to control those costs. The need for expansion of limited coverage for long-term care services will continue to be an issue. The future of employer-provided retiree health benefits is an issue resulting from rising employer costs for a growing retired population and questions about future commitments and funding for these costs.

ISSUE DEFINITION

Gaps in public and private health benefits coverage that result in large numbers of uninsured and underinsured individuals and families have been of concern to Congress for many years. There are a number of reasons for this. The rising cost of health care, which is reflected in rising health care premiums, underlies the problem. Cost discourages some employers and individuals from obtaining health care coverage and results in restrictive coverage definitions that exclude certain individuals under both public and private coverage. Other reasons for coverage gaps include the voluntary nature of insurance in this country.

Lack of health benefits coverage may result in individuals not seeking or not being able to obtain health care services; exposure to medical care expenses that may consume an individual or family's income and savings; shifting of costs from those who cannot pay to others who can; or services being provided in inappropriate settings, such as emergency rooms.

Congress is considering alternatives for more complete health insurance coverage. However, budgetary considerations may preclude alternatives that would involve substantial new Federal spending. Numerous bills have been introduced in the 101st Congress to expand health insurance coverage. The generic approaches embodied in these bills include expanding health insurance coverage through Medicaid; providing tax incentives to provide coverage privately; mandating employers to extend health insurance benefits to uncovered or underinsured groups; and instituting a national health insurance system.

There is also strong congressional interest in controlling health care costs. Rising costs affect the Federal budget (chiefly through Medicare and Medicaid) and State budgets (through Medicaid); access to care for the uninsured; and the competitiveness of employers who offer health benefits or the willingness of those employers to continue to offer benefits. Proposals have been considered by Congress that would contain health care costs or reduce Federal expenditures (for example, by changing the tax treatment of health benefits).

Several groups have been developing recommendations to address the issues of health care coverage, the uninsured, and health care costs. On Mar. 2, 1990, the U.S. Bipartisan Commission on Comprehensive Health Care (the "Pepper Commission") announced its recommendations on comprehensive health care services for all Americans and long-term care for the elderly. Two other groups are also examining these issues: a task force established by the Secretary of Health and Human Services is due to report in October 1990, and the Advisory Council on Social Security plans to issue its findings in January 1991.

BACKGROUND AND ANALYSIS

The Uninsured

According to a Congressional Research Service analysis of the March 1989 Current Population Survey (CPS) conducted by the Census Bureau, in 1988 most individuals (57%) obtained insurance coverage through their own or a family member's employment. Others received coverage through public programs such as Medicare (13%) or Medicaid (6%) and 9% received coverage from privately purchased policies, CHAMPUS or other health plans.

An estimated 36.8 million Americans (15%) were without any form of health insurance coverage in 1988. Other estimates, using different surveys or different assumptions, range from 31 to 37 million uninsured. While there is disagreement on the exact number of uninsured Americans, there is a consensus that the proportion of the population without coverage grew during the 1980s. The following discussion examines the characteristics of the uninsured, some possible explanations for recent declines in coverage, and the impact of lack of coverage on access to care. This is followed by a review of proposals for providing coverage to the uninsured.

Characteristics of the Uninsured

Age. Because most senior citizens have Medicare or other retirement health benefits, nearly all the uninsured are under 65, with the greatest concentration among children and young adults. Of those under age 18, nearly 1 in 5 are without coverage; children make up one-third of the total uninsured population. However, the rate of uninsurance peaks in the 18-24 age group; 25% of young adults are without coverage. The uninsured in this age group are often too old to be covered as dependents on their parents' policies. Those in poor families are no longer part of their parents' (often mother's) household and therefore ineligible for Medicaid. Those working may be in entry-level jobs that do not provide coverage. Some of the younger uninsured may also fail to obtain insurance that is available to them, because they do not foresee the need for medical care. The rate of uninsurance declines steadily from age 25 on, chiefly because older workers are more likely to obtain coverage through their own employment.

Employment Status. Of Americans with health insurance, two-thirds receive coverage through their own employment or that of another family member. (Most of the rest are covered by Medicare or Medicaid.) Among the uninsured in 1988, 84% had at least some ties to the work force; 35% were full-time, full-year workers or the dependents of such workers, but failed to obtain employment-based coverage. The uninsured are concentrated in small firms, especially those with fewer than 25 employees, in industries characterized by seasonal or temporary employment, and in those with a lower skilled or less unionized work force. The industries with the lowest rates of insurance coverage are agriculture, personal services, entertainment and recreation, and retail trade.

Income. The uninsured are disproportionately poor. In 1988, 41% of the uninsured had family incomes below 100% of the Federal poverty thresholds, and another 17% had incomes between 100% and 150% of the poverty line. Medicaid is

the major source of coverage for the low-income population. However, the maximum allowable income under Medicaid for most types of persons is below the poverty line. Also, Medicaid has categorical limits: some persons, such as single adults and childless couples who are neither aged nor disabled, cannot qualify regardless of income. As a result, Medicaid covered only 43% of persons in poverty in 1986.

Trends in Insurance Coverage

The proportion of the population that is uninsured rose sharply during the early and mid-1980s. In 1979, the uninsured represented 14.6% of the nonelderly population. By 1988, the proportion of uninsured had grown to 17.0%.

This growth in the uninsured has occurred for several reasons. First, although the proportion of the population in the work force has been growing, the percent receiving benefits has been dropping. Some analysts attribute this trend to shifts in employment. Many of the new jobs created in this decade have been in the service and other nonmanufacturing industries, the least likely to provide coverage. However, this factor accounts for only a small part of the growth in the uninsured.

Second, the proportion of the population receiving coverage through another family member's employment has been dropping. Several factors have contributed to this decline. As coverage of primary workers has dropped, so too has coverage of their dependents. Also, a growing number of workers appear to be electing coverage for themselves but not for their dependents. In 1986, workers who were themselves covered through employment failed to cover their spouses in about 3% of the cases. About 8% of the children of insured workers were uninsured. This reflects in part a decline in employer contributions to the cost of dependent coverage. In 1980, wholly-paid health care for individual and family coverage was available to 72% and 51% of employees in medium- and large-size firms. By 1988, wholly-paid individual coverage had dropped to 51% and family coverage to 32%. Changes have also occurred in family structure; there are more households with older children or unrelated individuals. Such family units are less likely to meet the definitions in insurance coverage rules.

Third, coverage from nonemployment sources declined, particularly Medicaid coverage. Welfare and Medicaid eligibility standards failed to keep pace with inflation; while the absolute number of people in poverty was rising, the number of people receiving Medicaid stayed relatively flat for a decade. Recent changes in the Medicaid program, such as initiatives to cover more pregnant women and children, may reverse this trend. However, data on the impact of these changes are not yet available.

Implications for Access

Insurance status has implications for access to health services. The uninsured use fewer health care services and have poorer health status than the insured population. The uninsured are more likely to delay seeking care; when they finally seek care, the ailment may be more serious and costly to treat. The uninsured also rely more on emergency rooms for basic services.

While the uninsured use comparatively fewer services, they nevertheless generally do receive health care. Some of the uninsured pay for these services out-of-pocket; some receive care from clinics and facilities that receive public subsidies; and some get it from providers who are subsidizing the care through increased charges to their paying customers. For example, hospitals recorded about $7 billion in free care and bad debt for 1986. Much of that uncompensated care was financed by increased charges to patients with insurance.

A problem facing the uninsured is that the sources of subsidized care may be dwindling. Increasing pressures on hospitals to negotiate rates and new methods of reimbursement are making it difficult for hospitals to make up their uncompensated care costs by raising their charges to insurers or other third-party payers. Hospitals' reduced profit margins and constraints on public monies are also limiting the dollars to finance uncompensated care. If these trends continue, the access problems of the uninsured could grow more severe. One reason these trends are likely to continue is our nation's inability to harness health care costs. It is relatively easy to provide free care when that care is inexpensive, but more difficult to do so when that care becomes a major cost.

Policy Options for the Uninsured

Policy responses to the uninsured are being considered at the State and local, as well as Federal, levels of government. The following discussion focuses on the major options being considered or likely to be considered by Congress, including proposals to reach specific target groups and broader proposals to cover virtually all of the population.

Public Programs. Existing Government insurance programs, such as Medicare and Medicaid, could be expanded to reach a larger population. There are proposals to expand Medicare, for example by eliminating the current 24-month waiting period for benefits for the disabled or permitting early retirees to purchase Medicare coverage. However, most legislative interest has focused on Medicaid, the Federal-State program for certain groups of low-income persons. In recent years, Congress has steadily expanded Medicaid eligibility for pregnant women and young children. Most recently, the Omnibus Budget Reconciliation Act of 1989 (OBRA 89, P.L. 101-239) requires all States to offer coverage to pregnant women and children under age 6 with family incomes below 133% of the Federal poverty line by Apr. 1, 1990. As passed by the House, OBRA 89 would have extended coverage of pregnant women and infants to 185% of poverty and would have covered all children in poverty through age 17; these provisions were omitted from the conference agreement. Similar proposals targeted to women and children include H.R. 1573, S. 339, S. 440, S. 949, and S. 1230. S. 768 and H.R. 1845 would extend coverage to the entire low-income population, without regard to the current categorical limits that restrict Medicaid to certain families with children, the aged, and the disabled. H.R. 950 takes a similar approach.

Tax System Options. Federal or State tax law might be modified in a variety of ways to help more individuals purchase health insurance or to encourage more employers to provide group health plans. Some options being considered to encourage individuals to purchase coverage include: (1) allowing people who do not itemize their tax returns to deduct health care costs in excess of some specified percent of adjusted

gross income; (2) providing a refundable tax credit (much like the earned income tax credit) to low-income families to subsidize the cost of health insurance (see, for example, S. 1185 and S. 5 as passed by the Senate and S. 2032. See also H.R. 3 as passed by the Senate Apr. 24, 1990.); and (3) creating a voucher program using the Federal tax system to subsidize the purchase of health insurance by low-income families. Possible options to encourage employers to purchase group coverage include: (1) making the cost of purchasing health insurance for sole proprietors and the self-employed 80% or 100% deductible as opposed to the current law deduction of 25% (see, for example H.R. 694, H.R. 4122, H.R. 1846, S. 494, S. 1168, S. 1381, and S. 1507); and (2) changing/clarifying the tax treatment of prefunding mechanisms to encourage employers to self insure.

Another approach would be to change the tax treatment of employer contributions to their employee's health insurance. Under current law, the employer's premium contribution is not counted as taxable income to the employee. A cap could be placed on any employer contribution in excess of a specified amount, such as $100 per month for an individual and $250 per month for a family. Such a measure would produce new revenues that could be used to finance other access options. Such a measure might also curb medical inflation by removing the existing tax incentive for employers to provide rich benefit packages requiring little or no employee cost-sharing. However, it could be difficult to determine where to set the cap on the employer contribution so that it does not discourage the purchase of necessary health benefits. In addition, regional variations in health care costs mean that an employer contribution that purchases an excessive benefit package in one area might buy a much less generous package in another area. Opponents of the tax cap add that a cap could result in the elimination of important health benefits, such as the coverage of mental health services.

Employment-Based Options. Federal initiatives could be used to provide employment-based coverage to more persons or to improve coverage already provided by employers. Three distinct approaches are possible: (1) Federal requirements on existing health insurance plans to reach greater numbers of people or requirements on existing plans to provide specific benefits (for example, H.R. 2563 requires employers with existing plans to provide coverage to part-time workers); (2) requirements on employers receiving Federal funds, such as State and local governments and government grantees or contractors, to provide coverage to their employees (see, for example, H.R. 43); and (3) a Federal mandate on employers to provide coverage.

Legislation was enacted as part of OBRA 1989 (P.L. 101-239) to expand Federal health insurance continuation of coverage requirements (mandated by Title X of COBRA) to enable individuals who are determined to be Social Security disabled at the time of termination of employment to receive a total of 29 months of continued coverage under their employers' group plans. (See CRS Issue Brief 87182) Bills to mandate that employers provide health insurance and expand Medicaid to pick up those not covered under the employer mandate (H.R. 1845, S. 768) are under active consideration. (See CRS Issue Brief 87168.)

Universal Access. Universal access proposals were more widely considered in the 1970s than today, but renewed momentum has been gathering in and outside of Congress for some type of universal program. The legislative proposals have

generally taken one of three approaches: a social insurance program modelled after that of Canada or Western European nations in which services are primarily financed through general revenues but are furnished by independent providers; a national health service like the English National Health Service in which the government both finances and furnishes health care services; and a mixed public-private program in which the government shares the financing burden with employers (for example, through a combination of an expanded Medicaid program and mandated employer-provided health insurance), but health services would continue to be furnished by independent providers.

While a number of proposals are pending, S. 768 and H.R. 1845, combining an employer mandate and a Medicaid/Federal-State program expansion, have moved furthest along. Hearings have been held on both proposals and on July 12, 1989, the Senate Labor and Human Resources Committee voted to report an amended version of S. 768 to the full Senate (reported on Nov. 20).

Expanding Availability. Some individuals or employers may wish to purchase insurance coverage but find it unaffordable or unavailable because of characteristics of the private insurance market or other factors. The final set of options focuses on possible interventions that might help make coverage more accessible or affordable for potential purchasers. These include the following:

1. Regulation of insurance underwriting practices, under which certain individuals or groups expected to incur high medical costs may be refused coverage, receive coverage subject to exclusion of payment for "preexisting conditions," or be required to pay higher rates than other applicants. H.R. 2649 would require States to regulate the treatment of preexisting conditions.

2. Federal preemption of State mandated benefit laws. These laws, which require insurance policies to include specific types of coverage regardless of whether the purchaser desires the coverage, are alleged to increase the price of insurance. S. 1274 includes this approach.

3. Encouraging private insurers to develop pooling mechanisms to spread the risks of high-cost cases. H.R. 872 combines this approach with an employer mandate.

Finally, some proposals assume that the private insurance market may not be able to reach very low-income or high-risk individuals and would have government assume the role of selling insurance directly. One option is the development of a Medicaid "buy-in" program, under which individuals or families whose income exceeds Medicaid standards could obtain coverage by paying a premium which would be reduced through public subsidies. OBRA 89 provides for demonstrations to test this concept for low-income women and children. H.R. 2996 would provide grants to States to develop buy-in programs, while H.R. 2218 would establish a similar program on a national basis. States may also establish special programs to cover high-risk, "uninsurable" individuals. S. 1274 would provide grants to States for this purpose.

Recommendations of the Pepper Commission. The U.S. Bipartisan Commission on Comprehensive Health Care (known as the Pepper Commission) was established by the Medicare Catastrophic Coverage Act of 1988 (P.L. 100-230) to (1) examine shortcomings in the current health care delivery system and its financing

mechanisms which limit or prevent access to comprehensive health care; (2) make specific recommendations to Congress respecting Federal programs, policies, and financing needed to assure the availability of comprehensive health care services for all individuals in the U.S. and comprehensive long-term care services for the elderly and disabled; and (3) consider in making its recommendations the amount of Federal funds necessary to finance needed services, the sources of those funds, and the most efficient and effective manner for administering programs for those services.

The Pepper Commission recommendations, released Mar. 2, 1990, had two components: access to health care and long-term care. The net Federal cost of a fully phased in program based on the Commission's recommendations for both components would be $66.2 billion (in 1990 dollars). A description of the Pepper Commission's recommendations for access to health care follows. A description of the long-term care recommendations can be found in the "Long-Term Care" section of this issue brief.

Employers with more than 100 employees would be required either to provide health insurance to their employees (with a specified benefit package and paying 80% of the premium), or to contribute to the public plan on their behalf. Smaller employers would be encouraged to provide insurance through insurance market reforms (such as guaranteed acceptance of all employer groups wishing to purchase insurance); tax credits/subsidies for certain small employers; and 100% deduction for the self-employed and unincorporated. If small employers failed to meet specified coverage targets, they would be required to provide health insurance or contribute to the public plan.

The public plan would cover employees and dependents that contribute, and non-working individuals who buy in or are subsidized. The plan would be financed and administered primarily by the Federal government; replace Medicaid for specified services; and pay providers according to Medicare's rules. The Commission's plan would be phased in, beginning with coverage of children and pregnant women through the public plan.

The Underinsured

Even persons with insurance can face substantial health care costs if their insurance does not adequately cover their medical expenses. Private sector health plans and public programs such as Medicare and Medicaid may all, to some degree, leave their enrollees underinsured because of uncovered services, cost-sharing requirements (i.e., enrollee deductible and coinsurance amounts), limits on payments to providers, or maximums on plan benefit payments.

The extent of out-of-pocket expenses for health care can be measured in absolute dollars (such as $2,000) or as a percent of income (such as 5% or 10%). A study by the Department of Health and Human Services (*Catastrophic Illness Expenses*, November 1986) used a combination of these methods to determine the population at risk for out-of-pocket catastrophic medical expenses. For a catastrophic threshold that ranged from $4,400 plus 10% of income, to $2,200 plus 5% of income, the study reported that in 1986, the incidence of catastrophic out-of-pocket expenditures ranged

from 2.4 million to 6.2 million persons, or from 1.2% to 3.2% of those under age 65 or in families headed by a person under age 65. About 35% of poor families (those below poverty) and about 3% of high-income families (those above 400% of poverty) had out-of-pocket expenses exceeding 5% of income. Overall, the Department estimated that about 10 million persons (in addition to the approximately 35 million uninsured) had insurance that was inadequate to protect them from risk of catastrophic illness expense.

Several features of health insurance plans determine the extent of out-of-pocket expense for which an enrollee is at risk. First, if a health service is excluded from coverage, an enrollee must pay the full cost of such services. Although plans provided by large firms cover a variety of services, plans provided by some smaller firms may not cover services such as physician office visits, outpatient prescription drugs and mental health care. In addition, some plans may exclude coverage for specified conditions or diseases for a new enrollee, either permanently or for a specified period of time (these exclusions are known as preexisting condition clauses or exclusion waivers).

For medical care expense covered by a plan, cost sharing (deductibles, coinsurance, or copayments) are usually required. Many plans include a limit on enrollee out-of-pocket expenses due to cost-sharing requirements. Once the enrollee has reached the limit, the plan pays 100% for covered services. Such limits range from $500 to $4,000 for medium-to-large firms. Nongroup enrollees are more than twice as likely as group enrollees to be at risk for unlimited health care expenses due to the absence of an out-of-pocket cap.

Gaps in coverage under the Medicare program have been criticized; on average, Medicare covers less than half of the health care costs of the elderly because of its durational limits for certain covered services, cost-sharing requirements, rules for payments to providers, and exclusion of certain items and services from coverage. Congress expanded Medicare's protection by passing the Medicare Catastrophic Coverage Act of 1988. However, opposition to the financing mechanism and opposition from beneficiaries who felt they already had comparable protection under private plans led to repeal of the law in late 1989. In recent years, Congress has focussed on abuses in the sale of Medigap insurance, which is private insurance designed to fill in certain gaps in Medicare's coverage. Numerous hearings have been held and regulatory reform bills introduced in the 101st Congress.

Most options for improving the coverage of the underinsured do so only incidentally as a part of broader proposals to reach the uninsured. For example, proposals to require that employers furnish a minimum package of health benefits to all employees could widen the coverage of some employees who are already insured. Only a few proposals are more specifically targeted at underinsurance. First, existing insurance policies or employer health benefit plans could be required to include catastrophic coverage provisions. Such rules would not require any individual or employer to obtain insurance, but would specify the minimum benefits for those choosing to do so. Second, low-income persons enrolled in plans with deductible and/or coinsurance requirements could be assisted in meeting those requirements through a public program. Such assistance is already available through Medicaid for Medicare beneficiaries with incomes below the poverty line. There are proposals to

extend this assistance to higher-income beneficiaries or have Medicaid pay enrollee cost-sharing for the working poor enrolled in employer plans.

Other Health Insurance Issues

Several issues will affect the cost and availability of public and private health insurance coverage in the future. These include health care costs and efforts to control them, coverage for long-term care, and retiree health benefits.

Health Care Costs and Cost Containment

The United States spends more per capita, and a greater proportion of its gross domestic product (GDP), on medical care than any other nation. U.S. health expenditures in 1987 reached $489 billion, 10.8% of GDP, as compared to 8.6% in Canada, 6.8% in Japan, and 6.1% in the United Kingdom. All of these countries have universal health insurance coverage and perform at least as well as the United States on standard measures of health care outcomes, such as life expectancy or infant mortality rates. These international comparisons have led some observers to conclude that our medical care system is much less efficient than those elsewhere. There is also concern about the rate of growth in health care expenditures. Inflation in the U.S. medical sector has outpaced inflation in the rest of the economy for many years, averaging 15% a year from 1970-80. After a brief period of moderate increases in the mid-1980s, annual increases in health care expenditures again reached the double digit level in 1988. Costs grew 10.5% over their 1987 level, reaching $540 billion, or 11.1 percent of GNP. Continued health care inflation could affect the Federal budget (chiefly through Medicare and Medicaid) and State budgets, could impede efforts to expand access to care for the uninsured, and could either damage the competitiveness of employers who offer health benefits or lead some of those employers to reduce or eliminate benefits. For all these reasons, there is strong congressional interest in controlling health care costs.

Most Federal efforts in health care cost containment have focused on the Medicare program. Past initiatives have included reviews by peer review organizations (PROs) of the appropriateness of services furnished to beneficiaries and the 1983 enactment of the prospective payment system (PPS) for inpatient hospital services, which provides an incentive for greater efficiency by establishing a fixed predetermined payment for each Medicare patient treated. OBRA 89 includes a revamping of the way physicians are paid. The previous system set maximum payments by comparing physicians' charges to those of their peers. The new system sets fixed rates for each type of service and sets overall targets for physician spending; rates in future years could be reduced if the targets were not met. The system is designed to encourage physicians to limit the number of services provided to patients, especially costly surgical and diagnostic procedures. OBRA 89 also provides for an expanded research program on the effectiveness and appropriateness of medical treatments. The program would seek to develop medical practice guidelines in order to improve quality and reduce the incidence of unnecessary treatments, both for Medicare beneficiaries and for other patients.

Private sector cost containment efforts have followed three main strategies. First, enrollees in employer plans have been held directly responsible for a larger portion of the costs of their care, through higher deductibles or coinsurance, in order

to discourage unnecessary utilization. Second, private insurers have followed Medicare in increasing their scrutiny of the appropriateness of services obtained by subscribers. Third, enrollees have been encouraged to join "managed care" programs, such as health maintenance organizations (HMOs), which attempt to control the care furnished to members through an organized system of health care providers.

Long-Term Care

"Long-term care" refers to a wide array of medical, social, personal, supportive, and specialized housing services needed by individuals who have lost some capacity for self care because of a chronic illness or condition. Long-term care services include skilled and therapeutic care for the treatment and management of chronic conditions. These services also include assistance with basic human functions, such as bathing, dressing, and eating, often referred to as activities of daily living (ADLs), as well as assistance with household tasks such as cleaning, cooking, and shopping. Major subgroups of individuals needing long-term care include the elderly and nonelderly disabled, the developmentally disabled (primarily the mentally retarded), and the mentally ill.

Both public program and private insurance coverage for long-term care services is very limited. Recent congressional action on catastrophic health insurance for the elderly brought new attention to the uncovered liability many persons face for long-term care services not covered by Medicare or private insurance. These services include both nursing home care and home and community-based care.

Expenditures for long-term care services, particularly nursing home care, strain private resources as well as the budgets of public programs. In 1988, total national nursing home expenditures of $43.1 billion were financed about equally by private resources and by public programs. Nearly all private spending for nursing home care was paid directly by the consumer out of pocket. With the average annual cost of nursing home care about $25,000, paying for such care can represent a catastrophic expense beyond the financial reach of most persons. Moreover, private insurance to cover the costs of both nursing home care and community-based services is very limited. For example, in 1988, private insurance covered only 1% of total spending on nursing home care.

The Medicare program covers principally acute health care services and was never expected to provide protection for long-term care. Coverage of nursing home care, for instance, is limited to short-term stays in certain kinds of nursing homes, referred to as skilled nursing facilities, and only for those persons who can demonstrate a need for daily skilled nursing care following a hospitalization. Many persons who require long-term nursing home care do not need daily skilled nursing care, and, therefore, do not qualify for Medicare's benefit. As a result of these restrictions, Medicare paid for less than 2% of the nation's expenditures for nursing home care in 1988.

Only one public program, Medicaid, the Federal-State health program for the poor, covers long-term stays in nursing homes. It does so, however, only for those persons who meet strict income and assets rules. For many persons facing the catastrophic expenses of nursing home care, these rules require that they first apply most of their assets and income toward the cost of their nursing home care before

they can become eligible for Medicaid coverage. In 1988, Medicaid payments for nursing home care amounted to 44% of total national expenditures for this care. The great majority of Medicaid's payments for nursing home care are for persons who are not initially poor by cash welfare standards, but who deplete their assets and income on the cost of needed care.

Public programs provide only limited support for nonmedical home and community-based long-term care services. The great majority of this care is provided by relatives and friends who are not compensated for the care they provide.

Developing a strategy for providing coverage for nursing home and home and community-based care is difficult for a number of reasons. These include uncertainty about the costs and utilization of services, budgetary constraints, and the complex interrelationships of Federal and State programs currently supporting long-term care.

In addition, observers differ in their views about what public and private sector responsibilities in financing long-term care should be. Some believe that the Federal government should assume the major role in financing long-term care for those in need regardless of their financial circumstances. Others believe that the costs of any public sector expansion may be prohibitive and that the private sector, through private insurance and other risk-pooling mechanisms encouraged with tax incentives, should take the lead. Still others believe that a combination of public and private sector strategies is needed, including Federal benefits together with beneficiary cost-sharing responsibilities that could be financed through the purchase of private insurance.

Long-Term Care Legislation. A wide range of long-term care proposals, introduced in the 100th and 101st Congresses, reflects these divergent views as to what public and private sector responsibilities should be for financing long-term care. Approaches range from those that would establish totally public benefits, without a role for the private sector or specifically private insurance, to those that would rely almost exclusively on the private sector--whether this be individuals or insurance--to provide the additional financing needed for long-term care.

S. 2163 (Kennedy), for example, would establish, in a new title of the Public Health Service Act, a long-term care program covering nursing home and home care for certain chronically disabled persons of all ages regardless of financial circumstances. Benefits would be primarily publicly financed, without deductibles or significant copayments. This bill aims to assure that additional sources of private financing would be unnecessary. H.R. 2263 (Pepper) takes a similar approach to public sector financing of long-term care, but focuses coverage strictly on home and community-based care.

At the other end of the spectrum are bills that leave to the private sector the responsibility for providing the additional financing needed for long-term care. Some of these bills would provide tax incentives to individuals for the care they provide others. Other bills would provide tax incentives to individuals and employers for the purchase of private insurance in order to encourage the growth of this fairly new market. The cost of these approaches is limited to the revenues that would be lost for providing tax deductions for various purposes.

In between are bills that would establish comprehensive long-term care benefits at the Federal level but, to a greater or lesser extent, would include with these new benefits certain beneficiary cost-sharing responsibilities that could be paid for with private insurance. H.R. 3140 (Waxman) and H.R. 5393 (Stark, 100th Congress) would each establish in Medicare comprehensive nursing home and home care benefits that would be accompanied by limited copayments and deductibles. For those below 200% of the Federal poverty level, Medicaid would share in the cost of these copayments and deductibles. Others could purchase private long-term care insurance to cover these costs. In this case, private insurance would function as a supplement to Medicare benefits in the way that Medigap policies have paid for costs of acute care benefits not covered by Medicare.

Another bill, S. 2305 (Mitchell, 100th Congress), would create a larger role for private insurance than the Medigap model, specifically with regard to coverage of a chronic nursing home benefit. Under this proposal, persons would be required to incur the first 2 years of nursing home costs before a new Medicare nursing home benefit would begin to pay. Since studies of nursing home utilization have shown that 75% of persons entering a nursing home stay less than 1 year and 83% stay less than 2 years, most persons would either have to rely on out-of-pocket payments for their care or purchase private insurance to cover the costs. This benefit has been designed to limit Federal expenditures and to encourage private insurers to develop policies and to encourage persons to be able to afford long-term care insurance.

Pepper Commission Long-Term Care Recommendations. The Pepper Commission's proposal for long-term care includes three components: (1) a federally financed social insurance program covering home and community-based care for severely disabled individuals of all ages; (2) a federally financed social insurance program covering the first 3 months of a nursing home stay; and (3) a means-tested Federal and State financed nursing home program covering stays beyond 3 months that would protect certain levels of income and assets of persons needing care. For both the home and community-based care program and first 3 months of a nursing home stay, individuals would be responsible for 20% of the costs of care, with the Federal government subsidizing this required cost sharing for persons with incomes below 200% of the Federal poverty level. For the nursing home program that would cover stays longer than 3 months, individuals would be required to apply to the cost of their care nonhousing assets above $30,000 for single persons and $60,000 for married persons, before the program would begin to pay for care. Individuals would also be required to contribute to the cost of their care income that remains after certain set-asides for housing and personal needs were made. Private long-term care insurance could fill in the gaps not covered by this plan. The Pepper Commission has estimated the costs of these benefits to be $42.8 billion (in 1990 dollars).

Retiree Health Benefits

Many medium and large employers offer their employees post-retirement health benefits. Employees usually qualify for these benefits after working 10 or more years and achieving a certain age. When a worker retires, the employer's health plan may be his or her only source of health insurance until becoming eligible for Medicare, and an important source of additional coverage thereafter. In 1987, an estimated 10.8 million retirees and their dependents were covered by employer-sponsored retiree health plans.

Congress is becoming increasingly concerned about the future of employer-financed retiree health benefits. As more and more companies seek to reduce or terminate their plans, the danger grows that retirees will lose an important source of privately sponsored health insurance.

Several factors are converging to make retiree health benefits more expensive for employers, including health care inflation, unfavorable demographic trends, and changes in Medicare payment policy. Perhaps most important is that certain companies have accumulated a vast unfunded liability for the coverage of current and future retirees. All but a small percentage of firms that offer retiree health benefits pay for the benefits as they are incurred. The total unfunded liability of employers for current and future retiree health benefits has been estimated by the GAO to be over $400 billion. The liability question may become explosive now that the Financial Accounting Standards Board has issued draft rules requiring companies to recognize the aggregate costs of their retiree health plans on financial statements. Companies with substantial commitments to pay for their retirees' health care and insufficient funds to pay for them may be seen as poor investment risks.

Some companies have already sought to reduce their retiree health commitment by modifying or eliminating their plans. Others have tried to eliminate their liability through Chapter 11 reorganization under the U.S. Bankruptcy Code. The latter approach was taken by the LTV Corporation. After filing for reorganization in 1986, LTV terminated health and life insurance benefits for more than 78,000 retirees. The company restored the benefits after substantial public pressure, and Congress stepped in with a stopgap measure to further protect the LTV retirees.

The LTV case sent a warning that retiree health benefits are uncertain for current, let alone, future retirees. The 99th Congress enacted a law to ensure that retirees of certain companies that had filed for bankruptcy continued to receive health benefits. In the 100th Congress, legislation was enacted to help safeguard retiree health benefits in cases where companies file for Chapter 11 reorganization. In the 101st Congress, House and Senate proposals were included in the Omnibus Budget Reconciliation Act of 1989 (H.R. 3299, S. 1750) to allow employers on a tax-favored basis to use excess pension funds to finance the health benefits of current retirees. These were dropped in conference although a technical provision relating to contribution limitations on 401(h) accounts was adopted.

Legislation (S. 2199, H.R. 4134) similar to the proposals dropped in conference has been introduced in the second session of the 101st Congress. The Administration's fiscal year 1991 budget also includes a proposal to permit the transfer of excess pension funds to pay current retiree health benefits. The transfer would have to occur before Jan. 1, 1993, and in a plan year beginning after Dec. 31, 1990.

Consideration may also be given to bills imposing new Federal requirements on employers to provide for vesting and portability of retiree health benefits, as well as new standards for plan administration.

WASHINGTON POST, HEALTH SECTION, NOVEMBER 18, 1986, pp. 12-15.

THE RIGHT CHOICE

WHICH MEDICAL INSURANCE PLAN IS BEST FOR YOU?

By Victor Cohn
Washington Post Staff Writer

More than half a million Washington area federal workers, retirees and their families are in the midst of asking themselves:

"Should we stick with our present health insurance or health plan or switch?"

Their decision will determine how much money they will pay for coverage, how much they will have to pay if they get sick—and what doctor or doctors and even what hospitals they will be permitted to use.

The "feds" are in their annual open season, a period ending Dec. 5 during which they must decide between a record number of 23 health plans now competing here.

The rest of us don't have that many choices. But, if you work for a firm with 25 employes or more, you still must be offered an annual choice between several plans. It's all part of a new day in health care, one far different from the time when most people were covered by Blue Cross and Blue Shield and never thought about "switching."

Today switching can pay in dollars and health. But the decisions aren't necessarily easy.

You may have to pay more to stick with your present plan. Although some plans have cut premiums or plan no raise, premiums are going up 4 percent on the average while the next federal pay raise will be 3 percent.

A federal employe with a family of four can pay up to $3,000 a year for coverage, though most choose a plan that costs something around $1,500. This is only about 40 percent of the entire cost; the government pays more than 60 percent.

And beware: you may switch to an apparently economical plan for 1987, only to find that it implements a steep rate increase next year. Year to year rate changes can vary.

Still, says Washington Consumers' Checkbook, publisher of an annual guide for federal employes, many workers can save $1,000 in 1987 by picking the right plan.

The Patient's Advocate
Commentary

Which Plan Is 'Right' for You?

The hard fact is that there is no right plan for everybody, and no single "best" plan or choice. The right plan for you may depend on your paycheck, your age, your sex and whether you're single or part of a family, as well as your health and the kind of doctor and medical care you prefer.

- If you're expecting a child, for example, you can have $4,000 in doctor and hospital bills, so you want a plan with generous coverage of maternity expense.
- Do you think you or a family member may need psychiatric or mental health care, or treatment for alcohol or drug abuse? Look for good mental health benefits.
- Is there a possibility of an operation? Hospitalization? Find out what your out-of-pocket expenses might be.
- Getting older? You may want to pay special attention to "catastrophic" benefits, payment for massive care beyond an ordinary year's expense. Or home care benefits after hospitalization.

Five Main Types of Insurance

- The traditional "service" or "indemnity" plans—Blue Cross-Blue Shield or Aetna, for example, or the "self-insured" plans operated by many employers. You go to any doctor or hospital you want. The plan, if you have a good one, pays most—but not all—of your bills. You may have to do the paperwork, though some employers and some doctors, by no means all, will do most of it for you.
- Cash indemnity or "supplementary" policies. These are not one of the federal choices but are often advertised by direct mail, newspaper ads or TV. They typically offer so many dollars a day when you're hospitalized "no matter" what other insurance you have. A nice sounding idea, but often not a great buy.
- Health maintenance organizations, or HMOs, which give you all your care (almost) for a set monthly payment. Staff-type HMOs include Group Health Association, Kaiser and George Washington University Health Plan, which have their own doctors and nurses in clinics throughout the area.
- Individual Practice Associations, or IPAs. These are also known as "HMOs without walls," like MD-IPA, HealthPlus and others. These plans have many associated doctors who practice in their own offices but are paid by the HMO instead of billing you.

In both types of HMOs, you must use the plan's doctors except for referrals in special cases, or else pay the bill yourself.

- Preferred Provider Organizations, or PPOs, a sort of insurance hybrid. Aetna's CHOICE plan is an example. PPOs vary greatly, but you typically get full coverage when you use the plan's "preferred" doctors or hospitals. You get perhaps 20 percent less reimbursement if you go elsewhere.

How to Choose?

Consumers' Checkbook sensibly advises:

"Try to focus your decision on two or three key questions. Either you are willing to join an HMO or you are not. Either you expect big bills for a particular problem such as maternity or surgery, or not. Either you really want to have a particular type of benefit . . . or not. Either you can afford a big premium to get the benefits you want, or you cannot and must pick a plan which has a low premium even if it exposes you to bigger risk."

And—one of the best guides of all—ask as many coworkers and friends as possible about their experience with various plans. A plan may look good on paper, but its service may be sloppy, its doctors not to your liking, its payment slow, its "denials"—refusals to pay because you didn't fit the fine print—frequent.

Two Key Questions

- *How much will the plan cost me?*

You can often buy either a "high option" or, if you think you'll be healthy or it's all you can afford, a "low" or "standard option" plan. But don't just look at the premium cost. Are there extra copayments or deductibles, sums you have to pay each time you use the plan?

HMOs or IPAs often cost more per month, but typically they cover more services. Some HMOs do charge $4 or $5 or $10 a visit, to discourage too many visits.

To assess your real costs, see what the plan does about "extra" items like prescriptions, mental care, eye and hearing tests, dental care and medical equipment.

- *Should I join an HMO of one type or another, or buy traditional health insurance?*

This will determine not only the cost but also the type and quality of care you will get.

The young, healthy and childless may pay an HMO more than they get back in care. A family with young children who are forever being lugged to the pediatrician, or an older person with many or recurring ailments, may come out well ahead.

In a well-run HMO, you pick your own primary care doctor from the plan's list. He or she is either an internist, a family physician, a pediatrician (for children) or, in a few plans, an obstetrician-gynecologist for women who prefer one as primary doctor. This doctor is expected to coordinate all your care. This can make for very good medicine, with cooperation with the plan's specialists when needed.

At the same time, this doctor is also the plan's "gatekeeper," who must okay any visits to specialists, inside or outside the plan. For women, this may include seeing an OB-GYN doctor if the OB-GYN is not the primary physician.

In some plans, you may find yourself seeing a nurse-practitioner instead of a doctor, unless you specifically say, "I want to see the doctor." Some people like this—the nurse-practitioners frequently take more time and are very caring, patients say—and some do not.

HMOs commonly offer, and even urge, routine physical exams, well-baby care (often through age 5), immunizations and health education classes. Some traditional health insurance plans have recently begun offering well-baby care, too.

HMOs try hard to keep patients' waiting time down to 20 or 25 minutes. But—among HMO minuses for consumers—they keep their doctors on a tight and "efficient" schedule that often allows an average of 15 minutes a visit.

There may also be a lack of continuity. You may have "your" doctor, but he or she may leave the plan abruptly. Some young doctors still use HMOs as entry points in their career and then join another practice.

In addition, well-known leaders in the medical community generally prefer private practice or a medical school post to working for an HMO. The exception is the George Washington University plan's main clinic, where all the doctors are university faculty members. Overall, HMO doctors are well qualified. With today's generous doctor supply, HMOs can hire good physicians.

HMO Questions

If you're thinking of joining an HMO of whatever type, ask:

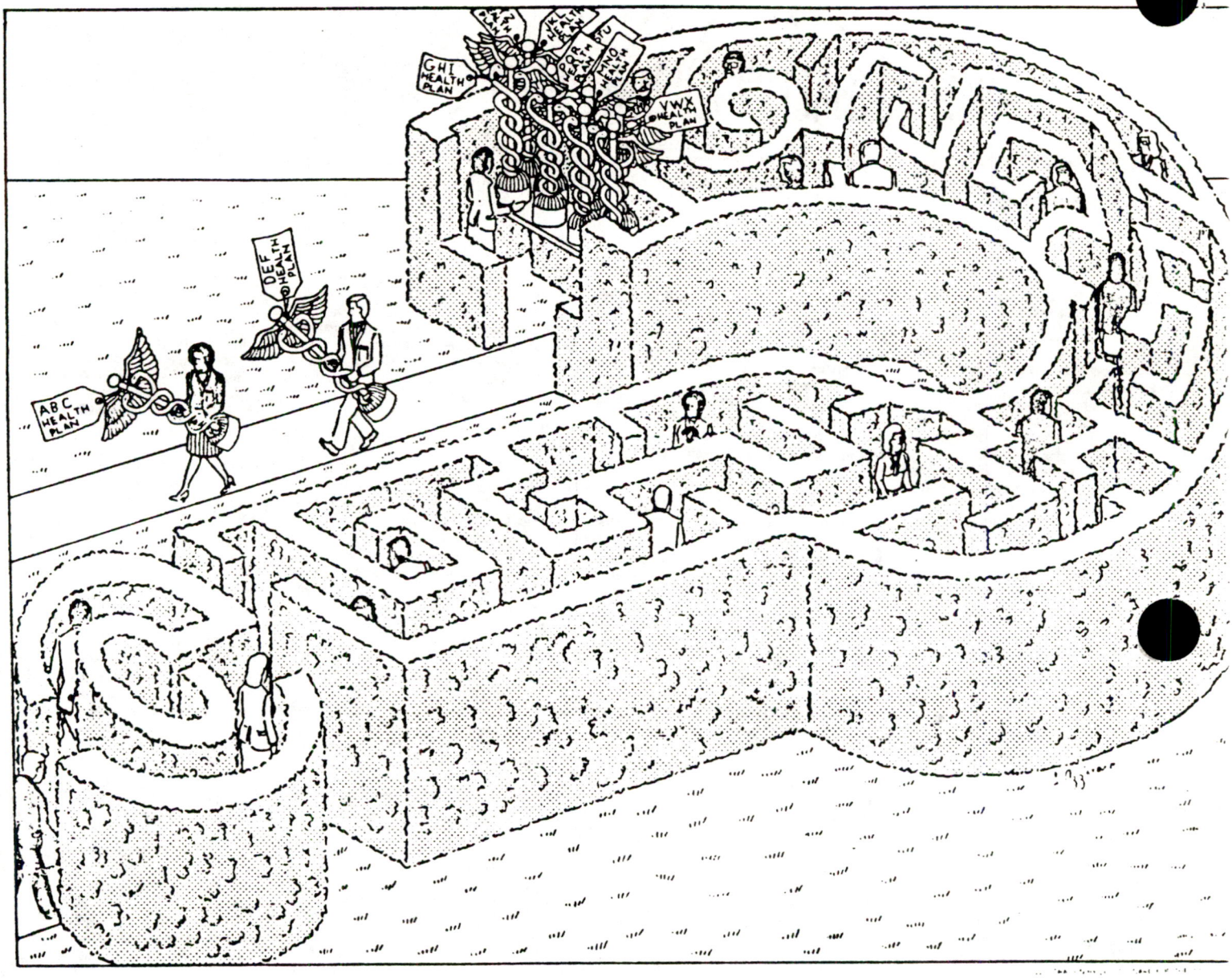
- Where would I go for care? Is it convenient? What are the hours? What hospitals would I go to?
- How long does it take to get an appointment? In some HMOs, it is only a few days. It shouldn't be more than a week or two for non-urgent problems; no more than a few weeks to see a specialist.
- What about emergencies? After-hours care? Nights, weekends, holidays? You should be able to get prompt service in all these cases, though it will probably be at a specified hospital or other site, not the usual clinic. In serious emergencies, however, you should be able to go to the nearest hospital, or whatever hospital a rescue service takes you to, and still be covered.
- Who will my doctor be? Is he or she board certified (by a specialty examining board)? Many good doctors are not certified, but this is one test of excellence. How easy is it to change doctors? Some plans limit changes to twice a year to discourage doctor-hopping and encourage continuity of care.
- What specialties does the plan have? How easy or hard is it to be referred to a specialist outside the plan?
- What if I travel? Most HMOs will reimburse you only for bona fide emergencies elsewhere, and many will pay only a small part of what can be very high costs.

I can testify from many letters and phone calls that many people love their HMO care. And some hate it. Most of the satisfied HMO patients have found a good doctor and stayed with that doctor.

To Switch or Not to Switch

Traditional insurance plans have a proven track record. At last count, 84 percent of federal employes still belonged to Blue Cross-Blue Shield, Aetna or similar plans.

Most patients wisely put sticking with a good doctor ahead of choosing a health plan on the basis of a few dollars' (or even many dollars') difference in costs. If you've been lucky enough to find a doctor you're happy with, the comm



wisdom is to stay put, whether with HMO care or traditional insurance.

What's more, many doctors in private practice are signing up with IPA-type HMOs or PPOs for a share of their patients. This can be worth asking about.

Traditional Coverage

If you're considering traditional health insurance, ask:

- What's covered? What's not covered? At the doctor's office? The hospital? The prescription counter? The dentist? The rehabilitation center? The alcohol and drug abuse clinic?
- Are there limits—there probably are—on paying doctors' charges, which would leave you to pay the rest? Health insurors usually pay only "customary and reasonable" charges. Your doctor may charge more, sometimes a lot more. The Checkbook guide advises: "Discuss the fee with your doctor before any high-cost service is provided. In most cases, the doctor will agree to accept what the plan will allow. If not, consider using another doctor who will accept the usual rate."

But be warned: a few plans that advertise low rates have some fee schedules considerably lower than most doctors will ordinarily accept.

- Are there lifetime dollar limits on how much the plan will pay? Deductibles for hospital and physician services? How high is the limit on catastrophic payments?

More Questions

No matter what kind of plan you're thinking about, ask:

- Are all my other family members covered? To what age are my children covered?
- Can I renew my policy or membership as often as I like? Can I be canceled for any reason? What happens after I reach age 65?
- What if my spouse has our only coverage and I get divorced? What if I leave my employer or group? In many cases, you can buy coverage in the group plan for a period, then buy an individual plan, though it may cost you much more for fewer benefits.
- What if I want to make a complaint? Is there an ombudsman or patient representative I can talk to? If you tell me I'm "not covered" for something, can I appeal?

This is the time to read the fine print on the brochure and ask friends about their good and bad experiences. They may tell you more than any guidelines can. ■

Comparison of plans ..... *Page 14*
The economics of insurance ..... *Page 16*

Where to Turn for Help

Federal workers can get detailed information about competing health insurance plans from:

- The Office of Personnel Management's free "1987 Enrollment Information Guide and Plan Comparison Chart," a pamphlet available at each agency. Excellent on costs, very general on benefits.
- The health plans' own brochures—essential for detailed information on benefits—available at some agencies and agency "health fairs."
- The "Checkbook's Guide to 1987 Health Insurance Plans for Federal Employes," $4.95, published by Washington Consumers' Checkbook magazine. Available at newsstands—it's digest sized, with a hot pink cover—or by writing Washington Consumers' Checkbook, Suite 925, 806 15th St. NW, Washington, D.C. 20005.
- Checkbook's equally valuable report on Washington area HMOs, available for $5.95 by writing the same address for a copy of Checkbook's summer 1986 issue.

Though one is addressed to federal employes, both Checkbook publications can be valuable to anyone.

- For retirees, a special OPM information package, available (if you haven't received it) by writing OPM Open Season Task Force, P.O. Box 809, Washington, D.C. 20044, or by phoning 632-5272.
- Washington area retirees [illegible] United Seniors' "Medigap C[illegible] by phoning Steve Kilkelly at 393-[illegible] or writing United Seniors' Consumer Cooperative, 12334 G St. NW., Washington, D.C. 20005. United Seniors will send you a form so you can indicate what coverage you have and what plans you're considering, then send you a personal analysis. $20 ($12 for members).

— Victor Cohn

Cassandra Doyle, a Navy employe who lives in Southeast Washington, belongs to George Washington University Health Plan. "I'm very satisfied," Doyle says. "I was in the hospital for 19 days for major surgery this year, I didn't have to pay a penny and I had very good doctors."

High Option (Self and Family): $95.58
andard Option (Self Only): $17.58
andard Option (Self and Family): 1.29

For high option, plan kicks in after $200 calendar year deductible. For standard, plan kicks in after $250 deductible. High option pays 100 percent of hospital charges after room and board charges the first day, subject to certain conditions. Standard pays 100 percent after $150, subject to conditions. For high option, catastrophic limit of $2,000; for standard, catastrophic limit of $1,000 per individual and $2,000 for family.

■ **NTEU (National Treasury Employees Union) Health Benefit Plan**
High Option (Self Only): $60.24
High Option (Self and Family): $143.67
Standard Option (Self Only): $12.65
Standard Option (Self and Family): $28.57

For high option, plan kicks in after $200 calendar year deductible; for standard, plan kicks in after $250. High option pays for 100 percent of hospital room and board, 80 percent of other charges after $50 hospital deductible. Standard pays for 75 percent of all hospital charges after calendar year deductible is met. For high option, catastrophic limit of $1,500 for individual and $2,000 for family; for standard, limit of $2,000.

■ **Postal Supervisors Health Benefit Plan**
Self Only: $27.30
Self and Family: $74.19
Plan kicks in after $200 calendar year ductible. Plan pays for 100 percent of spital charges after $165. Catastrophic imit of $1,000.

■ **Postmasters Benefit Plan**
High Option (Self Only): $59.82
High Option (Self and Family): $125.99
Standard Option (Self Only): $15.43
Standard Option (Self and Family): $37.61

For high option, plan kicks in after $200 calendar year deductible; standard kicks in after $250 deductible. High option pays for 100 percent of hospital room and board charges after $175, 80 percent of other hospital charges, subject to certain conditions. Standard pays up to $250 per day for room and board charges, 80 percent of other charges. For high option, catastrophic limit of $2,000 for individual and $2,500 for family; for standard, catastrophic limit of $2,500.

HMOs

Unlike fee-for-service plans, HMOs offer a range of health services for one pre-paid fee, including routine check-ups, hospitalization, and surgery. HMO enrollees also agree to receive their care from the doctors and hospitals chosen by the plan.

The biggest drawback of HMOs, by most accounts, is that you don't have the complete freedom, except in emergency situations, to select doctors who are not affiliated with the plan. On the other hand, HMOs charge virtually no out-of-pocket expenses and they save members the trouble of filling out and arguing over claims forms. The best HMOs also have their own philosophy of health care, stressing preventive medicine and comprehensive review of doctor quality.

There are two main classes of HMOs: group practice or clinic models, and individual practice associations (IPAs), plus the closely related preferred provider organizations (PPOs).

Group Practice Models

Group practice HMOs offer health care at central facilities staffed by their own personnel. Their doctors either work on salary for the plan directly or are part of a group that contracts to provide service for the HMO.

One of the advantages of this model is the convenience of "one-stop" shopping; often the HMO clinics house not only doctors' offices, but also laboratories, pharmacies, and diagnostic equipment. Consumers should make sure, however, that the central locations are easily accessible from home or work. You should also investigate how long it takes to get an appointment, and, once you get an appointment, how long you will wait to see a doctor.

There are three group-model HMOs operating thoughout the Washington metropolitan area:

■ **Group Health Association**
High Option (Self Only): $31.85
High Option (Self and Family): $110.15
Standard Option (Self Only): $17.52
Standard Option (Self and Family): $56.83

For high option, $100 yearly copayment for hospital care, no copayments for office visits. For standard option, $200 yearly copayment for hospital care, $10 copayment for each office visit. Under high option, $2,158 maximum in out-of-pocket expenses for individual, $5,693 for families. Under standard option, $1,070 maximum for individual, $2,838 for families.

GHA offers clinics throughout the metropolitan area, but patients who do not live near these centers can also visit a network of affiliated doctors the HMO is putting together.

■ **The George Washington University Health Plan**
High Option (Self Only): $34.28
High Option (Self and Family): $121.38
Standard Option (Self Only): $18.49
Standard Option (Self and Family): $77.72

For high option, no copayment for hospital care or office visits. For standard option, $75 per day copayment for inpatient hospital care, up to $500 maximum for individual and $1,000 maximum for family; $10 copayment for each office visit. Under high option plan, $105 maximum in out-of-pocket expenses for individual, $250 for family. Under standard option, $1,707 for individual and $4,774 for family.

Doctors associated with the plan are on the faculty of GWU School of Medicine and Health Sciences; the primary hospital used is GWU Medical Center.

■ **Kaiser Permanente Health Plan of the Mid-Atlantic States**
Self Only: $26.50
Self and Family: $83.24

No copayment for hospital care or office visits. Plan is part of the Kaiser Permanente system, the largest system in the country and the group that pionneered the HMO concept before they were called HMOs.

Individual Practice Associations

IPAs have no central facilities, but rather contract with private doctors who see patients in their own offices.

Navy worker A.R. Habayeb of Bowie, his wife and three children now have Blue Cross-Blue Shield. But "I'm shopping around like everyone else," he says and is considering HealthPlus—an "independent practice" HMO, where he can see any doctor on the HealthPlus list. "It's confusing," Habayeb says of the many available plans. "Like buying a car—so many models."

Otherwise, they are similar to group-model HMOs in that you must choose doctors associated with the plan and use the hospitals affiliated with the plan. Often, however, members will have a greater selection of doctors to choose from than in a group model HMO.

■ **CapitalCare**
Self Only: $20.67
Self and Family: $80.79
$50 copayment for each day of hospitalization, starting on second day of hospitalization, up to a $150 limit. $5 copayment for office visit. $500 maximum in out-of-pocket expenses per member. CapitalCare is the HMO offering of the area Blue Cross and Blue Shield plan.

■ **HealthPlus**
High Option (Self Only): $33.87
High Option (Self and Family): $75.64
Standard Option (Self Only): $17.87
Standard Option (Self and Family): $39.79

For high option, no copayment for hospital care, $5 copayment for office visits. For standard option, $200 copayment per medical admission to hospital; $400 per surgical or maternity admission; $50 per outpatient visit; $5 copayment for office visit. $650 maximum in out-of-pocket expenses for individual, $1,500 maximum for family.

■ **M.D. IPA**
Self Only: $20.37
Self and Family: $82.55
No copayment for hospital care or office visits. $938 maximum in out-of-pocket expenses for individual, $2,518 for family.

■ **Network Health Plan**
High Option (Self Only): $38.89
High Option (Self and Family): $110.82
Standard Option (Self Only): $28.60
Standard Option (Self and family): $85.41

For high option, no copayment for hospital care, $5 copayment for office visit. For standard option, $200 copayment per medical admission; $400 per maternity admission; $400 per surgical admission; $50 per outpatient surgery; $5 copayment for office visit. $1,000 maximum in out-of-pocket expenses for individual, $2,500 maximum for family.

■ **Physicians Care**
Self Only: $39.46
Self and Family: $96.98
No copayment for hospital care; $5 copayment for office visit.

Preferred Provider Organizations

A PPO is a hybrid, someplace in between an IPA and traditional insurance.

■ **Choice Healthcare Plan**
Self Only: $30.08
Self and Family: $97.54
$100 copayment each time you go into the hospital; $5 copayment for office visits. $750 maximum out-of-pocket expenses for individual, $1,500 for family. Choice is sponsored by Aetna. You pick a primary care physician (or, for women, a general and an OB-GYN doctor). You are covered only for care by this physician or those he or she refers you to, and for care at selected hospitals—in both cases, except in emergencies.

Choosing a Plan: Cheaper Is Not Necessarily Better

The following shows some basic cost differences between the health plans available to all federal workers in the Washington metropolitan area.

Consumers should bear in mind, however, that cost is not the only factor in choosing a plan. You should examine the brochures provided by the plans for differences in benefits, convenience, and the doctors and hospitals available under the plans. Consumers should also be aware that premiums are only one part of the cost picture; many plans have significant copayments for hospital and office visits, as well as other out-of-pocket expenses for prescription drugs and dental care. In addition, plans have increasingly adopted various cost-cutting measures, like requiring you to get a second opinion for elective surgery.

Consumers and the federal government share the cost of premiums, according to a pre-determined formula. For this year, the monthly government contribution to health plans is $58.82 for individuals amd $129.33 for families. Listed below is the amount of the monthly premium employes must pay. Some of the union plans also require you to pay a small fee in addition to join.

— Michael Abramowitz

Fee for Service

These are the traditional service or indemnity plans that essentially allow you to go to any hospital or doctor and will pay for the entire bill for covered services, subject to certain deductibles or copayments. Such a plan is for people whose paramount interest is complete latitude in selecting physicians. At the same time, you may also have the hassles of filling out your own claim forms.

In evaluating plans, consumers should try to anticipate the amount of medical care they will need over the year. A rough rule of thumb is that the "high option" plans—which charge higher premiums and have lower deductibles and copayments—are attractive to sicker patients who expect they will need a lot of hospitalization. By contrast, "standard option" plans charge lower premiums but also have higher out-of-pocket expenses; these generally attract healthier enrollees who expect to stay out of the hospital.

Virtually all the plans have maximum limits, beyond which you will pay no more out-of-pocket expenses. This way, you are protected against catastrophic medical costs.

There are 13 fee-for-service plans available to all federal workers in the Washington area. Another 12 are available for members of specific groups, like the Foreign Service or Secret Service:

- **Aetna**
  High Option (Self Only): $80.78
  High Option (Self and Family): $130.26
  Standard Option (Self Only): $18.69
  Standard Option (Self and Family): $39.99

  For high option, plan kicks in after calendar year deductible of $200; for standard, $250 deductible. High option plan pays 80 percent of hospital charges; standard option pays 75 percent. For both options, catastrophic limit of $1,500 for individual, $3,000 for family.

- **AFGE (American Federation of Government Employees) Health Benefit Plan**
  High Option (Self Only): $40.41
  High Option (Self and Family): $83.46
  Standard Option (Self Only): $11.27
  Standard Option (Self and Family): $24.50

  For high option, plan kicks in after calendar year deductible of $200; for standard, various deductibles for different services. High option pays 100 percent of hospital charges after $100. Standard option pays 100 percent of room and board after $100; 80 percent of other services. For high option, catastrophic limit of $1,500; for standard, catastrophic limit of $2,500 per person.

- **Alliance Health Benefit Plan**
  High Option (Self Only): $39.83
  High Option (Self and Family): $131.51
  Standard Option (Self Only): $10.34
  Standard Option (Self and Family): $27.85

  For high option, plan kicks in after $200 calandar year deductible; for standard, $300 deductible. High option pays 100 percent of hospital room and board, 80 percent of other hospital charges. Standard option pays 75 percent of hospital charges. For high option, catastrophic limit of $1,000 for individual and $2,000 for family in high option; for standard option, catastrophic limit of $2,000.

- **APWU (American Postal Workers Union) Health Plan**
  Self Only: $26.52
  Self and Family: $50.83

  Plan kicks in after calendar year deductible of $175. Plan pays 100 percent of first five days of room and board in hospital; 100 percent of the rest if pre-admission certification is obtained from plan; and 80 percent of other hospital charges. Catastrophic limit of $1,500.

- **Blue Cross and Blue Shield**
  High Option (Self Only): $73.65
  High Option (Self and Family): $159.81
  Standard Option (Self Only): $18.49
  Standard Option (Self and Family): $41.14

  For high option, plan kicks in after calendar year deductible of $200; for standard, $250 deductible. High option pays 100 percent of hospital charges after $50 deductible; standard option pays 100 percent after $100 deductible. For high option, catastrophic limit of $1,500; for standard, limit of $2,500.

- **Government Employees Hospital Association Benefit Plan**
  Self Only: $26.31
  Self and Family: $49.20

  Plan kicks in after calendar year deductible of $200. Plan pays 100 percent of hospital charges. Catastrophic limit of $2,000.

- **Mail Handlers Benefit Plan**
  High Option (Self Only): $15.16
  High Option (Self and [illegible]): $39.
  Standard Option (Self Only): $12.77
  Standard Option (Self and Family): $30.22

  No calendar year deductible. Plans pay in full for hospital room and board, as well as 100 percent of other charges after $125. Catastrophic limit of $2,5(for individual and $5,000 for family.

- **NAGE (National Association of Government Employees) Health Bene Plan**
  High Option (Self Only): $42.90
  High Option (Self and Family): $107
  Standard Option (Self Only): $14.87
  Standard Option (Self and Family): $35.46

  For high option, plan kicks in after $200 calendar year deductible; for standard, after $250 deductible. High option pays 100 percent of hospital charges after $150, subject to pre-admission certification. Standard pays 75 percent of hospital charges, subject to pre-admission certification. F high option, catastrophic limit of $1,00 per individual and $2,000 per family. F standard, limit of $2,000 per individual and $3,000 per family.

- **NALC (National Association of Lett Carriers) Health Benefit Plan**
  Self Only: $44.55
  Self and Family: $76.66

  Plan kicks in after $150 calendar yea deductible. Plan pays 100 p[illegible]t of hospital charges, less $12[illegible]day the first five days of each [illegible]n. Catastrophic limit of $1,0[illegible]

- **NFFE (National Federation of Feder Employees) Health Benefit Plan**
  High Option (Self Only): $41.06

PHOTOS BY ELLSWORTH J. DAVIS—THE WASHINGTON POST

Ed Corcoran of Fairfax County is both a retired military man and Navy civilian employe. At o of a series of health insurance fairs to help federal workers choose a health plan, he tells Group Health Association's Lilla Oxaal that he thinks he'll join GHA. "With Gramm-Rudman cuts a all," he says, he and his wife are having a "harder time" getting military care. "I've talked to m fellow workers and friends, and they like GHA."

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Health Insurance: Employer Mandated Benefits IP 389H

There has been increasing public and congressional concern over the large number of Americans with no health insurance. In 1986, Congress passed Title X of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA, P.L. 99-272) which requires certain employers to offer continued health insurance coverage to their employees who would otherwise lose coverage for certain reasons. The Tax Reform Act of 1986 added nondiscrimination rules to Section 89 of the Internal Revenue Code to ensure that certain employee benefit plans, including health plans, are broadly based and do not primarily favor certain categories of employees who are owners, officers or highly placed individuals. Language repealing Section 89 and restoring the nondiscrimination rules to what they were prior to the Tax Reform Act of 1986 was included in P.L. 101-140, signed into law on November 8, 1989. There is also some interest in the 101st Congress in expanding health insurance coverage through mandated employee health benefits. This Info Pack summarizes the provisions of Title X, Section 89, and the subsequent changes to these laws.

Three other Info Packs are available on related topics. They are "Catastrophic Health Insurance" (IP 370C), "Health Insurance" (IP 72H), and "Health Care Access: Federal Policy Issues" (IP 421H).

Members of Congress who want further information on this topic may contact CRS at 707-5700. Additional CRS Reports may be identified by looking in the current *Guide to CRS Products* (for congressional use only) under "Health Insurance" and in the latest *Update* under "Health."

Additional information on this subject, primarily in periodicals and newspapers, may be found at a local library through the use of indexes such as the *Readers' Guide to Periodical Literature*, Public Affairs Information Service *Bulletin* (PAIS), *General Science Index*, and various newspaper indexes.

We hope this information will be helpful.

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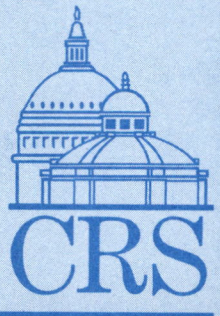
CRS Issue Brief

Health Insurance Continuation Coverage

Updated May 21, 1990

by
Beth C. Fuchs
Education and Public Welfare Division



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Health Insurance Continuation Coverage

SUMMARY

Most Americans with private group health insurance are covered through an employer. In the past, that coverage was generally dependent on being employed or being related to the employed worker. A change in the individual's work or family status often resulted in the loss of that coverage. In April 1986, a law was enacted which helps many people retain their health insurance in the event of a change in their work or family status for 18 or 36 months, depending on the nature of the event. Under Title X of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA, P.L. 99-272), and subsequent amendments, an employer with 20 or more employees is required to provide his or her employees and their families the option of continued coverage under the employer's group health insurance plan in the case of certain designated events. The employer is not required to pay for this coverage. Employers who fail to provide the continued health insurance option are subject to penalties under the Internal Revenue Code, and the Employee Retirement Income Security Act (ERISA); State and local governments are subject to penalties under the Public Health Service Act.

COBRA was signed into law on Apr. 7, 1986. Since then, Title X has been modified several times. The Tax Reform Act of 1986 (P.L. 99-514) included technical corrections, and the Omnibus Budget Reconciliation Act of 1986 (P.L. 99-509) provided for continuation coverage for retirees in cases of bankruptcy. Additional changes were made as part of the Technical and Miscellaneous Revenue Act of 1988 (P.L. 100-647), and the Omnibus Budget Reconciliation Act of 1989 (OBRA, P.L. 101-239). The Departments of Labor and Treasury have provided preliminary guidance on implementation of the Title X provisions.

Title X was enacted in response to increasing congressional concern about the large number of Americans who lack health insurance. In 1985, an estimated 37 million Americans under age 65 were without any health insurance coverage. Some of these individuals would have retained health insurance had they not lost it as a result of a lay-off, or as a result of the death of or divorce from the covered worker. Congress considered and enacted continuation coverage legislation with the expectation that it would help expand access to health insurance coverage for at least these individuals.

Some Members of Congress believe that COBRA went too far in mandating that employers provide their employees and their employees' families continued coverage. They argue that it has resulted in extra costs for employers as well as added administrative burdens. In contrast, others in Congress believe that COBRA should be expanded to include new eligibility categories. As part of OBRA of 1989, Title X was modified to allow persons to extend coverage from 18 to 29 months to those with a disability at the time of termination from employment (or reduction in hours), and to allow beneficiaries to retain their existing continued coverage if their new employer's plan contains a preexisting condition limitation.

ISSUE DEFINITION

Most Americans with private group health insurance are covered through an employer. In the past, that coverage was generally dependent on being employed or being related to the employed worker. A change in the individual's work or family status often resulted in the loss of coverage. In April 1986, a law was enacted which helps many individuals retain their health insurance in the event of a change in their work or family status. Under Title X of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA, P.L. 99-272), and subsequent amendments, an employer with 20 or more employees is required to provide his or her employees and their families the option of continued coverage under the employer's group health insurance plan in the case of certain designated events. The employer is not required to pay for this coverage.

Some in Congress believe that COBRA went too far in mandating that employers provide their employees and their employees' families continued coverage. They argue that it has resulted in new costs for employers as well as additional administrative burdens. One bill, H.R. 585, would allow employers to terminate continued coverage for individuals who become eligible for another group health plan. In contrast, some Members believe that COBRA should be expanded to bring additional individuals under the continuation of coverage option and/or to increase the duration of COBRA coverage for specific groups of people. A proposal to extend COBRA coverage from 18 to 29 months to those with a disability at the time of termination from employment (or a reduction in hours) was included in the Omnibus Budget Reconciliation Act of 1989 (P.L. 101-239). In any event, Members of Congress have received, and are likely to continue to receive, numerous inquiries from the public about the Title X provisions.

BACKGROUND AND ANALYSIS

Expanding Access to Private Health Insurance

Title X of COBRA is one of a number of recent laws mandating that private (and most public) employers who offer health insurance conform to certain Federal requirements. (See CRS Issue Brief 87168, Mandated Employer Provided Health Insurance.) One of the factors leading to new Federal benefit requirements on employers is the concern of Congress about the large number of medically uninsured Americans. While most Americans under age 65 obtain private health insurance coverage through the workplace, in 1986 there were an estimated 37 million Americans under age 65 who were without any health insurance coverage. Surveys indicated that a substantial number of the uninsured lost coverage as a result of the termination of employment or a change in family status. For example, many workers and their families lost access to an employer's health insurance plan when the workers were laid off. Coverage for the family was also lost if the worker died. Congress considered and enacted continuation coverage legislation with the expectation that it would help expand access to coverage for at least these individuals. Continuation coverage was not, however, expected to lead to coverage

of the vast majority of uninsured Americans, a goal for which other solutions would be more appropriate.

Prior to the enactment of Title X of COBRA, if an employee's job was terminated (voluntarily or involuntarily), the insurance offered by the employer also terminated. While there were exceptions, paid benefits usually terminated within 30 to 60 days after leaving the job. Continued coverage, where the employee would have the option to buy into the employer's group plan, might be of longer duration, but there was no certainty that an employer would provide such an option. In addition, in 1985, 10 States mandated that insurance policies sold in their States had to include a continuation of coverage option for laid-off workers. However, self-insured employers (employers which assume the risk of the health care costs of their employees rather than passing the risk onto insurers) were not regulated by these State-mandated benefit laws, thus leaving a large portion of the workforce unaffected by the mandates. Self-insured plans are considered employee welfare benefit plans and are regulated by the Federal Government under the Employee Retirement Income Security Act (ERISA). According to researchers from the National Center for Health Services Research, 13% or 1.4 million unemployed workers lost health insurance in 1982 as a direct result of unemployment. These individuals had private health insurance prior to the date of unemployment and were without such coverage for several months after the termination of employment.

Also, prior to COBRA, employer practices varied greatly as to whether any continuation of coverage would be available in the event of a change in family status. For example, data from the Bureau of Labor Statistics for 1985 indicate that a majority of medium and large sized firms offered some continued coverage to the families of deceased workers. That coverage ranged, however, from less than 30 days to indefinite coverage, sometimes lasting until the widow became eligible for Medicare. About 12% of the firms for which there were data reported no continuation coverage.

Women were especially likely to have been affected by a change in family status because, traditionally, their health insurance was dependent on both marital and employment status. Most married women, whether or not in the paid labor force, have private insurance. However, in 1977 (the last year for which data are available), only 50% of all widows and 33% of all divorced women, ages 35-64, who did not have paid jobs had private insurance (1977 National Medical Care Expenditure Survey). A large number of these women and their dependent children relied on Medicaid for health insurance. Of those women not in the paid labor force, more than 40% of all divorced women and about 25% of all widows, ages 35 to 64, depended on Medicaid as their only source of insurance.

Debate over Health Insurance Continuation

The principal advocates for legislation to provide for federally mandated continuation coverage were women's organizations, although they were later joined by other groups concerned about the medically uninsured. The arguments for and against the continued coverage legislation changed as the various proposals were broadened to include coverage for terminated employees.

Proponents of a Federal health insurance continuation law observed that for a large percentage of women, access to health insurance was through their husband's employer-based group. It followed that a Federal continuation provision was necessary to protect women and their families from losing access to this health insurance when the husband died, became eligible for Medicare or retired. In addition, it was important to protect women from the loss of coverage that resulted from a divorce or legal separation. At best, the loss of the husband's coverage could result in major increases in insurance costs if the woman attempted to buy coverage through the private individual insurance market. At worst, the woman might not be able to obtain any private coverage at all if she had a preexisting illness. She might then go on the Medicaid rolls or remain uninsured.

Proponents of continuation also asserted that a Federal mandate would not necessarily cost employers any money. Beneficiaries could be asked by employers to pay the total cost of the premium, and any administrative costs. In addition, reporting and other administrative requirements could be designed to ensure that employers did not incur major new burdens. Finally, it was argued that employers would ultimately share in the savings to the community that would result from reduced stress on Medicaid and lower levels of uncompensated care, through lower taxes and lower health insurance premiums for their active workers.

Those who strongly opposed the continuation of coverage legislation argued that it was not appropriate for the Federal Government to regulate employer-sponsored benefits. They pointed to data showing that large numbers of employers already offered continuation of coverage. They also argued that by forcing employers to offer continuation, the Federal Government would be discouraging employers from providing health benefits, and that increasing numbers of employers, especially smaller ones, would drop their health benefits entirely.

However, most of the groups who were opposed to continuation indicated a willingness to accept the legislation if certain modifications were incorporated. They unsuccessfully pressed for a shorter duration of coverage, the elimination of coverage for laid-off employees and those who voluntarily terminated their jobs, higher beneficiary premiums to allow for what they argued would be increased administrative costs, and enactment of a preemption of State-mandated benefits to allow uniform administration of health benefit plans that encompassed employees in more than one State. In pressing for these changes, these groups argued that most people who were laid off would obtain coverage through their spouse's employer-provided plan. In addition, they said that a shorter duration of coverage and more narrow definitions of qualified beneficiaries were needed to prevent adverse selection into their plans, in which there would be an above-average probability that individuals enrolling in the plan would use its coverage. This argument was most often used in efforts to reduce coverage for widows, divorced spouses and dependents. The rationale was that these individuals were likely to be higher users of health care than, for example, active workers. The theory was that women and children used health services more frequently than working males. They therefore, would be likely to elect the continuation of coverage option. The insurers would factor in this higher utilization in the rating of the employers' premiums, thereby driving up the costs of the employers' plans.

Legislative History of Continued Private Health Insurance Coverage

The principal health insurance continuation proposals were included in the budget reconciliation bills for the FY86 budget (H.R. 3128, H.R. 3500, and S. 1730) and, after a set of complex procedural steps, were incorporated in the House and Senate versions of H.R. 3128. The final version of Title X of COBRA was the product of conference committee negotiations among five committees: three from the House (Education and Labor, Energy and Commerce, and Ways and Means) and two from the Senate (Finance, and Labor and Human Resources). (See CRS Report 87-613, Private Health Insurance Continuation Coverage: Legislative History of Title X of COBRA.)

COBRA was signed into law on Apr. 7, 1986. Before the end of the year, Title X was modified twice: The Tax Reform Act of 1986 (P.L. 99-514) included technical corrections, and the Omnibus Budget Reconciliation Act of 1986 (P.L. 99-509) provided for continuation coverage for retirees in cases of bankruptcy. The Technical and Miscellaneous Revenue Act of 1988 (P.L. 100-647) made changes to the tax penalties for noncompliance, as well as certain other technical modifications. The Omnibus Budget Reconciliation Act of 1989 (OBRA, P.L. 101-239) contains provisions to extend continued coverage to 29 months for persons who were disabled at the date of job termination (or reduction in hours). OBRA 1989 makes other changes which are described below (see **Action in the 101st Congress**.)

Regulatory Actions

Title X amends three statutes: the Internal Revenue Code, administered by the Internal Revenue Service of the Department of the Treasury; ERISA, administered by the Department of Labor; and the Public Health Service Act, administered by the Public Health Service of the Department of Health and Human Services. In this regard, the conference report for COBRA (H.Rept. 99-453, p. 562) states:

> To avoid the issuance of duplicate and perhaps inconsistent regulations, the conferees authorized the Secretary of Labor to promulgate regulations implementing the disclosure and reporting requirements, and the Secretary of the Treasury to issue regulations defining required coverage, deductions and inclusions. The Secretary of Health and Human Services is to issue regulations regarding the requirement that State and local governments provide continuation coverage for qualified beneficiaries. The conferees intend that any regulation issued by the Secretary will conform (in terms of actual requirements) with those regulations issued by the Secretary of the Treasury and Labor....

The conference report also says that "pending the promulgation of regulations, employers are required to operate in good faith compliance with a reasonable interpretation of these substantive rules, notice requirements, etc. (p. 563)."

On June 26, 1986, the Department of Labor issued a technical bulletin to assist employers and group health plans in informing workers about the availability of

extended health care coverage under Title X. The bulletin contains a model notice summarizing the rights and obligations of employees and their families under Title X. Employers may use this model notice to satisfy the general notification requirements of the law.

On June 15, 1987, the Internal Revenue Service issued proposed regulations relating to Title X and the relevant provisions in the Tax Reform Act of 1986, which "clarify which plans must offer COBRA continuation coverage and the tax consequences of failing to do so. They also provide guidance on a variety of details, including the scope of the continuation coverage, who is a qualified beneficiary, what is a qualifying event, how elections [of continued coverage] are made, and when payment must be made." The Internal Revenue Service has not yet issued proposed rules regarding computation of the applicable premium to be charged for the continuation coverage, something that is especially relevant to the calculation of premiums for self-insured plans. In addition, the proposed regulations do not cover the amendments made by OBRA of 1986 relating to certain bankruptcies as qualifying events, or any of the Title X changes made since June 1987.

In compliance with the language of the conference report on COBRA, the Public Health Service does not plan to issue regulations until final regulations have been promulgated by the Departments of Treasury and Labor. The Department of Labor is currently considering whether regulations are necessary regarding Title X's disclosure and reporting requirements.

New Law

What Does Title X of COBRA Do?

COBRA requires employers with 20 or more employees that offer a group health insurance plan to offer qualified employees and their families the option of continued health insurance at group rates when faced with loss of their coverage because of certain events. Self-insured firms (ones which assume the risk of paying for their employees' health care costs rather than passing that risk onto insurers) are also covered under Title X. An employer is considered as having normally employed 20 or more employees during a particular year if it had 20 employees on at least 50% of its working days during that year.

An employer must comply with COBRA even if he does not contribute to the health plan; he need only maintain such a plan to come under the statute. Church plans, the Federal Government, the government of the District of Columbia, and territories and possessions of the United States are excluded from the COBRA continuation requirement. (However, under P.L. 100-654, enacted late in 1988, Federal employees are entitled to continued coverage under the Federal Employees Health Benefits Program, starting Jan. 1, 1990. See: The Federal Employees Health Benefits Program. CRS Issue Brief 89124.)

The events that trigger COBRA continuation of coverage are defined to include: (1) termination or reduction in hours of employment (for reasons other than gross misconduct), (2) the death of the employee, (3) divorce or legal separation from the

employee, (4) the employee becomes eligible for Medicare, and (5) the end of a child's dependency under a parent's health insurance policy. An event will trigger continuation if, under the terms of the employer's group health plan, the event causes the employee, or the spouse, or a dependent child of the employee, to lose coverage under the plan. The loss of coverage need not occur immediately after the event, so long as the loss of coverage will occur before the end of the maximum coverage period. Title X has very specific effective dates (see below). An event that occurred prior to the effective date will not be considered a qualifying event for continuation of coverage purposes. When a covered employee experiences termination or reduction in hours of employment, then the continued coverage of the employee and any qualified beneficiaries must continue for 18 months. For all the other qualifying events, the coverage for the qualified beneficiaries must be continued for 3 years.

The Internal Revenue Service's proposed regulations for Title X provide guidance on who is eligible for COBRA continuation coverage and what constitutes a qualifying event. For example, voluntary termination of employment is a qualifying event. With the exception of gross misconduct, it does not matter whether the employee voluntarily quit, retired, or was discharged. A strike or reduction of work hours also are qualifying events if they result in the loss of coverage. Newborn children, adopted children and spouses who join the family of a qualified beneficiary after the day before a qualifying event are not included as beneficiaries for COBRA continuation purposes.

The continuation coverage must be identical to that provided to similarly situated beneficiaries who did not lose coverage, and it must generally be the same as the group health plan coverage enjoyed by the qualified beneficiary immediately before the qualifying event. The term "similarly situated" is intended to ensure that beneficiaries who elect, for example, continued coverage under the employer's family option (as opposed to the self-only option) receive the identical coverage as active workers who elect the family option.

The employer's health plan may require the employee or beneficiary to pay the premium for the continuation coverage, but the premium may not exceed 102% of the otherwise applicable premium for that period. The plan must allow a qualified beneficiary to pay for the coverage in monthly installments, although alternative intervals may also be offered.

Title X spells out specific rules for notice and election of continuation coverage. Once an employer's health insurance plan becomes subject to the Title X provisions, the plan is required to notify in writing each covered employee and his or her spouse of their rights to continued coverage. The plan is also required to give such notice when an employee begins to be covered under the health plan. A person qualified to elect continuation coverage must do so within 60 days of the date after which coverage under the group plan would otherwise terminate, or the date that the beneficiary is sent notice of his or her right to elect COBRA. In general, the employer or plan administrator is responsible for determining when a qualifying event has occurred and notifying the eligible beneficiaries. However, each covered employee or qualified beneficiary is responsible for notifying the employer or other plan administrator when the event is a dependent child ceasing to be a dependent child of the covered employee or a divorce or legal separation of a covered employee.

The duration of COBRA continuation coverage is for at least the period beginning on the date of the qualifying event and ending not before the earlier of the following dates: (a) the last day of the maximum coverage period (for example, 18 months for a covered worker who has terminated employment), (b) the first day for which timely payment of the premium is not made to the plan with respect to the qualified beneficiary, (c) the date on which the employer ceases to maintain any group health plan, (d) the first date after the date of the election on which the qualified beneficiary elects coverage (that is, is actually covered and not just eligible to be covered) under any group health plan that is not maintained by the employer, and (e) the date the qualified beneficiary is entitled to Medicare benefits.

COBRA also requires that, in some cases, the employer's group health plan offer qualified beneficiaries the option of converting to an individual policy at the end of the COBRA continuation period. This is only true for those plans which provide a conversion option to similarly situated active employees. Conversion enables an individual to buy health insurance from the employer's plan without being subject to medical screening. While the premiums for an individual policy are higher than for the group policy, the conversion option may be attractive to a person who would otherwise have difficulty obtaining health insurance because he or she has a major illness or disability.

Under the original Title X law, employers who failed to provide continued health coverage could lose their tax deductibility for employer contributions to their employees' health insurance, and be subject to penalties. In addition, the income exclusion under section 106(a) of the Internal Revenue Code could be denied to certain highly compensated employees of that employer. (This means that for plans out of compliance, the IRS could deny to highly compensated employees the exclusion from taxable gross income payments made by the employer for health insurance coverage.) Under changes made by the Technical and Miscellaneous Revenue Act of 1988 (P.L. 100-647), these tax penalties have been replaced by an excise tax of $100 per day for each violation involving a Title X beneficiary. For group health plans covered under ERISA, the general enforcement provisions of ERISA apply: employers and plan administrators are subject to civil and/or criminal legal action (depending on the alleged violation), and civil penalties of up to $100 per day would apply for failure to provided the required notification. In addition to the requirements imposed on private sector employees, Title X also imposes similar requirements on group health plans maintained by any State or political subdivision that receives funds under the Public Health Service Act.

Title X became effective for health plan years beginning on or after July 1, 1986 (generally, health insurance coverage is on a yearly basis and may start at any point during the calendar year). In the case of plans established under collective bargaining agreements ratified before COBRA was enacted, there is a special rule. The continuation provisions do not apply to plan years beginning before the date on which the agreement terminates, or before Jan. 1, 1987, whichever is later. The IRS has provided the following example to help clarify. Assume that the plan year of a collectively bargained group health plan is the calendar year and that, as of Apr. 7, 1986, the plan is maintained pursuant to three collective bargaining agreements having expiration dates in October 1987, February 1988 and July 1988. The plan must offer health insurance continuation beginning on Jan. 1, 1989. But the plan

must begin to comply by Jan. 1, 1987, with respect to a collective bargaining unit that was not, as of Apr. 7, 1986, covered by one of those three agreements.

Tax Reform Act of 1986

In the Tax Reform Act of 1986 (P.L. 99-514), Congress included a number of technical corrections to Title X of COBRA. Some of the provisions were clarifications and some imposed new parameters on the nature of the continued health insurance benefit. Specifically, the provisions (1) establish a 60-day notification period for certain potential beneficiaries of continuation (eg., divorced and legally separated spouses of covered employees), (2) specify the maximum duration of continued health coverage when there is more than one qualifying event (in no event may the coverage period exceed 36 months), (3) clarify that each qualified beneficiary is entitled to a separate election of continuation coverage, (4) specify the length of the grace period for non-payment of premiums, (5) clarify that the continued health benefits are to be treated in the same manner as benefits for similarly situated beneficiaries under the plan, (6) define health benefits to mean health benefit plans, including dental and vision care, and (7) exclude a non-resident alien with no earned income from sources within the United States from the definition of "qualified beneficiary." The effective date for these provisions is the same as for Title X of COBRA.

OBRA of 1986

In 1986, Congress considered an expansion of COBRA to require that employers provide continued health coverage to laid-off workers for 4 months, during which time the employer would continue to pay whatever portion of the health insurance premium he or she was paying before the layoff (See H.R. 4742 (Stark), S. 2402 (Kennedy), and S. 2403 (Durenberger)). While this provision did not pass, Congress did enact as a part of the OBRA of 1986 (P.L. 99-509) an expansion of Title X to require continuation coverage for retirees in cases where the employer files for bankruptcy. This provision was motivated largely by the bankruptcy filing of LTV Corporation, one of the Nation's major steel manufacturers. LTV had 78,000 retirees who were receiving health benefits under the company's plan, and who were threatened with the termination of benefits as a result of the bankruptcy action.

Specifically, OBRA adds a new qualifying event which consists of a proceeding in a case under the bankruptcy provisions of Title XI of the United States Code, commencing on or after July 1, 1986. In such cases, a loss of a retiree's coverage means a substantial elimination of the beneficiary's coverage within one year before or after the date the bankruptcy proceedings commenced. The continued coverage extends until the death of the retiree. For the surviving spouse or the dependent children of the covered employee, the coverage is limited to 36 months. These amendments apply in any plan years ending during the 12-month period beginning July 1, 1986, but only with respect to Chapter II bankruptcy qualifying events or the death of a covered employee after the date of bankruptcy. (See CRS Report 87-196 A.)

Action in the 100th Congress

The 100th Congress considered several modifications to Title X of COBRA. Most significant were proposals to change the tax penalties on employers that fail to offer continuation of coverage and proposals to allow persons to keep their continued coverage for 18 or 36 months regardless of whether they become newly covered under an employer's group health plan. The penalty changes were proposed in response to concerns that the original law's tax sanctions were too severe, especially in cases where the employer may have unintentionally violated the law. The latter set of proposals were intended to allow continuation coverage to fill gaps created by preexisting condition coverage exclusions in a new employer's policy.

Proposals actively considered by the House in the 100th Congress were contained in H.R. 4333, H.R. 4845, and H.R. 5080. The Senate's proposed changes were contained in S. 2238. Those provisions that were enacted are in the conference agreement for H.R. 4333, the Technical and Miscellaneous Revenue Act of 1988 (see House conference Report 100-1104). The bill was signed by President Reagan on Nov. 10, 1988 (P.L. 100-647).

P.L. 100-647 replaced the sanctions for employers that violated Title X with an excise tax of $100 per day for each violation involving a Title X beneficiary. When violations involve a family, the maximum penalty would be $200 per day. The excise tax would be assessed for each day during the noncompliance period. This period ends on the earlier of (1) the date the failure is corrected, or (2) 6 months after the last date on which the employer could have been required to provide continuation coverage to the qualified beneficiary. The excise tax would not apply if the employer could prove that the failure was inadvertent or if the failure was corrected within a 30-day grace period. The exception to this is in the case of a special audit rule. For violations discovered by the Internal Revenue Service that were not corrected before the employer received a "notice of examination of tax liability," employers would be subject to a $2,500 penalty per affected beneficiary or the excise tax that would be due based on the length of the violation, whichever is less.

P.L. 100-647 limits the annual maximum liability for employers to 10% of what the employer paid for employee health benefits the previous year, or $500,000, whichever was less. Multiemployer plans are to be treated as single trusts for purposes of assessing the penalty. Under specified conditions, persons other than the employer (such as the insurer) could be liable for the excise tax. The provisions became effective for taxable years beginning after Dec. 31, 1988.

In a separate action, the Congress also approved legislation (H.R. 5102) to provide health insurance continuation coverage for enrollees in the Federal Employees Health Benefits Program. The provisions of H.R. 5102 are similar to Title X of COBRA. H.R. 5102 was signed into law (P.L. 100-654) on Nov. 14, 1988, and took effect Jan. 1, 1990. (See: The Federal Employees Health Benefits Program. CRS Issue Brief 89124.)

Action in the 101st Congress

In the first session of the 101st Congress, several proposals were considered as part of the budget reconciliation process to modify Title X of COBRA. A proposal to extend COBRA coverage from 18 to 29 months to those with a disability at the time of termination from employment (or reduction in hours) was included in the Ways and Means Committee's fiscal year 1990 budget reconciliation package (see H.R. 3150 and H.R. 3299). The House Education and Labor and Senate Finance Committees also included changes to COBRA Title X in their reconciliation packages (see H.R. 3299 and S. 1740 respectively).

The conference agreement for H.R. 3299, the Omnibus Budget Reconciliation Act of 1989, (OBRA, P.L. 101-239) makes several changes in the COBRA health insurance continuation coverage provisions that are generally effective for 1990 plan years. These provisions are described in the "Legislation" section of this issue brief.

LEGISLATION

P.L. 101-239 (H.R. 3299)

The Omnibus Budget Reconciliation Act of 1989. Sections 6701-6801 and section 7862(c) contain the following changes to COBRA Title X: **(1)** *Disabled Beneficiaries:* The 18-month maximum benefit period has been extended to 29 months for COBRA beneficiaries who were determined to be disabled under the Social Security Act at the date of the qualifying event (either reduction in hours or termination from employment). The employer is permitted to charge the beneficiary 150% (rather than 102%) of the premium for coverage beyond the 18 months. This provision is designed to provide a source of coverage while individuals are waiting for Medicare. (There is a five-month waiting period for Social Security disability cash benefits and another 24 months waiting period for Medicare benefits.) **(2)***Preexisting Conditions:* Prior to OBRA 1989, a person would generally lose their continued health benefits once they became covered under another group health plan. This provision caused problems for individuals whose new plan contained exclusions on preexisting conditions. P.L. 101-239 provides that the COBRA continued coverage will terminate only if the other plan "does not contain any exclusion or limitation with respect to any preexisting limitation of such beneficiary." If the new plan does include these limitations, the individual can be covered under both plans. (It is assumed that coordination of benefit rules would apply.) The restriction on preexisting conditions is effective (a) for qualifying events after Dec. 31, 1989; and (b) for qualified beneficiaries electing COBRA coverage after Dec. 31, 1988 -- the period during which the premium was paid (or attempted to be paid) by the COBRA beneficiary, but was rejected due to the existence of coverage under another plan. **(3)** *Additional Changes:* The conference agreement includes additional changes relating to multiemployer plans, the definition of covered employees, timing of the initial premium payment, and the duration of COBRA coverage of dependents of employees when the employee becomes eligible for Medicare. (See H.R. 3299 for legislative history.)

H.Con.Res. 77 (Shaw)

Expresses the sense of the Congress that insurance providers should be encouraged to permit employers to extend the opportunity to purchase health care coverage when benefits are terminated to workers subject to collective bargaining agreements who do not currently have such an opportunity under Title X of COBRA. Introduced Mar. 15, 1989; referred to Committee on Education and Labor.

H.R. 585 (Henry)

Amends the Internal Revenue Code, the Employee Retirement Income Security Act, and the Public Health Service Act to terminate a person's eligibility to receive benefits under mandated employee health benefit continuation coverage (title X of COBRA) as soon as that person becomes eligible for coverage under another group health plan, as an employee or otherwise. Introduced Jan. 20, 1989; referred to Committees on Education and Labor, Energy and Commerce, and Ways and Means.

H.R. 2308/2309/2310 (Pelosi)

H.R. 2308 amends the Employee Retirement Income Security Act, H.R. 2309 amends the Public Health Service Act, and H.R. 2310 amends the Internal Revenue Code to require that continuation of health insurance coverage for 29 months be offered to those with a disability at the time of termination from employment. Introduced May 10, 1989; referred to Committee on Education and Labor (see P.L. 101-239).

H.R. 2794 (Clay)

Amends the Employee Retirement Income Security Act and related provisions of the Internal Revenue Code of 1986 to provide for technical corrections and other changes to the health insurance continuation provisions. Establishes monetary penalties under ERISA to be assessed by the Secretary of Labor of $100 for each day in which an employer is in noncompliance with the law. Similar to penalty provisions under the IRC included in P.L. 100-647. Requires that the GAO conduct a study of the extent to which employers have lengthened the eligibility period for group coverage as a result of Title X of COBRA, and that the GAO report to Congress on the study results by Aug. 31, 1990. Changes the definition of "covered employees," and provides that continuation coverage is not terminated when the qualified beneficiary becomes covered under another group health plan. Introduced June 29, 1989; referred to Committee on Education and Labor. Provisions of H.R. 2794 incorporated as an amendment to the Committee's fiscal year 1990 budget reconciliation bill, ordered to be reported by the Committee on July 13, 1989. (See Section 3111(g) of H.R. 3299.)

H.R. 3150 (Rostenkowski)

Amends the Social Security Act and Internal Revenue Code to provide for budget reconciliation for FY90 and FY91. Includes changes to Title X of COBRA: (1) extends COBRA coverage to 29 months for those workers with a disability under Titles II or XVI of the Social Security Act at the time of termination of employment or reduction in hours. Provides that the employer may charge such individuals 150% of the premium for any month of continued coverage after the 18th month; (2) makes changes affecting multiemployer plans; and (3) provides that continuation coverage would not end upon the coverage of the qualified beneficiary under a group health plan of another employer if that plan excludes from coverage any preexisting

condition of the beneficiary. Introduced Aug. 4, 1989; referred to Committee on Ways and Means.

H.R. 3299 (Panetta)

Omnibus Budget Reconciliation Act of 1989. Section 3111(g) includes the COBRA Title X changes made by the House Education and Labor Committee in H.R. 2794. Section 10181 and section 11862 include the COBRA Title X changes made by the House Ways and Means Committee in H.R. 3150. Introduced Sept. 29, 1989; referred to Committee on the Budget (House Report 101-247). Passed House (amended) on Oct. 5, 1989. Passed Senate on Oct. 13, 1989, in lieu of S. 1750, after stripping "extraneous" provision including Senate Finance Committee's COBRA Title X changes (see S. 1750). Conference agreement approved by the House on Nov. 21, 1989, and approved by the Senate on Nov. 22, 1989. Signed into law (P.L. 101-239) on Dec. 19, 1989. For conference agreement provisions, see P.L. 101-239.

S. 1750 (Sasser)

Omnibus Budget Reconciliation Act of 1989. Section 6862(c) provides for changes in COBRA Title X, including changing the definition of "covered employee," eliminating the provision terminating continuation coverage if the qualified beneficiary becomes covered under another group health plan, and other changes relating to the timely payment of premiums, and the maximum period of coverage for persons with multiple qualifying events. Introduced Oct. 12, 1989; referred to the Committee on Budget. On Oct. 13, 1989, Senate passed amended version of H.R. 3299 in lieu of S. 1750 after stripping COBRA Title X and other "extraneous" provisions.

CONGRESSIONAL HEARINGS, REPORTS, AND DOCUMENTS

U.S. Congress. House. Committee of Conference. Omnibus Budget Reconciliation Act of 1989. Conference Report to Accompany H.R. 3299. Washington. U.S. Govt. Print. Off., Nov. 21, 1989. 101st Congress, 1st session. House Report No. 101-386.

U.S. Congress. House. Providing for reconciliation pursuant to section 2 of the Concurrent Resolution on the Budget for Fiscal Year 1987; conference report to accompany H.R. 5300. Washington, U.S. Govt. Print. Off., Oct. 17, 1986. (99th Congress, 2d session. House. Report no. 99-1012)

U.S. Congress. House. Committee of Conference. Technical and Miscellaneous Revenue Act of 1988; Conference Report to Accompany H.R. 4333. Washington, U.S. Govt. Print. Off., Oct. 21, 1988. (100th Congress, 2d Session, House. Report no. 100-1104).

U.S. Congress. House. Committee of Conference. Consolidated Omnibus Budget Reconciliation Act of 1985. Washington, U.S. Govt. Print. Off., Dec. 19, 1985. (99th Congress, 1st session. House. Report no. 99-453)

U.S. Department of Labor. Office of Pension and Welfare Benefit Programs. ERISA Technical Release no. 86-2. Guidance on group health continuation coverage notification provisions. Washington, June 26, 1986.

U.S. Department of the Treasury. Internal Revenue Service. 26 CFR Part 1. Income tax; continuation coverage requirements of group health plans; notice of proposed rulemaking, Federal register, June 15, 1987: 22716-22732.

CHRONOLOGY

Title X of COBRA

04/07/86 --- President signed H.R. 3128 into law as P.L. 99-272 (COBRA).

03/20/86 --- House agreed to Senate version of H.R. 3128, clearing the bill for the President's signature.

12/19/85 --- Conference report for H.R. 3128 filed in House (H.Rept. 99-453). Senate agreed to conference report but House rejected it.

12/05/85 --- House incorporated H.R. 3500 (containing Committee on Education and Labor's health insurance continuation provisions) into H.R. 3128. House asked for a conference on H.R. 3128.

11/14/85 --- Senate amended and passed H.R. 3128 (93-6) by substituting the text of S. 1730 for House-passed provisions.

10/31/85 --- H.R. 3128 passed House (245-174).

10/24/85 --- H.R. 3500, as amended, passed House (228-199).

10/03/85 --- H.R. 3500 (Omnibus Budget Reconciliation Act) introduced in House, containing Committee on Education and Labor's health insurance continuation provision.

10/02/85 --- S. 1730 (Consolidated Omnibus Budget Reconciliation Act) introduced in Senate containing a health insurance continuation provision that was a modification of several bills: S. 1211, Health Equity and Fairness Act; S. 1615, Health Care Improved Access Act; and S. 1632.

09/11/85 --- H.R. 3128 reported from House Committee on Education and Labor containing a health insurance continuation coverage provision.

07/31/85 --- H.R. 3128, Deficit Reduction Amendments of 1985, introduced in House incorporating continuation provisions of H.R. 3210 and H.R. 21, Continued Access to Group Health Insurance Act. Reported by Committee on Ways and Means to the House.

Regulatory Actions

06/15/87 --- Department of Treasury published proposed rules in the Federal Register for Continued Private Health Insurance Coverage as per P.L. 99-272 and P.L. 99-514.

06/26/86 --- Department of Labor issued ERISA Technical Release providing guidance on group health insurance continuation coverage notification provisions.

11/04/86 --- Department of Treasury held public hearings in Washington, DC, for continued private Health Insurance Coverage.

Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA)
(P.L. 99-272) Title X--Private Health Insurance Coverage

TITLE X—PRIVATE HEALTH INSURANCE COVERAGE

SEC. 10001. EMPLOYERS REQUIRED TO PROVIDE CERTAIN EMPLOYEES AND FAMILY MEMBERS WITH CONTINUED HEALTH INSURANCE COVERAGE AT GROUP RATES (INTERNAL REVENUE CODE AMENDMENTS).

(a) DENIAL OF DEDUCTION FOR EMPLOYER CONTRIBUTION TO PLAN.—Subsection (i) of section 162 of the Internal Revenue Code of 1954 (relating to deduction for trade or business expenses with respect to group health plans) is amended by redesignating paragraph (2) as paragraph (3) and by inserting after paragraph (1) the following new paragraph:

"(2) PLANS MUST PROVIDE CONTINUATION COVERAGE TO CERTAIN INDIVIDUALS.—

"(A) IN GENERAL.—No deduction shall be allowed under this section for expenses paid or incurred by an employer for any group health plan maintained by such employer unless all such plans maintained by such employer meet the continuing coverage requirements of subsection (k).

"(B) EXCEPTION FOR CERTAIN SMALL EMPLOYERS, ETC.—Subparagraph (A) shall not apply to any plan described in section 106(b)(2)".

(b) DENIAL OF EXCLUSION FOR HIGHLY COMPENSATED INDIVIDUALS.—Section 106 of the Internal Revenue Code of 1954 (relating to contributions by employer to accident and health plans) is amended by inserting "(a) IN GENERAL.—" before "Gross" and by inserting at the end thereof the following new subsection:

"(b) EXCEPTION FOR HIGHLY COMPENSATED INDIVIDUALS WHERE PLAN FAILS TO PROVIDE CERTAIN CONTINUATION COVERAGE.—

"(1) IN GENERAL.—Subsection (a) shall not apply to any amount contributed by an employer on behalf of a highly compensated individual (within the meaning of section

Source: Congressional Record, April 8, 1986, p. S3841-S3845

105(h)(5)) to a group health plan maintained by such employer unless all such plans maintained by such employer meet the continuing coverage requirements of section 162(k).

"(2) EXCEPTION FOR CERTAIN PLANS.—Paragraph (1) shall not apply to any—

"(A) group health plan for any calendar year if all employers maintaining such plan normally employed fewer than 20 employees on a typical business day during the preceding calendar year,

"(B) governmental plan (within the meaning of section 414(d)), or

"(C) church plan (within the meaning of section 414(e)).

Under regulations, rules similar to the rules of subsections (a) and (b) of section 52 (relating to employers under common control) shall apply for purposes of subparagraph (A).

"(3) GROUP HEALTH PLAN.—For purposes of this subsection, the term 'group health plan' has the meaning given such term by section 162(i)(3).".

(c) CONTINUATION COVERAGE REQUIREMENTS.—Section 162 of the Internal Revenue Code of 1954 is amended by redesignating subsection (k) as subsection (l) and by inserting after subsection (j) the following new subsection:

"(k) CONTINUATION COVERAGE REQUIREMENTS OF GROUP HEALTH PLANS.—

"(1) IN GENERAL.—For purposes of subsection (i)(2) and section 106(b)(1), a group health plan meets the requirements of this subsection only if each qualified beneficiary who would lose coverage under the plan as a result of a qualifying event is entitled to elect, within the election period, continuation coverage under the plan.

"(2) 'CONTINUATION COVERAGE.—For purposes of paragraph (1), the term 'continuation coverage' means coverage under the plan which meets the following requirements:

"(A) TYPE OF BENEFIT COVERAGE.—The coverage must consist of coverage which, as of the time the coverage is being provided, is identical to the coverage provided under the plan to similarly situated beneficiaries under the plan with respect to whom a qualifying event has not occurred.

"(B) PERIOD OF COVERAGE.—The coverage must extend for at least the period beginning on the date of the qualifying event and ending not earlier than the earliest of the following:

"(i) MAXIMUM PERIOD.—In the case of—

"(I) a qualifying event described in paragraph (3)(B) (relating to terminations and reduced hours), the date which is 18 months after the date of the qualifying event, and

"(II) any qualifying event not described in subclause (I), the date which is 36 months after the date of the qualifying event.

"(ii) END OF PLAN.—The date on which the employer ceases to provide any group health plan to any employee.

"(iii) FAILURE TO PAY PREMIUM.—The date on which coverage ceases under the plan by reason of a failure to make timely payment of any premium required under the plan with respect to the qualified beneficiary.

"(iv) REEMPLOYMENT OR MEDICARE ELIGIBILITY.—The date on which the qualified beneficiary first becomes, after the date of the election—

"(I) a covered employee under any other group health plan, or

"(II) entitled to benefits under title XVIII of the Social Security Act.

"(v) REMARRIAGE OF SPOUSE.—In the case of an individual who is a qualified beneficiary by reason of being the spouse of a covered employee, the date on which the beneficiary remarries and becomes covered under a group health plan.

"(C) PREMIUM REQUIREMENTS.—The plan may require payment of a premium for any period of continuation coverage, except that such premium—

"(i) shall not exceed 102 percent of the applicable premium for such period, and

"(ii) may, at the election of the payor, be made in monthly installments.

If an election is made after the qualifying event, the plan shall permit payment for continuation coverage during the period preceding the election to be made within 45 days of the date of the election.

"(D) NO REQUIREMENT OF INSURABILITY.—The coverage may not be conditioned upon, or discriminate on the basis of lack of, evidence of insurability.

"(E) CONVERSION OPTION.—In the case of a qualified beneficiary whose period of continuation coverage expires under subparagraph (B)(i), the plan must, during the 180-day period ending on such expiration date, provide to the qualified beneficiary the option of enrollment under a conversion health plan otherwise generally available under the plan.

"(3) QUALIFYING EVENT.—For purposes of this subsection, the term 'qualifying event' means, with respect to any covered employee, any of the following events which, but for the continuation coverage required under this subsection, would result in the loss of coverage of a qualified beneficiary:

"(A) The death of the covered employee.

"(B) The termination (other than by reason of such employee's gross misconduct), or reduction of hours, of the covered employee's employment.

"(C) The divorce or legal separation of the covered employee from the employee's spouse.

"(D) The covered employee becoming entitled to benefits under title XVIII of the Social Security Act.

"(E) A dependent child ceasing to be a dependent child under the generally applicable requirements of the plan.

"(4) APPLICABLE PREMIUM.—For purposes of this subsection—

"(A) IN GENERAL.—The term 'applicable premium' means, with respect to any period of continuation coverage of qualified beneficiaries, the cost to the plan for such period of the coverage for similarly situated beneficiaries with respect to whom a qualifying event has not occurred (without regard to whether such cost is paid by the employer or employee).

"(B) SPECIAL RULE FOR SELF-INSURED PLANS.—To the extent that a plan is a self-insured plan—

"(i) IN GENERAL.—Except as provided in clause (ii), the applicable premium for any period of continuation coverage of qualified beneficiaries shall be equal to a reasonable estimate of the cost of providing coverage for such period for similarly situated beneficiaries which—

"(I) is determined on an actuarial basis, and

"(II) takes into account such factors as the Secretary may prescribe in regulations.

"(ii) DETERMINATION ON BASIS OF PAST COST.—If a plan administrator elects to have this clause apply, the applicable premium for any period of continuation coverage of qualified beneficiaries shall be equal to—

"(I) the cost to the plan for similarly situated beneficiaries for the same period occurring during the preceding determination period under subparagraph (C), adjusted by

"(II) the percentage increase or decrease in the implicit price deflator of the gross national product (calculated by the Department of Commerce and published in the Survey of Current Business) for the 12-month period ending on the last day of the sixth month of such preceding determination period.

"(iii) CLAUSE (ii) NOT TO APPLY WHERE SIGNIFICANT CHANGE.—A plan administrator may not elect to have clause (ii) apply in any case in which there is any significant difference, between the determination period and the preceding determination period, in coverage under, or in employees covered by, the plan. The determination under the preceding sentence for any determination period shall be made at the same time as the determination under subparagraph (C).

"(C) DETERMINATION PERIOD.—The determination of any applicable premium shall be made for a period of 12 months and shall be made before the beginning of such period.

"(5) ELECTION.—For purposes of this subsection—

"(A) ELECTION PERIOD.—The term 'election period' means the period which—

"(i) begins not later than the date on which coverage terminates under the plan by reason of a qualifying event,

"(ii) is of at least 60 days' duration, and

"(iii) ends not earlier than 60 days after the later of—

"(I) the date described in clause (i), or

"(II) in the case of any qualified beneficiary who receives notice under paragraph (6)(D), the date of such notice.

"(B) EFFECT OF ELECTION ON OTHER BENEFICIARIES.—Except as otherwise specified in an election, any election by a qualified beneficiary described in clause (i)(I) or (ii) of paragraph (7)(B) shall be deemed to include an election of continuation coverage on behalf of any other qualified beneficiary who would lose coverage under the plan by reason of the qualifying event.

"(6) NOTICE REQUIREMENTS.—In accordance with regulations prescribed by the Secretary—

"(A) the group health plan shall provide, at the time of commencement of coverage under the plan, written notice to each covered employee and spouse of the employee (if any) of the rights provided under this subsection,

"(B) the employer of an employee under a plan must notify the plan administrator of a qualifying event described in subparagraph (A), (B), or (D) of paragraph (3) with respect to such employee within 30 days of the date of the qualifying event,

"(C) each covered employee or qualified beneficiary is responsible for notifying the plan administrator of the occurrence of any qualifying event described in subparagraph (C) or (E) of paragraph (3), and

"(D) the plan administrator shall notify—

"(i) in the case of a qualifying event described in subparagraph (A), (B), or (D) of paragraph (3), any qualified beneficiary with respect to such event, and

"(ii) in the case of a qualifying event described in subparagraph (C) or (E) of paragraph (3) where the covered employee notifies the plan administrator under subparagraph (C), any qualified beneficiary with respect to such event,

of such beneficiary's rights under this subsection.

For purposes of subparagraph (D), any notification shall be made within 14 days of the date on which the plan administrator is notified under subparagraph (B) or (C), whichever is applicable, and any such notification to an individual who is a qualified beneficiary as the spouse of the covered employee shall be treated as notification to all other qualified beneficiaries residing with such spouse at the time such notification is made.

"(7) DEFINITIONS.—For purposes of this subsection—

"(A) COVERED EMPLOYEE.—The term 'covered employee' means an individual who is (or was) provided coverage under a group health plan by virtue of the individual's employment or previous employment with an employer.

"(B) QUALIFIED BENEFICIARY.—

"(i) IN GENERAL.—The term 'qualified beneficiary' means, with respect to a covered employee under a group health plan, any other individual who, on the day before the qualifying event for that employee, is a beneficiary under the plan—

"(I) as the spouse of the covered employee, or

"(II) as the dependent child of the employee.

"(ii) SPECIAL RULE FOR TERMINATIONS AND REDUCED EMPLOYMENT.—In the case of a qualifying event described in paragraph (3)(B), the term 'qualified beneficiary' includes the covered employee.

"(C) PLAN ADMINISTRATOR.—The term 'plan administrator' has the meaning given the term 'administrator' by section 3(16)(A) of the Employee Retirement Income Security Act of 1974.".

(d) CONFORMING AMENDMENT.—Paragraph (1) of section 162(i) is amended by striking out "GENERAL RULE" in the heading thereof and inserting in lieu thereof "COVERAGE RELATING TO END STAGE RENAL DISEASE".

(e) EFFECTIVE DATES.—

(1) GENERAL RULE.—The amendments made by this section shall apply to plan years beginning on or after July 1, 1986.

(2) SPECIAL RULE FOR COLLECTIVE BARGAINING AGREEMENTS.—In the case of a group health plan maintained pursuant to one or more collective bargaining agreements between employee representatives and one or more employers ratified before the date of the enactment of this Act, the amendments made by this section shall not apply to plan years beginning before the later of—

(A) the date on which the last of the collective bargaining agreements relating to the plan terminates (determined without regard to any extension thereof agreed to after the date of the enactment of this Act), or

(B) January 1, 1987.

For purposes of subparagraph (A), any plan amendment made pursuant to a collective bargaining agreement relating to the plan which amends the plan solely to conform to any requirement added by this section shall not be treated as a termination of such collective bargaining agreement.

SEC. 10002. TEMPORARY EXTENSION OF COVERAGE AT GROUP RATES FOR CERTAIN EMPLOYEES AND FAMILY MEMBERS (ERISA AMENDMENTS).

(a) IN GENERAL.—Subtitle B of title I of the Employee Retirement Income Security Act of 1974 is amended by adding at the end thereof the following new part:

"PART 6—CONTINUATION COVERAGE UNDER GROUP HEALTH PLANS

"SEC. 601. PLANS MUST PROVIDE CONTINUATION COVERAGE TO CERTAIN INDIVIDUALS.

"(a) IN GENERAL.—The plan sponsor of each group health plan shall provide, in accordance with this part, that each qualified beneficiary who would lose coverage under the plan as a result of a qualifying event is entitled, under the plan, to elect, within the election period, continuation coverage under the plan.

"(b) EXCEPTION FOR CERTAIN PLANS.—Subsection (a) shall not apply to any group health plan for any calendar year if all employers maintaining such plan normally employed fewer than 20 employees on a typical business day during the preceding calendar year. Under regulations, rules similar to the rules of subsections (a) and (b) of section 52 of the Internal Revenue Code of 1954 (relating to employers under common control) shall apply for purposes of this subsection.

"SEC. 602. CONTINUATION COVERAGE.

"For purposes of section 601, the term 'continuation coverage' means coverage under the plan which meets the following requirements:

"(1) TYPE OF BENEFIT COVERAGE.—The coverage must consist of coverage which, as of the time the coverage is being provided, is identical to the coverage provided under the plan to similarly situated beneficiaries under the plan with respect to whom a qualifying event has not occurred.

"(2) PERIOD OF COVERAGE.—The coverage must extend for at least the period beginning on the date of the qualifying event and ending not earlier than the earliest of the following:

"(A) MAXIMUM PERIOD.—In the case of—

"(i) a qualifying event described in section 603(2) (relating to terminations and reduced hours), the date which is 18 months after the date of the qualifying event, and

"(ii) any qualifying event not described in clause (i), the date which is 36 months after the date of the qualifying event.

"(B) END OF PLAN.—The date on which the employer ceases to provide any group health plan to any employee.

"(C) FAILURE TO PAY PREMIUM.—The date on which coverage ceases under the plan by reason of a failure to make timely payment of any premium required under the plan with respect to the qualified beneficiary.

"(D) REEMPLOYMENT OR MEDICARE ELIGIBILITY.—The date on which the qualified beneficiary first becomes, after the date of the election—

"(i) a covered employee under any other group health plan, or

"(ii) entitled to benefits under title XVIII of the Social Security Act.

"(E) REMARRIAGE OF SPOUSE.—In the case of an individual who is a qualified beneficiary by reason of being the spouse of a covered employee, the date on which the beneficiary remarries and becomes covered under a group health plan.

"(3) PREMIUM REQUIREMENTS.—The plan may require payment of a premium for any period of continuation coverage, except that such premium—

"(A) shall not exceed 102 percent of the applicable premium for such period, and

"(B) may, at the election of the payor, be made in monthly installments.

If an election is made after the qualifying event, the plan shall permit payment for continuation coverage during the period preceding the election to be made within 45 days of the date of the election.

"(4) NO REQUIREMENT OF INSURABILITY.—The coverage may not be conditioned upon, or discriminate on the basis of lack of, evidence of insurability.

"(5) CONVERSION OPTION.—In the case of a qualified beneficiary whose period of continuation coverage expires under paragraph (2)(A), the plan must, during the 180-day period ending on such expiration date, provide to the qualified beneficiary the option of enrollment under a conversion health plan otherwise generally available under the plan.

"SEC. 603. QUALIFYING EVENT.

"For purposes of this part, the term 'qualifying event' means, with respect to any covered employee, any of the following events which, but for the continuation coverage required under this part, would result in the loss of coverage of a qualified beneficiary:

"(1) The death of the covered employee.

"(2) The termination (other than by reason of such employee's gross misconduct), or reduction of hours, of the covered employee's employment.

"(3) The divorce or legal separation of the covered employee from the employee's spouse.

"(4) The covered employee becoming entitled to benefits under title XVIII of the Social Security Act.

"(5) A dependent child ceasing to be a dependent child under the generally applicable requirements of the plan.

"SEC. 604. APPLICABLE PREMIUM.

"For purposes of this part—

"(1) IN GENERAL.—The term 'applicable premium' means, with respect to any period of continuation coverage of qualified beneficiaries, the cost to the plan for such period of the coverage for similarly situated beneficiaries with respect to whom a qualifying event has not occurred (without regard to whether such cost is paid by the employer or employee).

"(2) SPECIAL RULE FOR SELF-INSURED PLANS.—To the extent that a plan is a self-insured plan—

"(A) IN GENERAL.—Except as provided in subparagraph (B), the applicable premium for any period of continuation coverage of qualified beneficiaries shall be equal to a reasonable estimate of the cost of providing coverage for such period for similarly situated beneficiaries which—

"(i) is determined on an actuarial basis, and

"(ii) takes into account such factors as the Secretary may prescribe in regulations.

"(B) DETERMINATION ON BASIS OF PAST COST.—If an administrator elects to have this subparagraph apply, the applicable premium for any period of continuation coverage of qualified beneficiaries shall be equal to—

"(i) the cost to the plan for similarly situated beneficiaries for the same period occurring during the preceding determination period under paragraph (3), adjusted by

"(ii) the percentage increase or decrease in the implicit price deflator of the gross national product (calculated by the Department of Commerce and published in the Survey of Current Business) for the 12-month period ending on the last day of the sixth month of such preceding determination period.

"(C) SUBPARAGRAPH (B) NOT TO APPLY WHERE SIGNIFICANT CHANGE.—An administrator may not elect to have subparagraph (B) apply in any case in which there is any significant difference, between the determination period and the preceding determination period, in coverage under, or in employees covered by, the plan. The determination under the preceding sentence for any determination period shall be made at the same time as the determination under paragraph (3).

"(3) DETERMINATION PERIOD.—The determination of any applicable premium shall be made for a period of 12 months and shall be made before the beginning of such period.

"SEC. 605. ELECTION.

"For purposes of this part—

"(1) ELECTION PERIOD.—The term 'election period' means the period which—

"(A) begins not later than the date on which coverage terminates under the plan by reason of a qualifying event,

"(B) is of at least 60 days' duration, and

"(C) ends not earlier than 60 days after the later of—

"(i) the date described in subparagraph (A), or

"(ii) in the case of any qualified beneficiary who receives notice under section 606(4), the date of such notice.

"(2) EFFECT OF ELECTION ON OTHER BENEFICIARIES.—Except as otherwise specified in an election, any election by a qualified beneficiary described in subparagraph (A)(i) or (B) of section 607(3) shall be deemed to include an election of continuation coverage on behalf of any other qualified beneficiary who would lose coverage under the plan by reason of the qualifying event.

"SEC. 606. NOTICE REQUIREMENTS.

"In accordance with regulations prescribed by the Secretary—

"(1) the group health plan shall provide, at the time of commencement of coverage under the plan, written notice to each covered employee and spouse of the employee (if any) of the rights provided under this subsection,

"(2) the employer of an employee under a plan must notify the administrator of a qualifying event described in paragraph (1), (2), or (4) of section 603 within 30 days of the date of the qualifying event,

"(3) each covered employee or qualified beneficiary is responsible for notifying the administrator of the occurrence of any qualifying event described in paragraph (3) or (5) of section 603, and

"(4) the administrator shall notify—

"(A) in the case of a qualifying event described in paragraph (1), (2), or (4) of section 603, any qualified beneficiary with respect to such event, and

"(B) in the case of a qualifying event described in paragraph (3) or (5) of section 603 where the covered employee notifies the administrator under paragraph (3), any qualified beneficiary with respect to such event,

of such beneficiary's rights under this subsection.

For purposes of paragraph (4), any notification shall be made within 14 days of the date on which the administrator is notified under paragraph (2) or (3), whichever is applicable, and any such notification to an individual who is a qualified beneficiary as the spouse of the covered employee shall be treated as notification to all other qualified beneficiaries residing with such spouse at the time such notification is made.

"SEC. 607. DEFINITIONS.

"For purposes of this part—

"(1) GROUP HEALTH PLAN.—The term 'group health plan' means an employee welfare benefit plan that is a group health plan (within the meaning of section 162(i)(3) of the Internal Revenue Code of 1954).

"(2) COVERED EMPLOYEE.—The term 'covered employee' means an individual who is (or was) provided coverage under a group health plan by virtue of the individual's employment or previous employment with an employer.

"(3) QUALIFIED BENEFICIARY.—

"(A) IN GENERAL.—The term 'qualified beneficiary' means, with respect to a covered employee under a group health plan, any other individual who, on the day before the qualifying event for that employee, is a beneficiary under the plan—

"(i) as the spouse of the covered employee, or

"(ii) as the dependent child of the employee.

"(B) SPECIAL RULE FOR TERMINATIONS AND REDUCED EMPLOYMENT.—In the case of a qualifying event described in section 603(2), the term 'qualified beneficiary' includes the covered employee.

"SEC. 608. REGULATIONS.

"The Secretary may prescribe regulations to carry out the provisions of this part.".

(b) PENALTY FOR FAILURE TO PROVIDE NOTICE.—Section 502(c) of such Act (29 U.S.C. 1132(c)) is amended by inserting after "Any administrator" the following: "(1) who fails to meet the requirements of paragraph (1) or (4) of section 606 with respect to a participant or beneficiary, or (2)".

(c) CLERICAL AMENDMENTS.—The table of contents in section 1 of such Act is amended by inserting after the item relating to section 514 the following new items:

"PART 6—CONTINUATION COVERAGE UNDER GROUP HEALTH PLANS

"Sec. 601. Plans must provide continuation coverage to certain individuals.
"Sec. 602. Continuation coverage.
"Sec. 603. Qualifying event.
"Sec. 604. Applicable premium.
"Sec. 605. Election.
"Sec. 606. Notice requirements.
"Sec. 607. Definitions.
"Sec. 608. Regulations.".

(d) EFFECTIVE DATES.—

(1) GENERAL RULE.—The amendments made by this section shall apply to plan years beginning on or after July 1, 1986.

(2) SPECIAL RULE FOR COLLECTIVE BARGAINING AGREEMENTS.—In the case of a group health plan maintained pursuant to one or more collective bargaining agreements between employee representatives and one or more employers ratified before the date of the enactment of this Act, the amendments made by this section shall not apply to plan years beginning before the later of—

(A) the date on which the last of the collective bargaining agreements relating to the plan terminates (determined without regard to any extension thereof agreed to after the date of the enactment of this Act), or

(B) January 1, 1987.

For purposes of subparagraph (A), any plan amendment made pursuant to a collective bargaining agreement relating to the plan which amends the plan solely to conform to any requirement added by this section shall not be treated as a termination of such collective bargaining agreement.

(e) NOTIFICATION TO COVERED EMPLOYEES.—At the time that the amendments made by this section apply to a group health plan (within the meaning of section 607(1) of the Employee Retirement Income Security Act of 1974), the plan shall notify each covered employee, and spouse of the employee (if any), who is covered under the plan at that time of the continuation coverage required under part 6 of subtitle B of title I of such Act. The notice furnished under this subsection is in lieu of notice that may otherwise be required under section 606(1) of such Act with respect to such individuals.

SEC. 10003. CONTINUATION OF HEALTH INSURANCE FOR STATE AND LOCAL EMPLOYEES WHO LOST EMPLOYMENT-RELATED COVERAGE (PUBLIC HEALTH SERVICE ACT AMENDMENTS).

(a) IN GENERAL.—The Public Health Service Act is amended by adding at the end the following new title:

"TITLE XXII—REQUIREMENTS FOR CERTAIN GROUP HEALTH PLANS FOR CERTAIN STATE AND LOCAL EMPLOYEES

"SEC. 2201. STATE AND LOCAL GOVERNMENTAL GROUP HEALTH PLANS MUST PROVIDE CONTINUATION COVERAGE TO CERTAIN INDIVIDUALS.

"(a) IN GENERAL.—In accordance with regulations which the Secretary shall prescribe, each group health plan that is maintained by any State that receives funds under this Act, by any political subdivision of such a State, or by any agency or instrumentality of such a State or political subdivision, shall provide, in accordance with this title, that each qualified beneficiary who would lose coverage under the plan as a result of a qualifying event is entitled, under the plan, to elect, within the election period, continuation coverage under the plan.

"(b) EXCEPTION FOR CERTAIN PLANS.—Subsection (a) shall not apply to—

"(1) any group health plan for any calendar year if all employers maintaining such plan normally employed fewer than 20 employees on a typical business day during the preceding calendar year, or

"(2) any group health plan maintained for employees by the government of the District of Columbia or any territory or possession of the United States or any agency or instrumentality.

Under regulations, rules similar to the rules of subsections (a) and (b) of section 52 of the Internal Revenue Code of 1954 (relating to employers under common control) shall apply for purposes of paragraph (1).

"SEC. 2202. CONTINUATION COVERAGE.

"For purposes of section 2201, the term 'continuation coverage' means coverage under the plan which meets the following requirements:

"(1) TYPE OF BENEFIT COVERAGE.—The coverage must consist of coverage which, as of the time the coverage is being provided, is identical to the coverage provided under the plan to similarly situated beneficiaries under the plan with respect to whom a qualifying event has not occurred.

"(2) PERIOD OF COVERAGE.—The coverage must extend for at least the period beginning on the date of the qualifying event and ending not earlier than the earliest of the following:

"(A) MAXIMUM PERIOD.—In the case of—

"(i) a qualifying event described in section 2203(2) (relating to terminations and reduced hours), the date which is 18 months after the date of the qualifying event, and

"(ii) any qualifying event not described in clause (i), the date which is 36 months after the date of the qualifying event.

"(B) END OF PLAN.—The date on which the employer ceases to provide any group health plan to any employee.

"(C) FAILURE TO PAY PREMIUM.—The date on which coverage ceases under the plan by reason of a failure to make timely payment of any premium required under the plan with respect to the qualified beneficiary.

"(D) REEMPLOYMENT OR MEDICARE ELIGIBILITY.—The date on which the qualified beneficiary first becomes, after the date of the election—

"(i) a covered employee under any other group health plan, or

"(ii) entitled to benefits under title XVIII of the Social Security Act.

"(E) REMARRIAGE OF SPOUSE.—In the case of an individual who is a qualified beneficiary by reason of being the spouse of a covered employee, the date on which the beneficiary remarries and becomes covered under a group health plan.

"(3) PREMIUM REQUIREMENTS.—The plan may require payment of a premium for any period of continuation coverage, except that such premium—

"(A) shall not exceed 102 percent of the applicable premium for such period, and

"(B) may, at the election of the payor, be made in monthly installments.

If an election is made after the qualifying event, the plan shall permit payment for continuation coverage during the period preceding the election to be made within 45 days of the date of the election.

"(4) NO REQUIREMENT OF INSURABILITY.—The coverage may not be conditioned upon, or discriminate on the basis of lack of, evidence of insurability.

"(5) CONVERSION OPTION.—In the case of a qualified beneficiary whose period of continuation coverage expires under paragraph

(2)(A), the plan must, during the 180-day period ending on such expiration date, provide to the qualified beneficiary the option of enrollment under a conversion health plan otherwise generally available under the plan.

"SEC. 2203. QUALIFYING EVENT.

"For purposes of this title, the term 'qualifying event' means, with respect to any covered employee, any of the following events which, but for the continuation coverage required under this title, would result in the loss of coverage of a qualified beneficiary:

"(1) The death of the covered employee.

"(2) The termination (other than by reason of such employee's gross misconduct), or reduction of hours, of the covered employee's employment.

"(3) The divorce or legal separation of the covered employee from the employee's spouse.

"(4) The covered employee becoming entitled to benefits under title XVIII of the Social Security Act.

"(5) A dependent child ceasing to be a dependent child under the generally applicable requirements of the plan.

"SEC. 2204. APPLICABLE PREMIUM.

"For purposes of this title—

"(1) IN GENERAL.—The term 'applicable premium' means, with respect to any period of continuation coverage of qualified beneficiaries, the cost to the plan for such period of the coverage for similarly situated beneficiaries with respect to whom a qualifying event has not occurred (without regard to whether such cost is paid by the employer or employee).

"(2) SPECIAL RULE FOR SELF-INSURED PLANS.—To the extent that a plan is a self-insured plan—

"(A) IN GENERAL.—Except as provided in subparagraph (B), the applicable premium for any period of continuation coverage of qualified beneficiaries shall be equal to a reasonable estimate of the cost of providing coverage for such period for similarly situated beneficiaries which—

"(i) is determined on an actuarial basis, and

"(ii) takes into account such factors as the Secretary may prescribe in regulations.

"(B) DETERMINATION ON BASIS OF PAST COST.—If a plan administrator elects to have this subparagraph apply, the applicable premium for any period of continuation coverage of qualified beneficiaries shall be equal to—

"(i) the cost to the plan for similarly situated beneficiaries for the same period occurring during the preceding determination period under paragraph (3), adjusted by

"(ii) the percentage increase or decrease in the implicit price deflator of the gross national product (calculated by the Department of Commerce and published in the Survey of Current Business) for the 12-month period ending on the last day of the sixth month of such preceding determination period.

"(C) SUBPARAGRAPH (B) NOT TO APPLY WHERE SIGNIFICANT CHANGE.—A plan administrator may not elect to have subparagraph (B) apply in any case in which there is any significant difference, between the determination period and the preceding determination period, in coverage under, or in employees covered by, the plan. The determination under the preceding sentence for any determination period shall be made at the same time as the determination under paragraph (3).

"(3) DETERMINATION PERIOD.—The determination of any applicable premium shall be made for a period of 12 months and shall be made before the beginning of such period.

"SEC. 2205. ELECTION.

"For purposes of this title—

"(1) ELECTION PERIOD.—The term 'election period' means the period which—

"(A) begins not later than the date on which coverage terminates under the plan by reason of a qualifying event,

"(B) is of at least 60 days' duration, and

"(C) ends not earlier than 60 days after the later of—

"(i) the date described in subparagraph (A), or

"(ii) in the case of any qualified beneficiary who receives notice under section 2206(4), the date of such notice.

"(2) EFFECT OF ELECTION ON OTHER BENEFICIARIES.—Except as otherwise specified in an election, any election by a qualified beneficiary described in subparagraph (A)(i) or (B) of section 2208(3) shall be deemed to include an election of continuation coverage on behalf of any other qualified beneficiary who would lose coverage under the plan by reason of the qualifying event.

"SEC. 2206. NOTICE REQUIREMENTS.

"In accordance with regulations prescribed by the Secretary—

"(1) the group health plan shall provide, at the time of commencement of coverage under the plan, written notice to each covered employee and spouse of the employee (if any) of the rights provided under this subsection,

"(2) the employer of an employee under a plan must notify the plan administrator of a qualifying event described in paragraph (1), (2), or (4) of section 2203 within 30 days of the date of the qualifying event,

"(3) each covered employee or qualified beneficiary is responsible for notifying the plan administrator of the occurrence of any qualifying event described in paragraph (3) or (5) of section 2203, and

"(4) the plan administrator shall notify—

"(A) in the case of a qualifying event described in paragraph (1), (2), or (4) of section 2203, any qualified beneficiary with respect to such event, and

"(B) in the case of a qualifying event described in paragraph (3) or (5) of section 2203 where the covered employee notifies the plan administrator under paragraph (3), any qualified beneficiary with respect to such event,

of such beneficiary's rights under this subsection.

For purposes of paragraph (4), any notification shall be made within 14 days of the date on which the plan administrator is notified under paragraph (2) or (3), whichever is applicable, and any such notification to an individual who is a qualified beneficiary as the spouse of the covered employee shall be treated as notification to all other qualified beneficiaries residing with such spouse at the time such notification is made.

"SEC. 2207. ENFORCEMENT.

"Any individual who is aggrieved by the failure of a State, political subdivision, or agency or instrumentality thereof, to comply with the requirements of this title may bring an action for appropriate equitable relief.

"SEC. 2208. DEFINITIONS.

"For purposes of this title—

"(1) GROUP HEALTH PLAN.—The term 'group health plan' has the meaning given such term in section 162(i)(3) of the Internal Revenue Code of 1954.

"(2) COVERED EMPLOYEE.—The term 'covered employee' means an individual who is (or was) provided coverage under a group health plan by virtue of the individual's employment or previous employment with an employer.

"(3) QUALIFIED BENEFICIARY.—

"(A) IN GENERAL.—The term 'qualified beneficiary' means, with respect to a covered employee under a group health plan, any other individual who, on the day before the qualifying event for that employee, is a beneficiary under the plan—

"(i) as the spouse of the covered employee, or

"(ii) as the dependent child of the employee.

"(B) SPECIAL RULE FOR TERMINATIONS AND REDUCED EMPLOYMENT.—In the case of a qualifying event described in section 2203(2), the term 'qualified beneficiary' includes the covered employee.

"(4) PLAN ADMINISTRATOR.—The term 'plan administrator' has the meaning given the term 'administrator' by section 3(16)(A) of the Employee Retirement Income Security Act of 1974.".

(b) EFFECTIVE DATES.—

(1) GENERAL RULE.—The amendments made by this section shall apply to plan years beginning on or after July 1, 1986.

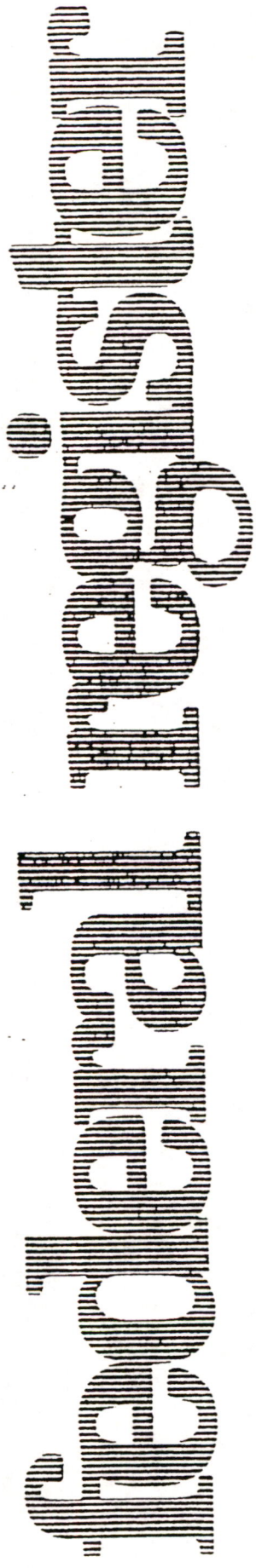
(2) SPECIAL RULE FOR COLLECTIVE BARGAINING AGREEMENTS.—In the case of a group health plan maintained pursuant to one or more collective bargaining agreements between employee representatives and one or more employers ratified before the date of the enactment of this Act, the amendments made by this section shall not apply to plan years beginning before the later of—

(A) the date on which the last of the collective bargaining agreements relating to the plan terminates (determined without regard to any extension thereof agreed to after the date of the enactment of this Act), or

(B) January 1, 1987.

For purposes of subparagraph (A), any plan amendment made pursuant to a collective bargaining agreement relating to the plan which amends the plan solely to conform to any requirement added by this section shall not be treated as a termination of such collective bargaining agreement.

(c) NOTIFICATION TO COVERED EMPLOYEES.—At the time that the amendments made by this section apply to a group health plan (covered under section 2201 of the Public Health Service Act), the plan shall notify each covered employee, and spouse of the employee (if any), who is covered under the plan at that time of the continuation coverage required under title XXII of such Act. The notice furnished under this subsection is in lieu of notice that may otherwise be required under section 2206(1) of such Act with respect to such individuals.



Monday
June 15, 1987

Part II

Department of the Treasury

Internal Revenue Service

26 CFR Part 1

Income Tax; Continuation Coverage Requirements of Group Health Plans; Notice of Proposed Rulemaking

DEPARTMENT OF THE TREASURY

Internal Revenue Service

26 CFR Part 1

[EE-143-86]

Income Tax; Continuation Coverage Requirements of Group Health Plans

AGENCY: Internal Revenue Service, Treasury.

ACTION: Notice of proposed rulemaking.

SUMMARY: This document contains proposed regulations relating to the requirement that a group health plan offer continuation coverage to people who would otherwise lose coverage as a result of certain events. They reflect changes made by the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) and the Tax Reform Act of 1986. The regulations will generally affect sponsors of and participants in group health plans, and they provide plan sponsors with guidance necessary to comply with the law.

DATES: Written comments and requests for a public hearing must be delivered or mailed on or before August 14, 1987. These regulations are proposed to be effective when final regulations are published in the **Federal Register** as a Treasury decision.

ADDRESS: Send comments and requests for a public hearing to: Commissioner of Internal Revenue, Attention: CC:LR:T (EE-143-86) Washington, DC 20224.

FOR FURTHER INFORMATION CONTACT: Mark Schwimmer of the Employee Plans and Exempt Organizations Division, Office of Chief Counsel, Internal Revenue Service, 1111 Constitution Avenue NW., Washington, DC 20224 (Attention: CC:LR:T). Telephone 202-566-6212 (not a toll-free number).

SUPPLEMENTARY INFORMATION:

Background

This document contains proposed amendments to the Income Tax Regulations (26 CFR Part 1) under sections 106(b), 162(i)(2), and 162(k) of the Internal Revenue Code of 1986 (Code). The proposed regulations conform the regulations to section 10001 of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) (100 Stat. 222) and to section 1895(d) of the Tax Reform Act of 1986 (100 Stat. 2936), which made technical corrections to the COBRA provisions.

COBRA added a new section 162(k) of the Code to specify continuation coverage requirements for employer-provided group health plans. In general, a group health plan must offer each "qualified beneficiary" who would otherwise lose coverage under the plan as a result of a "qualifying event" an opportunity to elect continuation of the coverage being received immediately before the qualifying event. A qualified beneficiary who properly elects continuation coverage can be charged an amount no greater than 102 percent of the "applicable premium." The "applicable premium" is based on the plan's cost of providing coverage.

If a group health plan fails to comply with these continuation coverage requirements, the employer will be unable to deduct contributions made to that or any other group health plan (section 162(i)(2)), and certain highly compensated individuals will be unable to exclude from income any employer-provided coverage under that or any other group health plan (section 106(b)).

In addition, there may be non-tax consequences if a group health plan fails to comply with parallel requirements that section 10002 of COBRA added to Title I of the Employee Retirement Income Security Act of 1974 (ERISA). Title I of ERISA is administered by the Department of Labor. Governmental plans (as defined in section 414(d) of the Code) are exempt from both the tax and ERISA provisions. However, State and local governmental group health plans are subject to parallel requirements that section 10003 of COBRA added to the Public Health Service Act, which is administered by the Department of Health and Human Services.

The proposed regulations do not reflect section 9501 of the Omnibus Budget Reconciliation Act of 1986, which extended the COBRA continuation coverage requirements to certain individuals receiving retiree medical benefits from employers that are involved in bankruptcy proceedings. The changes made by that act will be addressed in a later issuance.

The proposed regulations clarify which plans must offer COBRA continuation coverage and the tax consequences of failing to do so. They also provide guidance on a variety of details, including the scope of the continuation coverage, who is a qualified beneficiary, what is a qualifying event, how elections are made, and when payment must be made. Rules regarding computation of the applicable premium under section 162(k)(4) will be addressed in a later issuance.

Section 414(t) as added by the Tax Reform Act of 1986 extends the employer aggregation rules of sections 414 (b), (c), (m), and (o) to a variety of employee benefit provisions. The list of those provisions includes section 106 (denying an income exclusion to highly compensated employees of an employer maintaining a group health plan that fails to comply with section 162(k)), but does not include section 162(i)(2) (denying deductions to such an employer) or section 162(k) itself. A technical correction to add sections 162(i)(2) and 162(k) to the list was included in H.Con.Res. 395. Although the 99th Congress adjourned without enacting that concurrent resolution, the correction was identical in both House and Senate versions. Accordingly, the proposed regulations set forth employer aggregation rules that anticipate a similar technical correction with retroactive effect being enacted in the current session of Congress.

There is no connection between the proposed regulations and section 89 of the Code. For example, the definitions set forth in the proposed regulations will not affect the meaning of "core benefits," "non-core benefits," or any other terms for purposes of section 89. Also, the computation of applicable premiums for COBRA continuation coverage will not affect the determination of the value of group health plan benefits for purposes of section 89.

Effective Date

The regulations are proposed to be effective when final regulations are published in the **Federal Register** as a Treasury decision. Group health plans become subject to the COBRA continuation coverage requirements at different times, however, depending on the plan year of a plan and whether the plan is a collectively bargained plan. With respect to qualifying events that occur on or after the date that a plan became or becomes subject to those requirements and before the effective date of final regulations, the plan and the employer must operate in good faith compliance with a reasonable interpretation of the statutory requirements (i.e., title X of COBRA). For the period before the effective date of final regulations, the Internal Revenue Service will consider compliance with the terms of these proposed regulations to constitute good faith compliance with a reasonable interpretation of the statutory requirements (other than the statutory requirements regarding the computation of the applicable premium or the treatment, under section 9501 of the Omnibus Budget Reconciliation Act of 1986, of certain bankruptcies as qualifying events, which are not addressed in these proposed regulations). Moreover, plans and employers will be considered to be in

compliance with the terms of these proposed regulations if, between June 15, 1987 and September 14, 1987, they operate in good faith compliance with a reasonable interpretation of the statutory requirements and, from September 15, 1987 until the effective date of final regulations, they operate in compliance with the terms of these proposed regulations. In addition, the Internal Revenue Service will not consider actions inconsistent with the terms of these proposed regulations necessarily to constitute a lack of good faith compliance with a reasonable interpretation of the statutory requirements; whether there has been good faith compliance with a reasonable interpretation of the statutory requirements will depend on all the facts and circumstances of each case.

Special Analyses

The Commissioner of Internal Revenue has determined that this proposed rule is not a major rule as defined in Executive Order 12291. Therefore, a Regulatory Impact Analysis is not required. Although this document is a notice of proposed rulemaking which solicits public comment, the Internal Revenue Service has concluded that the regulations proposed herein are interpretative and that the notice and public procedure requirements of 5 U.S.C. 553 do not apply. Accordingly, these proposed regulations do not consitute regulations subject to the Regulatory Flexibility Act (5 U.S.C. chapter 6).

Comments and Requests for Public Hearing

Before adopting these proposed regulations, consideration will be given to any written comments that are submitted (preferably eight copies) to the Commissioner of Internal Revenue. All comments will be available for public inspection and copying. A pubic hearing will be held upon written request to the Commissioner by any person who has submitted written comments. If a public hearing is held, notice of the time and place will be published in the Federal Register.

Drafting Information

The principal author of these proposed regulations is Mark Schwimmer of the Employee Plans and Exempt Organizations Division of the Office of Chief Counsel, Internal Revenue Service. However, personnel from other offices of the Internal Revenue Service and Treasury Department participated in developing the regulations, both on matters of substance and style.

List of Subjects in 26 CFR 1.61–1 Through 1.281–4

Income taxes, Taxable Income, Deductions, Exemptions.

Proposed Amendments to the Regulations

The proposed amendments to 26 CFR Part 1 are as follows:

PART 1—[AMENDED]

Paragraph 1. The authority citation for Part 1 is amended by adding the following citation:

Authority: 26 U.S.C. 7805. * * * Sections 1.106–1 and 1.162–26 also issued under 26 U.S.C. 106(b), 162(i)(2), and 162(k).

Par. 2. Section 1.106–1 is amended by redesignating the existing text as paragraph (a), revising the first sentence of paragraph (a), and adding a new paragraph (b) to read as follows:

§ 1.106–1 Contributions by employer to accident and health plans.

(a) Except as set forth in paragraph (b) of this section, the gross income of an employee does not include contributions which his employer makes to an accident or health plan for compensation (through insurance or otherwise) to the employee for personal injuries or sickness incurred by him, his spouse, or his dependents, as defined in section 152. * * *

(b) In situations involving group health plans that do not comply with section 162(k), the exclusion described in paragraph (a) of this section is not available to highly compensated employees (as defined in section 414(q)). See § 1.162–26 (regarding continuation coverage requirements of group health plans).

Par. 3. A new § 1.162–26 is added immediately after § 1.162–25T to read as follows:

§ 1.162–26 Continuation coverage requirements of group health plans.

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Cobra in General

Question 1: What are the new health care continuation coverage requirements added to the Internal Revenue Code by the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA")?

Answer 1: Section 10001 of COBRA added a new section 162(k) to the Code to provide generally that a group health plan must offer each qualified beneficiary who would otherwise lose coverage under the plan as a result of a qualifying event an opportunity to elect, within the applicable election period, continuation coverage under the plan. That continuation coverage is referred to in this section as "COBRA" continuation coverage" and a group health plan that is subject to section 162(k) is referred to as being "subject to COBRA" (see Q&A–8 of this section). A qualified beneficiary can be required to pay for COBRA continuation coverage. A qualified beneficiary is defined in Q&A–15 of this section. A qualifying event is defined in Q&A–18 of this section. The election procedures are described in Q&A–32 through Q&A–37 of this section. COBRA continuation coverage is described in Q&A–22 through Q&A–31 of this section. Payment for COBRA continuation coverage is addressed in Q&A–44 through Q&A–48 of this section. Unless otherwise specified, any reference in this section to "COBRA" refers to section 10001 of COBRA and to section 162(k) of the Code as added by COBRA (as amended).

Question–2: What is the effect of a group health plan's failure to comply with section 162(k)?

Answer–2: If a group health plan subject to COBRA fails to comply with section 162(k), certain deductions are disallowed to the employer under section 162(i)(2) (see Q&A–3 of this section) and the income exclusion under section 106(a) is denied to certain highly compensated employees of the employer under section 106(b)(1) (see Q&A–4 of this section). There may be additional non-tax consequences if the plan fails to comply with parallel requirements that were added by section 10002 of COBRA to Title I of the Employee Retirement Income Security Act of 1974 (ERISA), which is administered by the Department of Labor. Although governmental plans are not subject to section 162(k) because they are not "subject to COBRA" (see Q&A–8 of this section), certain governmental plans are subject to parallel requirements that were added by section 10003 of COBRA to the Public Health Service Act, which is administered by the Department of Health and Human Services.

Question 3: How are employer deductions affected by a group health plan's failure to comply with section 162(k)?

Answer 3: (a) Under section 162(i)(2), if a group health plan subject to COBRA fails to comply with section 162(k), each employer maintaining the plan is denied a deduction for any contributions or other expenses paid or incurred in connection with any group health plan that it maintains. The deduction is denied for any taxable year of the taxpayer during which there are one or more days on which plan is not in compliance with section 162(k). Thus, if a failure to comply with section 162(k) arises in one taxable year of a taxpayer and is not corrected until after the beginning of the following taxable year, the deduction for contributions or expenses for both of those taxable years is denied. Section 162(i)(2) operates each taxable year to permanently deny a deduction for amounts paid or incurred in that year, and is applied before applying any provision of the Code that governs the timing of an otherwise available deduction. Examples of such provisions include sections 263A (capitalization and inclusion in inventory costs), 419 (treatment of funded welfare benefit plans), and 460 (special rules for long-term contracts). In addition, section 162(i)(2) operates with respect to each employer maintaining the group health plan, without regard to whether the employers are treated as a single employer (see Q&A–5 of this

section) and without regard to whether the failure to satisfy section 162(k) occurs with respect to only an employee of one of the employers. See Q&A–10 of this section regarding when an arrangement is treated as two or more separate group health plans.

(b) A failure of a group health plan to comply with section 162(k) that occurs before, and is not corrected by, the date that an employer maintaining the plan and another entity are first treated as a single employer under Q&A–5 of this section ("the combination date") will not result in a denial of a deduction to the other entity under paragraph (a) of this Q&A–3, so long as (1) the other entity did not also maintain the plan before the combination date, and (2) the failure is corrected before the end of the first taxable year of the other entity that begins after the combination date.

(c) The rules of this Q&A–3 are illustrated by the following examples:

Example 1: Plan A is a group health plan subject to COBRA that is maintained by two unrelated employers, X and Y. Section 162(k) became effective with respect to plan A before April 1, 1988. The taxable year of employer X ends on March 31, and the taxable year of employer Y ends on April 30. If Plan A fails to comply with section 162(k) on April 1, 1988, by not offering COBRA continuation coverage to a qualified beneficiary of an employee of employer X, and the failure is not corrected until June 1, 1988, both employers X and Y are disallowed deductions for their contributions and other expenses relating to all their group health plans (including any group health plan that is maintained only by employer X or only by employer Y) for each taxable year that includes one or more days of noncompliance. Thus, the disallowance applies to employer X for its taxable year ending March 31, 1989, and to employer Y for both its taxable year ending April 30, 1988, and its taxable year ending April 30, 1989. (However, see Q&A–10 of this section regarding when an arrangement is considered to be two or more separate group health plans.)

Example 2: Assume that companies Z and W are treated as a single employer under section 414(b) at all relevant times (see Q&A–5 of this section), that Z maintains group health plans P and Q, that W maintains group health plans R and S, and that none of these plans is excepted from COBRA (see Q&A–8 of this section). Assume further that the taxable year of company Z ends on May 31, that the taxable year of company W ends on July 31, and that section 162(k) becomes effective with respect to the group health plans as follows: for plan P on February 1, 1987; for plan Q on April 1, 1987; and for plans R and S on July 1, 1987. If at any time during February through May of 1987 plan P is not in compliance with section 162(k), then company Z is disallowed all deductions with respect to plans P and Q for its taxable year ending May 31, 1987, and company W is disallowed all deductions with respect to plans R and S for its taxable year ending July 31, 1987.

Example 3: Assume that a group health plan maintained only by M, a calendar year employer, is subject to COBRA and fails to comply with section 162(k) during February of 1988, that the failure is corrected during April of 1988, and that on June 1, 1988 employer M becomes a wholly-owned subsidiary of N, a previously unrelated corporation with a taxable year ending July 31. For 1988, M is disallowed a deduction for all its contributions with respect to any group health plan. Because M and N were not treated as a single employer (see Q&A–5 of this section) during the period of noncompliance by M's plan (i.e., February to April of 1988), the failure of M's plan to comply with section 162(k) during that period will not result in a disallowance of any deductions to N, the new parent corporation. Even if the failure to comply that arises in February of 1988 is not corrected until after June 1, 1988, it will not result in a disallowance of any deductions to N, so long as the failure to comply is corrected by July 31, 1989 (the end of N's first taxable year that begins after June 1, 1988). However, if the failure is not corrected until August of 1989, N will be disallowed a deduction for all its contributions with respect to any group health plan for its taxable years ending on July 31 of 1988, 1989, and 1990. Also, if another failure of M's plan to comply with section 162(k) arises on or after June 1, 1988, that second failure will result in a disallowance of deductions to N.

Example 4: Assume that a calendar year employer maintaining a group health plan through a welfare benefit fund contributes $800,000 to the fund in 1988 and $500,000 in 1989. Assume further that only $600,000 of the 1988 contribution would be deductible under section 419 for 1988, and that the remaining $200,000 would be deemed to be contributed in 1989 and deductible under section 419 for 1989 along with the $500,000 actually contributed in that year. However, the deduction under section 419 is only available if these amounts are otherwise deductible under section 162. Therefore, if at any time during 1988 the group health plan is not in compliance with section 162(k), the $800,000 contributed in 1988 is disallowed in full as a deduction for 1988 and for all later years. However, if the plan does comply with section 162(k) throughout 1988 but at some time during 1989 is not in compliance, the $600,000 deduction for 1988 is unaffected while the $700,000 otherwise deductible for 1989 is permanently disallowed.

Question 4: How is the gross income of certain individuals affected by a group health plan's failure to comply with section 162(k)?

Answer 4: (a) Under section 106(a), employer-provided coverage under an accident or health plan is generally excluded from the gross income of an employee. Under section 106(b), however, if a group health plan that is subject to COBRA fails to comply with section 162(k), certain individuals shall have certain employer-provided coverage included in their gross income for each of their taxable years during which the plan is not in compliance, even if the coverage would otherwise be excludable from income under section 106(a). The individuals referred to in the preceding sentence consist of each person who is, at any time during which the plan is not in compliance with section 162(k), a highly compensated employee (within the meaning of section 414(q) and the regulations under that section) of any employer maintaining the plan. The coverage included in the individual's gross income for each such taxable year shall consist of all coverage provided by the employer to the individual and his or her spouse and dependent children during that taxable year under any group health plan (other than a plan that is excepted from COBRA—see Q&A–8 of this section). For purposes of section 106(b) and this Q&A–4, whether an individual is a highly compensated employee shall be determined on the basis of plan years or any alternative period permitted under section 414(q) and the regulations under that section. As used in the preceding sentence, "plan year" means the plan year as defined in Q&A–13 of this section.

(b) A failure of a group health plan to comply with section 162(k) that occurs before, and is not corrected by, the date that an employer maintaining the plan and another entity are first treated as a single employer under Q&A–5 of this section ("the combination date") will not result in an income inclusion for highly compensated employees of the other entity under paragraph (a) of this Q&A–4, so long as (1) the other entity did not also maintain the plan before the combination date, and (2) the failure is corrected before the end of the first taxable year of the other entity that begins after the combination date.

(c) The rules of this Q&A–4 are illustrated by the following examples, in which it is assumed that all individuals are calendar year taxpayers:

Example 1: Employer Z maintains group health plan T, and maintains no other group health plans. If plan T fails to comply with section 162(k) on November 10, 1988, and the failure is not corrected until February 15, 1989, each individual who is a highly compensated employee of Z at any time from November 10, 1988, through February 15, 1989, shall have coverage included in gross income for that individual's 1988 and 1989 taxable years. If the individual was covered under plan T throughout those years, the coverage included in 1988 is all coverage provided by employer Z under plan T on behalf of the individual and the individual's family during 1988, and the coverage included in 1989 is all coverage provided by employer Z under plan T on behalf of the individual and the individual's family during 1989.

Example 2: The facts are the same as in Example 1, except that employer Z's highly compensated employees are covered under plan U. Even if plan U complies with section 162(k) at all times, each individual who is a highly compensated employee of Z at any time for November 10, 1988, through February 15, 1989 (the period of plan T's noncompliance), shall have coverage included in gross income for that individual's 1988 and 1989 taxable years. If the individual was covered under plan U throughout those years, the coveage included in 1988 is all coverage provided by employer Z under plan U on behalf of the individual and the individual's family during 1988, the coverage included in 1989 is all coverage provided by employer Z under plan U on behalf of the individual and the individual's family during 1989.

Example 3: The facts are the same as in Example 1, except that the failure to comply with section 162(k) is corrected on December 20, 1988, rather than on February 15, 1989. The income inclusion for highly compensated employees applies only for the 1988 taxable year and only to those individuals who are highly compensated employees of Z at some time from November 10 to December 20, 1988.

Example 4: The facts are the same as in Example 1. In addition, employer W maintains group health plan V, and maintains no other group health plans. Employer W's taxable year ends on May 31. Employer W becomes a wholly-owned subsidiary of employer Z on December 1, 1988. Plan T's failure to comply with section 162(k) that arises on November 10, 1988, does not result in an income inclusion to any of employer W's highly compensated employees because the failure is corrected on February 15, 1989, which is before May 31, 1990 (the end of employer W's first taxable year that begins after December 1, 1988). However, if another failure of Plan T to comply with section 162(k) arises on December 15, 1988, and that failure to comply is also corrected on February 15, 1989, each employee of employer W who is a highly compensated employee at any time from December 15, 1988, through February 15, 1989, is also subject to the income inclusion set forth in this Q&A–4.

Question 5: What is the employer?

Answer 5: For purposes of this § 1.162–26 and sections 106(b), 162(i), and 162(k), the term "employer" refers to the employer and any entity that is a member of a group described in section 414(b), (c), (m), or (o) that includes the employer, and to any successor of either the employer or such an entity. However, the rule of this Q&A–5 does not apply for purposes of determining whether a group health plan is a small-employer plan (see Q&A–9 of this section).

Question 6: How does COBRA apply to a group health plan before the effective date of this section?

Answer 6: This section is proposed to be effective when final regulations that include it are published in the **Federal Register** as a Treasury decision. Group health plans become subject to the COBRA continuation coverage requirements at different times, however, as set forth in Q&A–11 of this section. With respect to qualifying events that occur on or after the date that a plan became or becomes subject to those requirements and before the effective date of final regulations, the plan and the employer must operate in good faith compliance with a reasonable interpretation of the statutory requirements (i.e., title X of COBRA). For the period before the effective date of final regulations, the Internal Revenue Service will consider compliance with the terms of these proposed regulations to constitute good faith compliance with a reasonable interpretation of the statutory requirements (other than the statutory requirements regarding the computation of the applicable premium or the treatment, under section 9501 of the Omnibus Budget Reconciliation Act of 1986, of certain bankruptcies as qualifying events, which are not addressed in these proposed regulations). Moreover, plans and employers will be considered to be in compliance with the terms of these proposed regulations if, between June 15, 1987 and September 14, 1987, they operate in good faith compliance with a reasonable interpretation of the statutory requirements and, from September 15, 1987 until the effective date of final regulations, they operate in compliance with the terms of these proposed regulations. In addition, the Internal Revenue Service will not consider actions inconsistent with the terms of these proposed regulations necessarily to constitute a lack of good faith compliance with a reasonable interpretation of the statutory requirements; whether there has been good faith compliance with a reasonable interpretation of the statutory requirements will depend on all the facts and circumstances of each case.

Which Plans Must Comply and When

Question 7: What is a group health plan?

Answer 7: (a) A group health plan is any plan maintained by an employer to provide medical care (as defined in section 213(d)) to the employer's employees, former employees, or the families of such employees or former employees, whether directly or through insurance, reimbursement, or otherwise, and whether or not provided through an on-site facility (except as set forth in paragraph (e) of this Q&A-7), or through a cafeteria plan (as defined in section 125) or other flexible benefit arrangement. For purposes of this Q&A-7, insurance includes not only group insurance policies but also one or more individual insurance policies in any arrangement that involves the provision of medical care to two or more employees. A plan "maintained by an employer" is any plan of, or contributed to (directly or indirectly) by, an employer. Thus, a group health plan is "maintained by an employer," regardless of whether the employer contributes to it, if coverage under the plan would not be available at the same cost to an employee in the event that he or she were not employed by the employer. However, a plan that is maintained by an employee representative is not "maintained by an employer" if the employer does not contribute to the plan and has no involvement (e.g., payroll checkoff) in the operation of the plan. See Q&A-10 of this section for rules governing when a single arrangement is considered to be two or more separate group health plans.

(b) Medical care (as defined in section 213(d)) includes the diagnosis, cure, mitigation, treatment, or prevention of disease, and any other undertaking for the purpose of affecting any structure or function of the body. Medical care also includes transportation primarily for and essential to medical care as described in the preceding sentence. However, medical care does not include anything that is merely beneficial to the general health of an individual, such as a vacation. Thus, if an employer maintains a program that furthers general good health, but the program does not relate to the relief or alleviation of health or medical problems and is generally accessible to and used by employees without regard to their physical condition or state of health, that program is not considered a program that provides medical care and so is not a group health plan for purposes of this section.

(c) For example, if an employer maintains a spa, swimming pool, or exercise/fitness program that is normally accessible to and used by employees for reasons other than relief of health or medical problems, such a facility would not constitute medical care. In contrast, if the employer maintains a drug or alcohol treatment program or a health clinic, or any other facility or program that is intended to relieve or alleviate a physical condition or health problem (whether the condition or problem is chronic or acute), the facility or program is considered to be the provision of medical care and so is considered a group health plan for purposes of this section.

(d) Whether a benefit provided to employees constitutes medical care is not affected by whether the benefit is excludable from income under section 132 (relating to certain fringe benefits). For example, if a department store provides its employees discounted prices on all merchandise, including health care items such as drugs or eyeglasses, the mere fact that the discounted prices also apply to health care items will not cause the program to be a plan providing medical care, so long as the discount program would normally be accessible to and used by employees without regard to health needs or physical condition. If, however, the employer maintaining the discount program is a health clinic, so that the program is used exclusively by employees with health or medical needs, the program is considered as a plan providing medical care and so is considered a group health plan for purposes of this section.

(e) The provision of medical care at a facility that is located on the premises of an employer does not constitute a group health plan if (1) the medical care consists primarily of first aid that is provided during the employer's working hours for treatment of a health condition, illness, or injury that occurs during those working hours, (2) the medical care is available only to the employer's current employees, and (3) employees are not charged for the use of the facility.

Question 8: What group health plans are subject to COBRA?

Answer 8: (a) All group health plans are subject to COBRA (i.e., subject to section 162(k)) except group health plans described in section 106(b)(2). However, a group health plan is not subject to COBRA before the effective date prescribed for that plan in Q&A–11 of this section.

(b) The following group health plans are described in section 106(b)(2): (1) Small-employer plans (see Q&A–9 of this section), (2) church plans (within the meaning of section 414(e)), and (3) governmental plans (within the meaning of section 414(d)). Plans that are described in section 106(b)(2) are referred to in this § 1.162–26 as "excepted from COBRA." The income inclusion rule of section 106(b)(1), the deduction denial rule of section 162(i), and the continuation coverage requirements of section 162(k) do not apply with respect to group health plans that are excepted from COBRA. Certain governmental plans, however, are governed by parallel requirements that were added by section 10003 of COBRA to the Public Health Service Act, which is administered by the Department of Health and Human Services.

Question 9: What is a small-employer plan?

Answer 9: (a) A "small-employer plan" is a group health plan maintained by one or more employers where each of the employers maintaining the plan for a calendar year normally employed fewer than 20 employees during the preceding calendar year. For purposes of this definition, each employer maintaining the plan shall, in combination with all other entities under common control with that employer (as determined under section 52 (a) and (b)), be considered a single employer. See Q&A–10 of this section for rules governing when a single arrangement is considered to be two or more separate group health plans.

(b) An employer is considered as having normally employed fewer that 20 employees during a particular calendar year if, and only if, it had fewer than 20 employees on at least 50 percent of its working days during that year.

(c) In determining the number of its employees, an employer shall treat as employees all full-time and part-time employees, and all employees within the meaning of section 401(c)(1). For example, partners in a law firm are treated as employees for this purpose. An employer shall also treat as employees for this purpose all agents and independent contractors (and their employees, agents, and independent contractors, if any), and all directors (in the case of a corporation), but only if such individuals are eligible to participate in a group health plan maintained by the employer.

(d) The determination of whether a plan is a small-employer plan on any particular date depends on which employers are maintaining the plan on that date and on the workforce of those employers during the preceding calendar year. If a plan that is otherwise subject to COBRA ceases to be a small-employer plan because of the addition during a calendar year of an employer that did not normally employ fewer than 20 employees on a typical business day during the preceding calendar year, the plan ceases to be excepted from COBRA and section 162(k) becomes effective with respect to it immediately upon the addition of the new employer. In contrast, if the plan ceases to be a small-employer plan by reason of an increase during a calendar year in the workforce of an employer maintaining the plan, the plan ceases to be excepted from COBRA and section 162(k) becomes effective with respect to it on the January 1 immediately following the calendar year in which the employer's workforce increased. However, a plan described in the preceding sentence will be treated as not having become subject to section 162(k) on that January 1 (i.e., still excepted from COBRA) if all the employers who did not normally employ fewer than 20 employees in the preceding calendar year have ceased to maintain the plan by February 1 immediately following that January 1. For example, if each employer maintaining a group health plan normally employs fewer than 20 employees during each of 1986 and 1987 but two of the employers do not normally employ fewer than 20 employees during 1988, the entire plan becomes subject to COBRA and must begin to comply with section 162(k) on January 1, 1989, even if the plan year is not a calendar year, unless those two employers depart from the plan before February 1, 1989.

Question 10: When is an arrangement considered to be two or more separate group health plans rather than a single group health plan?

Answer 10: (a) The rules below in paragraphs (b) through (g) of this Q&A-10 determine when an arrangement is considered to be two or more separate group health plans. If more than one of those paragraphs applies to a particular arrangement, the paragraphs are applied in succession to break the arrangement into the smallest possible group health plans. For example, if an arrangement offers high option and low option benefit schedules (see paragraph (c)) and constitutes a multiple employer welfare arrangement maintained by three different employers (see paragraph (d)), the arrangement consists of six separate group health plans: Three high-option plans (one for each employer) and three low-option plans (one for each employer).

(b) The rules in this Q&A-10 apply without regard to whether the arrangement is maintained by one or more than one employer. Moveover, the fact that a particular arrangement has been traditionally referred to as a single plan or has reported as a single plan (e.g., by filing a single Form 5500) is not controlling in the determination of whether the arrangement will be considered as two or more separate plans for purposes of section 162(k). All references elsewhere in this section to a "group health plan" are references to a separate group health plan as determined under this Q&A-10. The identification of separate group health plans is relevant to determinations such as those involving which coverage must be separately electable, the effective

date of section 162(k), which employers will be denied deductions in the event of a failure to comply with section 162(k), the cost of continuation coverage, and the availability of the exception for small-employer plans (see Q&A-9 of this section). The relevance of treating an arrangement as two or more separate group health plans is illustrated by the following examples:

Example 1: If an employee is covered under more than one group health plan at the time of a qualifying event, the qualified beneficiaries must be offered an opportunity to elect COBRA continuation coverage with respect to each of the plans. In contrast, if the arrangement in which the employee participates is treated as a single group health plan with several features, no individual features of the plan would have to be made available to a qualified beneficiary unless the qualified beneficiary elects coverage under the entire plan. (But see Q&A-24 of this section regarding the election to receive only core coverage.)

Example 2: If an arrangement that involves many employers is considered to be a single group health plan, that plan will fail to qualify for the small-employer plan exception if any one of those employers had too many employees during the preceding calendar year. However, if the arrangement is considered to be a separate plan with respect to each employer, then the exception would be available for each of those particular employers that normally employed fewer than 20 employees during the preceding calendar year.

Example 3: An arrangement covering the employees of unrelated employers A and B fails to comply with section 162(k) by failing to offer COBRA continuation coverage to an employee of employer A, but complies with section 162(k) in all other respects. If the arrangement consists of two separate group health plans, one covering the employees of A and one covering the employees of B, employer A will lose deductions under section 162(i) and A's highly compensated employees will lose the benefit of the section 106(a) exclusion, but employer B and its employees will be unaffected. In contrast, if the arrangement consists of a single group health plan, the consquences of failing to comply with section 162(k) will apply to both employers A and B.

(c) Each different benefit package or option offered under an arrangement is treated as a separate group health plan. For this purpose, self-only coverage and self-and-family coverage are not considered to be separate packages or options. The rule of this paragraph (c) is illustrated by the following examples:

Example 1: If an arrangement offers "high option" and "low option" benefit schedules and the alternatives of self-only and self-and-family coverage, the arrangement is considered to be two separate plans: One offering high option coverage (whether self-only or self-and-family), and one offering low option coverage (whether self-only or self-and-family).

Example 2: If two types of coverage differ only because one has a $100 deductible and the other has a $250 deductible, or because one has a $1500 catastrophic limit and the other has a $2500 catastrophic limit, each type of coverage is a different benefit package and so is treated as a separate group health plan.

Example 3: An arrangement has a deductible equal to 1 percent of compensation, but consists of a single plan in all other respects. The fact that employees with different levels of compensation will have different deductibles will not cause the arrangement to be treated as separate group health plans for each resulting deductible.

Example 4: If an arrangement consists of a single plan in all respects except that an employee can choose to have either hospital benefits or hospital benefits combined with mental health benefits, there are two separate plans: One providing hospital coverage, and one providing hospital-and-mental-health coverage. If an employee could instead choose independently whether to have hospital benefits and whether to have mental-health benefits, there would also be two separate plans: One providing hospital-only coverage and one providing mental-health-only coverage. In such a case an employee receiving both hospital and mental-health benefits would be covered under two separate group health plans and would have separate COBRA election rights under each plan.

(d) An arrangement that constitutes a multiple employer welfare arrangement as defined in section 3(40) of the Employee Retirement Income Security Act of 1974 (ERISA), is considered a separate group health plan with respect to each employer maintaining the arrangement. Solely for purposes of this paragraph (d), the rules of section 3(40)(B) of ERISA (regarding trades or businesses under common control) shall apply in determining whether two or more employers are treated as a single employer.

(e) In the case of an insured arrangement, if two or more groups of employees are covered under separate contracts between a participating employer or employers and an insurer or insurers, each separate contract is considered a separate group health plan, even if the coverage under the separate contracts is identical.

(f) In the case of a self-funded arrangement, each segregated portion of the arrangement shall be considered a separate group health plan. A portion of an arrangement is a segregated portion if and only if (1) assets available to pay benefits under that portion are unavailable to pay benefits under any other portion, and (2) assets available to pay benefits under any other portion are unavailable to pay benefits out of that portion. For example, if several employers contribute to a trust that provides medical benefits but each employee's benefits are payable only out of contributions (and earnings on contributions) made by that employee's employer, each employer's portion of the arrangement is considered a separate group health plan. The rule of this paragraph (f) shall apply whether or not a trust is used, and whether or not the arrangement is partially insured through stop-loss insurance, insurance for some but not all benefits, or some other method.

(g) Arrangements providing medical benefits are broken down as described in Q&A-12 of this section into their collectively bargained portion (if any) and non-collectively-bargained portion (if any), each of which is considered a separate group health plan.

Question 11: When must group health plans comply with section 162(k)?

Answer 11: (a) *Non-collectively bargained plans:* For plans that are not excepted from COBRA (see Q&A-8 of this section) and that do not constitute collectively bargained group health plans (see Q&A-12 of this section), the requirements of section 162(k) apply as of the first day of the first plan year beginning on or after July 1, 1986. For example, if such a plan has a February 1 to January 31 plan year, it must begin to comply with section 162(k) by February 1, 1987.

(b) *Collectively bargained plans:* For plans that are not excepted from COBRA and that constitute collectively bargained group health plans (see Q&A-12 of this section), the requirements of section 162(k) apply as of the first day of the first plan year beginning on or after the later of (1) January 1, 1987, or (2) the date on which the last of the collective bargaining agreements relating to the plan terminates (determined without regard to any extension thereof agreed to after April 7, 1986). This rule is illustrated by the following example:

Example: Assume that the plan year of a collectively bargained group health plan is the calendar year and that, as of April 7, 1986, the plan is maintained pursuant to three collective bargaining agreements having expiration dates in October 1987, February 1988, and July 1988. The plan must comply with section 162(k) beginning on January 1, 1989. Of course, the plan must begin to comply by January 1, 1987, with respect to a collective bargaining unit that was not, as of April 7, 1986, covered by one of those three agreements.

Question 12: What is a collectively bargained group health plan?

Answer 12: (a) A collectively bargained group health plan is a group health plan covering only employees

and former employees (and their families) who are covered by an agreement that is a collective bargaining agreement entered into between employee representatives and one or more employers (as determined under section 7701(a)(46)). Thus, if an arrangement that would otherwise be considered to be a single group health plan under the standards set out in Q&A–10 of this section covers both (1) employees and former employees (and their families) who are covered by a collective bargaining agreement described in the preceding sentence and (2) employees and former employees (and their families) who are not covered by such an agreement, the arrangement consists of two separate group health plans: one plan that is a collectively bargained group health plan and one that is not. The plan that is collectively bargained will have an effective date determined under paragraph (b) of Q&A–11 of this section, and the other plan will have an effective date determined under paragraph (a) of Q&A–11 of this section. For example, if the plan year is the calendar year and the only collective bargaining agreement in effect as of April 7, 1986, expires March 31, 1988, the effective date of section 162(k) is January 1, 1989, for the plan covering bargaining-unit employees and their families, and January 1, 1987, for the plan covering the other employees and their families.

(b) For purposes of this Q&A–12, employees of an employee representative that is a party to a collective bargaining agreement described in paragraph (a) of this Q&A–12, and employees of a trust or fund maintained to pay benefits to individuals covered by the collective bargaining agreement, are considered to be employees covered by that collective bargaining agreement. Thus, a plan that is otherwise considered a single, collectively bargained plan will not fail to be a single, collectively bargained plan merely because it also covers employees or former employees (and their families) of the employee representative or of a trust or fund from which the benefits are paid.

Question 13: What is the plan year of a group health plan?

Answer 13: (a) For purposes of determining when a group health plan must begin to comply with section 162(k) (see Q&A–11 of this section), the plan year of a group health plan is the year that is designated as the plan year in the plan document. However, if the plan document does not designate a plan year, or if there is no plan document, the plan year is determined under paragraph (b) of this Q&A–13. The designation of a plan year on a Form 5500 filed by a group health plan is not controlling in the determination of the plan year under this Q&A–13.

(b) If the plan year of a group health plan is determined under this paragraph (b), the plan year is the plan's limit/deductible year except that (1) in the case of an insured group health plan, the plan year is the policy year if that is later than the limit/deductible year or if the plan has no limit/deductible year, and (2) in the case of a self-funded group health plan having no limit/deductible year, the plan year is the later of the calendar year or the employer's taxable year. For purposes of this paragraph (b), a plan's "limit/deductible year" means the year that is used by the plan in applying benefit limits and deductibles, except that if different years are used for benefit limits and for deductibles, it means the later of those years. For purposes of this paragraph (b), one year is "later" than another if it begins later in relation to the underlying date from which the effective date of section 162(k) is determined for the plan under Q&A–11 of this section. Compare, for example, a year that begins on March 1 with a year that begins on December 1. The March 1 year is later than a December 1 year in the case of a non-collectively-bargained plan, because the first March 1 occurring on or after July 1, 1986, is March 1, 1987, which is later than December 1, 1986 (the first December 1 occurring on or after July 1, 1986). If, however, the plan is a collectively-bargained plan and becomes subject to section 162(k) for the first plan year beginning on or after February 1, 1987, a December 1 year is later than a March 1 year.

Question 14: How do the COBRA continuation coverage requirements apply to cafeteria plans and other flexible benefit arrangements?

Answer 14: The provision of medical care through a cafeteria plan (as defined in section 125) or other flexible benefit arrangement constitutes a group health plan. However, the COBRA continuation coverage requirements of section 162(k) apply only to those medical benefits under the cafeteria plan or other arrangement that a covered employee has actually chosen to receive (if any). The application of this rule to a cafeteria plan is illustrated by the following examples:

Example 1: Under the terms of a cafeteria plan, employees can choose among life insurance coverage, membership in a Health Maintenance Organization (HMO), coverage for medical expenses under an indemnity arrangement, and cash compensation. Of these available choices, the HMO and the indemnity arrangement constitute separate group health plans. Assume that these group health plans are subject to COBRA (see Q&A–8 of this section) and that the employer does not provide any group health plan outside of the cafeteria plan. Assume further that B and C are unmarried employees, that B has chosen the life insurance coverage, and that C has chosen the indemnity arrangement. B does not have to be offered COBRA continuation coverage upon terminating employment, nor must a subsequent open enrollment period for active employees be made available to B. However, if C terminates employment and the termination constitutes a qualifying event, C must be offered an opportunity to elect COBRA continuation coverage under the indemnity arrangement. If C makes such an election and an open enrollment period for active employees occurs while C is still receiving the COBRA continuation coverage, C must be offered the opportunity to switch from the indemnity arrangement to the HMO (but not to the life insurance coverage because that does not constitute a group health plan).

Example 2: An employer maintains a group health plan under which all employees receive employer-paid coverage. Employees can arrange to cover their families by paying an additional amount. The employer also maintains a cafeteria plan, under which one of the options is to pay part or all of the charge for family coverage under the group health plan. Thus, an employee might pay for family coverage under the group health plan partly with before-tax dollars and partly with after-tax dollars. If an employee's family is receiving coverage under the group health plan when a qualifying event occurs, each of the qualified beneficiaries must be offered an opportunity to elect COBRA continuation coverage, regardless of how that qualified beneficiary's coverage was paid for before the qualifying event.

Example 3: One of the choices available under a cafeteria plan is an individual medical expense reimbursement arrangement. At the beginning of each calendar year, an employee can choose, instead of being paid a specified dollar amount of compensation, to have that amount placed in an account to be used for reimbursement of medical expenses incurred during the year by the employee or the employee's spouse or dependent children. Any amount remaining in the account as of the end of the year is forfeited. The reimbursement of medical expenses through these arrangements constitutes a group health plan.

Qualified Beneficiaries

Question–15: Who is a qualified beneficiary?

Answer–15: (a) Except as set forth in paragraphs (b) through (d) of this Q&A–15, a qualified beneficiary is any individual who, on the day before a qualifying event, is covered under a group health plan maintained by the employer of a covered employee by virtue of being on that day either (1) the

covered employee, (2) the spouse of the covered employee, or (3) the dependent child of the covered employee.

(b) An individual is not a qualified beneficiary if, on the day before the qualifying event referred to in paragraph (a) of this Q&A–15, the individual (1) is covered under the group health plan by reason of another individual's election of COBRA continuation coverage and is not already a qualified beneficiary by reason of a prior qualifying event, or (2) is entitled to Medicare benefits under Title XVIII of the Social Security Act.

(c) A covered employee can be a qualified beneficiary only in connection with a qualifying event that consists of the termination (other than by reason of the covered employee's gross misconduct), or reduction of hours, of the covered employee's employment.

(d) An individual is not a qualified beneficiary if the individual's status as a covered employee is attributable to a period in which the individual was a nonresident alien who received no earned income (within the meaning of section 911(d)(2)) from the individual's employer that constituted income from sources within the United States (within the meaning of section 861(a)(3)). If, pursuant to the preceding sentence, an individual is not a qualified beneficiary, then a spouse or dependent child of the individual shall not be considered a qualified beneficiary by virtue of the relationship to the individual.

Question–16: Who is a covered employee?

Answer–16: (a) A covered employee is any individual who is (or was) provided coverage under a group health plan (other than a plan that is excepted from COBRA on the date of the qualifying event; see Q&A–8 of this section) by virtue of the individual's employment or previous employment with an employer. For example, a retiree or former employee who is covered by such a group health plan is a covered employee if the coverage results in whole or in part from his or her previous employment. An individual (whether a present or former employee) who is merely eligible for coverage under a group health plan is not a covered employee if the individual is not and has not been actually covered under the plan. The reason for an individual's lack of actual coverage (such as the individual's having declined participation in the plan or failed to satisfy the plan's conditions for participation) is not relevant for this purpose.

(b) The following individuals are also covered employees, but only if they are (or were) actually covered under a group health plan by virtue of their relationship to an employer maintaining the plan, and only if that plan or some other group health plan maintained by the employer covers one or more common-law employees of the employer: (1) Employees within the meaning of section 401(c)(1), (2) agents and independent contractors (and their employees, agents, and independent contractors), and (3) directors (in the case of a corporation). The rule of this paragraph (b) is illustrated by the following example:

Example: A law firm maintains a group health plan for its common-law employees. If the firm also provides group health coverage for its partners, the partners are covered employees regardless of whether their coverage is provided under the same group health plan as the common-law employees or under a separate plan. In contrast, if the partners are the only individuals who receive any health coverage, they are not covered employees.

Question 17: Other than those individuals who are qualified beneficiaries as of the day before a qualifying event, can any other person (such as a newborn or adopted child or a new spouse) obtain qualified beneficiary status for COBRA continuation coverage purposes?

Answer 17: (a) No. The group of qualified beneficiaries entitled to elect COBRA continuation coverage as a result of a qualifying event is closed as of the day before the qualifying event. Thus, newborn children, adopted children, and spouses who join the family of a qualified beneficiary after that day do not become qualified beneficiaries. The new family members do not themselves become qualified beneficiaries even if they become covered under the plan. (For situations in which a plan is required to make coverage available to new family members of a qualified beneficiary who is receiving COBRA continuation coverage, see Q&A–31 of this section and paragraph (c) of Q&A–30 of this section.)

(b) A qualified beneficiary who fails to elect COBRA continuation coverage in connection with a qualifying event ceases to be a qualified beneficiary at the end of the election period (see Q&A–32 of this section). Thus, for example, if such a former qualified beneficiary is later added to a covered employee's coverage (e.g., during an open enrollment period) and then another qualifying event occurs with respect to the covered employee, the former qualified beneficiary will not be treated as a qualified beneficiary

(c) The rules of this Q&A–17 are illustrated by the following examples:

Example 1: Assume that A is a single employee who voluntarily terminates employment and properly elects COBRA continuation coverage under a group health plan. Under the terms of the plan, a covered employee who marries can choose to have his or her spouse covered under the plan as of the date of marriage. One month after electing COBRA continuation coverage, A marries and chooses, to cover A's spouse under the plan. A's spouse is not a qualified beneficiary. Thus, if A dies during the period of COBRA continuation coverage, the plan does not have to offer A's surviving spouse an opportunity to elect COBRA continuation coverage.

Example 2: Assume that B is a married employee who terminates employment. B properly elects COBRA continuation coverage for B but not B's spouse, and B's spouse declines to elect such coverage. B's spouse thus ceases to be a qualified beneficiary. Later, at the next open enrollment period, B adds the spouse as a beneficiary under the plan. The addition of the spouse during the open enrollment period does not make the spouse a qualified beneficiary. The plan will thus not have to offer the spouse an opportunity to elect COBRA continuation coverage upon a later divorce from or death of B.

Example 3: Assume that, under the terms of a group health plan, a covered employee's child ceases to be a dependent eligible for coverage upon attaining age 18. At that time, the child must be offered an opportunity to elect COBRA continuation coverage. If the child elects COBRA continuation coverage, the child marries during the period of the COBRA continuation coverage, and the child's spouse becomes covered under the group health plan, the child's spouse would not become a qualified beneficiary upon a later qualifying event as a result of that coverage.

Example 4: Assume that C is a single employee who, upon retirement, is given the opportunity to elect COBRA continuation coverage but declines it in favor of an alternative offer of 12 months of employer-paid retiree health benefits. C ceases to be a qualified beneficiary and will not have to be given another opportunity to elect COBRA continuation coverage at the end of those 12 months. Assume further that C marries D during the period of retiree health coverage and, under the terms of that coverage, D becomes covered under the plan. If a divorce from or death of C will result in D's losing coverage, D will be a qualified beneficiary because D's coverage under the plan on the day before the qualifying event (i.e., the divorce) will have been by reason of C's acceptance of 12 months of employer-paid coverage after the prior qualifying event (C's retirement) rather than by reason of an election of COBRA continuation coverage.

Example 5: Assume the same facts as in Example 4 except that, under the terms of the plan, the divorce or death does not cause D to lose coverage so that D continues to be covered for the balance of the original 12-month period. D does not have to be allowed to elect COBRA continuation coverage because the divorce of death does not

constitute a qualifying event. See Q&A–18 of this section.

Qualifying Events

Question 18: What is a qualifying event?

Answer 18: (a) A qualifying event is an event that satisfies paragraphs (b), (c), and (d) of this Q&A–18.

(b) An event satisfies this paragraph (b) if the event is either (1) the death of a covered employee, (2) the termination (other than by reason of the employee's gross misconduct), or reduction of hours, of a covered employee's employment, (3) the divorce or legal separation of a covered employee from the employee's spouse, (4) a covered employee becoming entitled to Medicare benefits under Title XVIII of the Social Security Act, or (5) a dependent child ceasing to be a dependent child of the covered employee under the generally applicable requirements of the plan. In the case of a covered employee who is not a commonlaw employee, termination of "employment" for this purpose means termination of the relationship (e.g., directorship of a corporation or membership in a partnership) giving rise to the individual's treatment as a covered employee under paragraph (b) of Q&A–16 of this section.

(c) An event satisfies this paragraph (c) if, under the terms of the group health plan, the event causes the covered employee, or the spouse or a dependent child of the covered employee, to lose coverage under the plan. For this purpose, to "lose coverage" means to cease to be covered under the same terms and conditions as in effect immediately before the qualifying event. If coverage is reduced or eliminated in anticipation of an event, the reduction or elimination is disregarded in determining whether the event causes a loss of coverage. Moreover, for purposes of this paragraph (c), a loss of coverage need not occur immediately after the event, so long as the loss of coverage will occur before the end of the maximum coverage period (see Q&A–39 and Q&A–40 of this section). However, if neither the covered employee nor the spouse or a dependent child of the covered employee will lose coverage before the end of what would be the maximum coverage period, the event does not satisfy this paragraph (c).

(d) An event satisfies this paragraph (d) if it occurs while the plan is subject to COBRA. Thus, an event will not satisfy this paragraph (d) if it occurs before the plan becomes subject to section 162(k) (see Q&A–11 of this section) or while the plan is excepted from COBRA (see Q&A–8). See Q&A–20 and Q&A–21 of this section.

(e) The rules of this Q&A–18 are illustrated by the following examples, each of which assumes that paragraph (d) is satisfied:

Example 1: If an employee who is covered by a group health plan terminates employment (other than by reason of the employee's gross misconduct) and, as of the date of separation, is given 3 months of employer-paid coverage under the same terms and conditions as before that date, the termination is a qualifying event because it satisfies both paragraphs (b) and (c) of this Q&A–18.

Example 2: Upon the retirement of an employee who, along with the employee's spouse, has been covered under a group health plan, the employee is given identical coverage for life but the spousal coverage will not be continued beyond 6 months unless premiums are then paid by the employee or spouse. The spouse will "lose coverage" 6 months after the employee's retirement when the premium requirement takes effect, so the retirement is a qualifying event and the spouse must be given an opportunity to elect COBRA continuation coverage.

Example 3: F is a covered employee who is married to G, and both are covered under a group health plan maintained by F's employer. F and G are divorced and, under the terms of the plan, the divorce will cause G to lose coverage. The divorce is a qualifying event. If G elects COBRA continuation coverage and then remarries during the period of COBRA continuation coverage, G's new spouse might become covered under the plan. (See Q&A–31 of this section and paragraph (c) of Q&A–30 of this section.) However, G's later death or divorce from G's new spouse will not be a qualifying event because G is not a covered employee.

Question 19: Can a qualifying event result from a voluntary termination of employment?

Answer 19: Yes. Apart from gross misconduct, the facts surrounding a termination or reduction of hours are irrelevant. It does not matter whether the employee voluntarily terminated or was discharged. For example, a strike or walkout is a termination or reduction of hours that constitutes a qualifying event if the strike or walkout results in a loss of coverage as described in paragraph (c) of Q&A–18 of this section. Similarly, a layoff that results in such a loss of coverage is a qualifying event.

Question 20: Can a qualifying event occur before the effective date of section 162(k) (as described in Q&A–11 of this section)?

Answer 20: No. An event that occurs before section 162(k) becomes effective for a group health plan does not satisfy paragraph (d) of the definition of qualifying event in Q&A–18 of this section. A group health plan does not have to offer individuals whose coverage ends as a result of such an event the opportunity to elect COBRA continuation coverage. For example, if an employee terminated employment on July 15, 1986, and the plan covering the employee had a November 1 to October 31 plan year (so that the plan became subject to section 162(k) on November 1, 1986), the plan does not have to permit the employee to elect COBRA continuation coverage. Even if that employee is given 6 months of additional coverage from the July 15, 1986, termination date (whether merely as a result of the terms of the plan, or pursuant to state or local law or otherwise) so that the coverage extends beyond the November 1 effective date, the employee does not have to be given the opportunity to elect COBRA continuation coverage at the end of the 6 months' coverage because there will be no qualifying event at that time. In contrast, if the employee's spouse is covered by the 6 months' coverage and, as a result of the employee's death after the November 1 effective date and before the end of the 6–month period, the spouse will lose coverage for the balance of the 6–month period, the death will constitute a qualifying event and the spouse will be a qualified beneficiary entitled to elect COBRA continuation coverage. See Q&A–42 of this section regarding the maximum coverage period in such a case.

Question 21: Can a qualifying event occur while a group health plan is excepted from COBRA (see Q&A–8 of this section)?

Answer 21: No. An event that occurs while a group health plan is excepted from COBRA does not satisfy paragraph (d) of the definition of qualifying event in Q&A/18 of this section. Even if the plan later becomes subject to COBRA, it does not have to provide COBRA election rights to anyone whose coverage ends as a result of such an event. For example, if a group health plan is excepted from COBRA as a small-employer plan during 1988 (see Q&A–9 of this section) and an employee terminates employment on December 31, 1988, the termination is not a qualifying event and the plan does not have to permit the employee to elect COBRA continuation coverage. This is the case even if the plan ceases to be a small-employer plan as of January 1, 1989. Also, the same result will follow even if the employee is given 3 months of coverage beyond December 31 (i.e., through March of 1989), because there will be no qualifying event as of the termination of coverage in March. However, if the employee's spouse is initially provided with the 3-month coverage through March 1989, but the spouse divorces the employee before the end of the 3 months and loses coverage

as a result of the divorce, the divorce will constitute a qualifying event during 1989 and so entitle the spouse to elect COBRA continuation coverage. See Q&A–42 of this section regarding the maximum coverage period in such a case.

COBRA Continuation Coverage

Question 22: What is COBRA continuation coverage?

Answer 22: If a qualifying event occurs, each qualified beneficiary (other than a qualified beneficiary for whom the qualifying event will not result in any immediate or deferred loss of coverage) must be offered an opportunity to elect to continue to receive the group health plan coverage that he or she received immediately before the qualifying event. This continued coverage is "COBRA continuation coverage." Except as set forth in Q&A–23 through Q&A–31 of this section, if the continuation coverage offered differs in any way from the coverage enjoyed immediately before the qualifying event, the coverage offered does not constitute COBRA continuation coverage and the group health plan is not in compliance with section 162(k) unless other coverage that does constitute COBRA continuation coverage is also offered. Any elimination or reduction of coverage in anticipation of a qualifying event is disregarded for purposes of this Q&A–22 and for purposes of any other reference in this section to coverage in effect immediately before (or on the day before) a qualifying event. COBRA continuation coverage must not be conditioned upon, or discriminate on the basis of lack of, evidence of insurability.

Question 23: How is COBRA continuation coverage affected by changes in the coverage that is provided to similarly situated beneficiaries with respect to whom a qualifying event has not occurred?

Answer 23: COBRA continuation coverage must generally be the same as the group health plan coverage enjoyed by the qualified beneficiary immediately before the qualifying event. However, if the coverage provided to similarly situated active employees is changed or eliminated but the employer continues to maintain one or more group health plans (so that the qualified beneficiary's COBRA continuation coverage cannot be terminated at that time—see Q&A–37 of this section), the employer must permit the qualified beneficiary receiving COBRA continuation coverage to elect to be covered under any of the remaining group health plans maintained by the employer or similarly situated active employees. If the coverage of the qualified beneficiary was subject to deductibles and the change in coverage occurs before the end of the prescribed period for accumulating such deductibles, the new coverage selected by the qualified beneficiary must credit him or her with the amounts incurred under the original coverage. The rule in the preceding sentence also applies to those limits that are in the nature of deductibles, such as copayment limits or catastrophic limits on a covered individual's out-of-pocket expenses. The qualified beneficiary can be charged the amount determined under Q&A–44 of this section for the coverage selected.

Question 24: Can a group health plan require a qualified beneficiary who wishes to receive COBRA continuation coverage to elect to receive a continuation of all of the coverage that he or she was receiving under the plan immediately before the qualifying event?

Answer 24: (a) In general, no. A qualified beneficiary who, immediately before the qualifying event, is covered by a plan that provides both core coverage and non-core coverage must be able to elect to receive either (1) the coverage that he or she had immediately before the qualifying event (including the core coverage and any non-core coverage), or (2) the core coverage only. However, there are two exceptions to this rule, as set forth in paragraphs (b) and (c) of this Q&A–24.

(b) If the applicable premium for core coverage would be at least 95 percent of the applicable premium for core coverage and non-core coverage combined, the plan does not have to offer qualified beneficiaries the opportunity to elect core coverage only. (See Q&A–44 of this section regarding the applicable premium.)

(c) If an employer maintaining a group health plan that includes non-core coverage also maintains at least one other group health plan for similarly situated active employees that does not provide any non-core coverage, the plan that includes non-core coverage does not have to offer a qualified beneficiary an opportunity to elect core coverage only. However, the qualified beneficiary must instead be offered the opportunity to elect coverage under any other group health plan maintained by the employer for similarly situated active employees.

Question 25: What is core coverage?

Answer 25: (a) "Core coverage" means all of the coverage that a qualified beneficiary was receiving under the group health plan immediately before a qualifying event that gives rise to the qualified beneficiary's COBRA election rights, other than "non-core coverage." "Non-core coverage" means coverage for vision benefits and dental benefits. However, coverage for vision benefits or dental benefits that must be provided under applicable law is core coverage.

(b) For purposes of this Q&A–25, vision benefits include only those benefits related to vision care of a type that is not required under local law to be performed by a physician.

(c) For purposes of this Q&A–25, dental benefits does not include any benefits for dental care or oral surgery in connection with an accidental injury.

(d) The definitions in this Q&A–25 apply only for purposes of this § 1.162–26 and sections 106, 162(i)(2), and 162(k) of the Code.

Question 26: Must a qualified beneficiary be given an opportunity to elect core coverage plus only one of two non-core coverages that the qualified beneficiary had under the plan immediately before the qualifying event?

Answer 26: No. A group health plan is required only to offer qualified beneficiaries the right to elect (a) core coverage, or (b) core coverage plus all non-core coverages that the qualified beneficiary had immediately before the qualifying event. Thus, a qualified beneficiary who has core coverage plus vision and dental coverage upon the occurrence of a qualifying event must be offered the opportunity to continue either the core coverage or the core coverage and both dental and vision coverage. Such a qualified beneficiary would not have to be offered the opportunity to elect core coverage plus vision coverage only or core coverage plus dental coverage only. Of course, if the vision and dental coverage are provided under two separate plans that are independent of the core plan, a qualified beneficiary would be able to continue one or both of the coverages. Assume, for example, that an employer maintains three group health plans—a core plan, a vision plan, and a dental plan—and that each active employee can elect to be covered under one or more of the three plans. (Thus, an employee could have vision-only, dental-only, or core-only coverage, or any combination of the three.) A qualified beneficiary who is covered under all three plans at the time of a qualifying event would have separate election rights with respect to each plan, and so would be able to elect coverage under the dental-only and core-only plans.

Question 27: Must a qualified beneficiary who is covered under a single plan providing both core coverage and non-core coverage be offered the opportunity to elect non-core coverage only?

Answer 27: No. A qualified beneficiary who is covered by a single plan providing both core coverage and non-core coverage need not be offered the opportunity to elect only non-core coverage. Of course, if immediately before the qualifying event the qualified beneficiary is covered by a group health plan that provides non-core coverage but no core coverage, the qualified beneficiary must be offered the opportunity to continue that non-core coverage. Moreover, such an individual generally would not have to be given the opportunity to elect core coverage. (But see Q&A–30 of this section regarding open enrollment periods.)

Question 28: What deductibles apply if COBRA continuation coverage is elected?

Answer 28: (a) Qualified beneficiaries electing COBRA continuation coverage are generally subject to the same deductibles as similarly situated employees for whom a qualifying event has not occurred. If a qualified beneficiary's COBRA continuation coverage begins before the end of the prescribed period for accumulating amounts toward deductibles, the qualified beneficiary must retain credit for expenses incurred toward those deductibles before the beginning of COBRA continuation coverage as though the qualifying event had not occurred. The specific application of this rule depends on the type of deductible, as set forth in paragraphs (b) through (d) of this Q&A–28. Special rules are set forth in paragraphs (e) and (f), and examples appear in paragraph (g).

(b) If a deductible is computed separately for each individual receiving coverage under the plan, each individual's remaining deductible amount (if any) on the date that COBRA continuation coverage begins is equal to that individual's remaining deductible amount immediately before that date.

(c) If a deductible is computed on a family basis, the deductible for each new family unit after the beginning of COBRA continuation coverage (or the existing family unit, in the case of a qualifying event that does not result in there being more than one family unit) is computed as follows: On the date that COBRA continuation coverage begins, the remaining deductible amount for each new family unit (or the remaining number of individual deductibles, in the case of a family deductible that is satisfied by completing a specified number of individual deductibles) is equal to the preexisting family unit's remaining deductible amount (or remaining number of individual deductibles, as applicable) immediately before that date. This rule applies regardless of whether the plan provides that the family deductible is an alternative to individual deductibles or an additional requirement.

(d) Deductibles that are not described in paragraphs (b) or (c) of this Q&A–28 must be treated in a manner consistent with the principles set forth in those paragraphs.

(e) If a deductible is computed on the basis of a covered employee's compensation instead of being a fixed dollar amount, the plan can treat the employee's compensation as frozen for the duration of the COBRA continuation coverage at the level that was used to compute the deductible in effect immediately before the COBRA continuation coverage began.

(f) If a single deductible is prescribed for core coverage and non-core coverage and a qualified beneficiary electing COBRA continuation coverage elects to receive core coverage only, the treatment of expenses for non-core coverage depends on when the expenses were incurred, as follows: If the expenses were incurred before the beginning of COBRA continuation coverage, they must continue to be counted toward satisfaction of the deductible, but they need not be counted if they were incurred after the begining of COBRA continuation coverage.

(g) The rules of the Q&A–28 are illustrated by the following examples; in each example it is assumed that deductibles are determined on a calendar year basis:

Example 1: A group health plan applies a separate $100 annual deductible to each individual whom it covers. The plan provides that the spouse and dependent children of a covered employee will lose coverage on the last day of the month after the month of the covered employee's death. A covered employee dies on June 11, 1988. The spouse and the two dependent children elect COBRA continuation coverage, which will begin on August 1, 1988. As of July 31, 1988, the spouse has incurred $80 of covered expenses, the older child has incurred no covered expenses, and the younger one has incurred $120 (i.e., already satisfied the deductible). At the beginning of COBRA continuation coverage on August 1, the spouse has a remaining deductible of $20, the older child still has the full $100 deductible, and the younger one has no further deductible.

Example 2: A group health plan applies a separate $200 annual deductible to each individual whom it covers, except that each family member will be treated as having satisfied the individual deductible once the family has incurred $500 of covered expenses during the year. The plan provides that upon the divorce of a covered employee, coverage will end immediately for the employee's spouse and any children who do not remain in the employee's custody. Assume that a covered employee with four dependent children is divorced, that the spouse obtains custody of the two oldest children, and that the spouse and those children all elect COBRA continuation coverage to begin immediately. Assume also that the family had accumulated $420 of covered expenses before the divorce, as follows: $70 by each parent, $200 by the oldest child, $80 by the youngest child, and none by the other two children. Each new family unit after the divorce (i.e., the employee plus two children, still receiving regular coverage under the plan, and the spouse plus two children, receiving COBRA continuation coverage) has a remaining family deductible amount of $80 ($500 minus $420).

Example 3: The facts are the same as in Example 2, except that the family deductible is defined as two individual $200 deductibles instead of a $500 aggregate (i.e., the plan disregards all remaining individual deductibles after the satisfaction of any two individual deductibles). Before the divorce, the family has satisfied one individual deductible (the oldest child's). At the beginning of COBRA continuation coverage, therefore, each new family unit is treated as having already satisfied one individual deductible even though the oldest child is included in only one of the new family units.

Example 4: Each year a group health plan pays 70 percent of the cost of an individual's psychotherapy after that individual's first three visits. A qualified beneficiary who elects COBRA continuation coverage beginning August 1, 1988, and has already made two visits as of that date need only pay for one more visit before the plan must begin to pay 70 percent of the cost of the remaining visits during 1988.

Example 5: A group health plan has a $250 annual deductible per covered individual. The plan provides that if the deductible is not satisfied in a particular year, expenses incurred during October through December of that year are credited toward satisfaction of the deductible in the next year. A qualified beneficiary who has incurred covered expenses of $150 from January through September of 1988 and $40 during October elects COBRA continuation coverage begining November 1, 1988. The remaining deductible amount for this qualified beneficiary is $60 at the beginning of the COBRA continuation coverage. If this individual incurs covered expenses of $50 in November and December of 1988 combined (so that the $250 deductible for 1988 is not satisfied), the $90 incurred from October through December of 1988 are credited toward satisfaction of the deductible amount for 1989.

Question 29: How do a plan's limits apply to COBRA continuation coverage?

Answer 29: (a) Limits are treated in the same way as deductibles (see Q&A–28 of this section). This rule applies both to limits on plan benefits (e.g., a maximum number of hospital days or dollar amount of reimbursable expenses) and limits that are in the nature of deductibles (e.g., a copayment limit, or a catastrophic limit on a covered employee's out-of-pocket

expenses). This rule applies equally to annual and lifetime limits.

(b) The rule of this Q&A–29 is illustrated by the following examples; in each example it is assumed that limits are determined on a calendar year basis:

Example 1: A group health plan pays for a maximum of 150 days of hospital confinement per individual per year. A covered employee who has had 20 days of hospital confinement as of May 1, 1989, terminates employment and elects COBRA continuation coverage as of that date. During the remainder of 1989 the plan need only pay for a maximum of 130 days of hospital confinement for this individual.

Example 2: A group health plan reimburses a maximum of $20,000 of covered expenses per family per year, and the same $20,000 limit applies to unmarried covered employees. A covered employee and spouse who have no children divorce on May 1, 1989, and the spouse elects COBRA continuation coverage as of that date. If the employee and spouse together incurred $15,000 of reimbursable expenses during January through April of 1989, each of these individuals has a $5,000 maximum benefit for the remainder of 1989, regardless who incurred what portion of the $15,000.

Example 3: A group health plan pays for 80 percent of covered expenses after satisfaction of a $100-per-individual deductible, and 100 percent of them after a family has incurred out-of-pocket costs of $2,000. An employee and spouse with three dependent children divorce on June 1, 1989, and one of the children remains with the employee. The spouse elects COBRA continuation coverage as of that date for the spouse and the other two children. During January through May of 1989, all five individual deductibles were satisfied and the family incurred $4,000 of covered expenses, resulting in out-of-pocket expenses totalling $1,200 (five $100 deductibles, plus the non-reimbursed 20 percent of the other $3,500, or $700). For the remainder of 1989, each new family unit has an out-of-pocket limit of $800.

Question 30: Can a qualified beneficiary who elects COBRA continuation coverage ever change from the coverage received by that individual immediately before the qualifying event?

Answer 30: (a) In general, a qualified beneficiary need only be given an opportunity to continue the coverage that he or she was receiving immediately before the qualifying event. This is true regardless of whether the coverage received by the qualified beneficiary before the qualifying event ceases to be of value to the qualified beneficiary, such as in the case of a qualified beneficiary covered under a region-specific Health Maintenance Organization (HMO) who leaves the HMO's service region. The only situations in which a qualified beneficiary must be allowed to change from the coverage received immediately before the qualifying event are as set forth in paragraphs (b) and (c) of this Q&A–30, in Q&A–24 of this section (regarding core coverage), and in Q&A–23 of this section (regarding changes to or elimination of the coverage provided to similarly situated active employees).

(b) If a qualified beneficiary participates in a region-specific plan (such as an HMO or an on-site clinic) that will not service his or her health needs in the area to which he or she is relocating (regardless of the reason for the relocation) and the employer has employees in the area to which the qualified beneficiary relocates, the qualified beneficiary must be given an opportunity to elect alternative coverage if (and on the same basis as) a similarly situated active employee who transfers to that new location while continuing to work for the employer would be given the opportunity to elect alternative coverage at the time of transfer.

(c) If an employer maintains more than one group health plan and an open enrollment period is available to similarly situated active employees with respect to whom a qualifying event has not occurred, the same open enrollment period rights must be available to each qualified beneficiary receiving COBRA continuation coverage. An open enrollment period means a period during which an employee covered under a plan can choose to be covered under another group health plan, or to add or eliminate coverage of family members.

(d) The rules of this Q&A–30 are illustrated by the following examples:

Example 1: Assume that (1) E is an employee who works for an employer that maintains several group health plans; (2) under the terms of the plans, if an employee chooses to cover any family members under a plan, all family members must be covered by the same plan and that plan must be the same as the plan covering the employee; (3) immediately before E's termination of employment (for reasons other than gross misconduct), E is covered along with E's spouse and children by a plan that provides only core coverage, and (4) the coverage under that plan will end as a result of the termination of employment. Upon E's termination of employment, each of the four family members is a qualified beneficiary. Even though the employer maintains various other plans and options, it is not necessary for the qualified beneficiaries to be allowed to switch to a new plan when E terminates employment. Assume further that none of the four family members declines to elect COBRA continuation coverage, and that 3 months after E's termination of employment there is an open enrollment period during which similarly situated active employees are offered an opportunity to choose to be covered under a new plan or to add or eliminate family coverage. During the open enrollment period, each of the four qualified beneficiaries must be offered the opportunity to switch to another plan (as though each beneficiary were an individual employee). For example, each member of E's family could choose coverage under a separate plan, even though the family members of employed individuals could not choose coverage under separate plans. Of course, if each family member chooses COBRA continuation coverage under a separate plan, each family member can be required to pay an amount for that coverage that is based on the applicable premium for individual coverage under that separate plan. See Q&A–44 of this section.

Example 2: The facts are the same as in Example 1, except that E's family members are not covered under E's group health plan when E terminates employment. Although the family members do not have to be given an opportunity to elect COBRA continuation coverage, E must be allowed to add them to E's COBRA continuation coverage during the open enrollment period. This is true even though the family members are not, and cannot become, qualified beneficiaries (see Q&A–17 of this section).

Question 31: Aside from open enrollment periods, can a qualified beneficiary who has elected COBRA continuation coverage choose to cover individuals (such as newborn children, adopted children, or new spouses) who join the qualified beneficiary's family on or after the date of the qualifying event?

Answer 31: If the plan covering the qualified beneficiary provides that such new family members of active employees can become covered (either automatically or upon an appropriate election) before the next open enrollment period, then the same right must be extended to the new family members of a qualified beneficiary. Of course, if the addition of a new family member will result in a higher applicable premium (e.g., if the qualified beneficiary was previously receiving COBRA continuation coverage as an individual, or if the applicable premium for family coverage depends on family size), the plan can require the qualified beneficiary to pay a correspondingly higher amount for the COBRA continuation coverage. See Q&A–44 of this section.

Electing COBRA Continuation Coverage

Question 32: What is the minimum period during which a group health plan must allow a qualified beneficiary to elect COBRA continuation coverage (i.e., the election period)?

Answer 32: A group health plan can condition the availability of COBRA continuation coverage upon a qualified beneficiary's timely election of such coverage. An election of COBRA continuation coverage is a timely election if it is made during the election period. The election period must begin

on or before the date that the qualified beneficiary would lose coverage on account of the qualifying event. (See paragraph (c) of Q&A–18 of this section for the meaning of "lose coverage.") The election period must not end before the date that is 60 days after the later of (a) the date that the qualified beneficiary would lose coverage on account of the qualifying event, or (b) the date that the qualified beneficiary is sent notice of his or her right to elect COBRA continuation coverage. An election is considered to be made on the date that it is sent to the employer or plan administrator. The rules of this Q&A–32 are illustrated by the following example:

Example: An unmarried employee who is receiving employer-paid coverage under a group health plan voluntarily terminates employment on June 1, 1988. *Case 1:* If the plan provides that the employer-paid coverage ends immediately upon the termination of employment, the election period must begin on or before June 1, 1988, and must not end earlier than July 31, 1988. If the notice of the right to elect COBRA continuation coverage is not sent to the employee until June 15, 1988, the election period must not end earlier than August 14, 1988. *Case 2:* If the plan provides that the employer-paid coverage does not end until 6 months after the termination of employment, the employee does not lose coverage until December 1, 1988. The election period can therefore begin as late as December 1, 1988, and must not end before January 30, 1989. *Case 3:* If employer-paid coverage for 6 months after the termination of employment is offered only to those qualifed beneficiaries who waive COBRA continuation coverage, the employee "loses coverage" on June 1, 1988, so the election period is the same as in Case 1. The difference between Case 2 and Case 3 is that in Case 2 the employee can receive 6 months of employer-paid coverage and then elect to pay for up to an additional 12 months of COBRA continuation coverage, while in Case 3 the employee must choose between 6 months of employer-paid coverage and paying for up to 18 months of COBRA continuation coverage. In all three cases, COBRA continuation coverage need not be provided for more than 18 months after the termination of employment (see Q&A–39 of this section), and in certain circumstances might be provided for a shorter period (see Q&A–38 of this section).

Question 33: Must a covered employee or qualified beneficiary inform the employer or plan administrator of the occurrence of a qualifying event?

Answer 33: In general, the employer or plan administrator must determine when a qualifying event has occurred. However, each covered employee or qualified beneficiary is responsible for notifying the employer or other plan administrator of the occurrence of a qualifying event that is either a dependent child ceasing to be a dependent child of the covered employee or a divorce or legal separation of a covered employee. If the notice is not sent to the employer or other plan administrator within 60 days after the later of (a) the date of the qualifying event, or (b) the date that the qualified beneficiary would lose coverage on account of the qualifying event, the group health plan does not have to offer the qualified beneficiary an opportunity to elect COBRA continuation coverage. For purposes of this Q&A-33, if more than one qualified beneficiary would lose coverage on account of a divorce or legal separation of a covered employee, a timely notice of the divorce or legal separation that is sent by the covered employee or any one of those qualified beneficiaries will be sufficient to preserve the election rights of all of the qualified beneficiaries.

Question 34: During the election period and before the qualified beneficiary has made an election, must coverage be provided?

Answer 34: (a) In general, each qualified beneficiary has until at least 60 days after the date that the qualifying event would cause him or her to lose coverage to decide whether to elect COBRA continuation coverage. If the election is made during that period, coverage must be provided from the date that coverage would otherwise have been lost (but see Q&A-35 of this section). This can be accomplished as described in paragraph (b) or (c) of this Q&A-34.

(b) In the case of an indemnity or reimbursement arrangement, the employer can provide for plan coverage during the election period or, if the plan allows retroactive reinstatement, the employer can drop the qualified beneficiary from the plan and reinstate him or her when the election is made. Of course, claims incurred by a qualified beneficiary during the election period do not have to be paid before the election (and, if applicable, payment for the coverage) is made.

(c) In the case of a group health plan that provides health services (such as a Health Maintenance Organization or a walk-in clinic), the plan can require that a qualified beneficiary who has not yet elected and paid for COBRA continuation coverage choose between (1) electing and paying for the coverage or (2) paying the reasonable and customary charge for the plan's services, but only if a qualified beneficiary who chooses to pay for the services will be reimbursed for that payment within 30 days after electing COBRA continuation coverage (and, if applicable, paying any balance due for the coverage). In the alternative, the plan can provide continued coverage and treat the qualified beneficiary's use of the facility as a constructive election. In such a case, the qualified beneficiary is obligated to pay any applicable charge for the coverage, but only if the qualified beneficiary is informed of the meaning of the constructive election before using the facility.

Question 35: Is a waiver before the end of the election period effective to end a qualified beneficiary's election rights?

Answer 35: A qualified beneficiary who, during the election period, waives COBRA continuation coverage can revoke the waiver at any time before the end of the election peirod. However, if a qualified beneficiary who waives COBRA continuation coverage later revokes the waiver, coverage need not be provided retroactively (i.e., from the date of the loss of coverage until the waiver is revoked). Waivers and revocations of waivers are considered made on the date that they are sent to the employer or plan administrator, as applicable.

Question 36: Can an employer withhold money or other benefits owed to a qualified beneficiary until the qualified beneficiary either waives COBRA continuation coverage, elects and pays for such coverage, or allows the election period to expire?

Answer 36: No. An employer must not withhold anything to which a qualified beneficiary is otherwise entitled (by operation of law or other agreement) in order to compel payment for COBRA continuation coverage or to coerce the qualified beneficiary to give up rights to COBRA continuation coverage (including the right to use the full election period to decide whether to elect such coverage). Such a withholding constitutes a failure to comply with section 162(k), and any purported waiver obtained by means of such a withholding is invalid.

Question 37: Can each qualified beneficiary make an independent election under COBRA?

Answer 37: Yes. Each qualified beneficiary must be offered the opportunity to make an independent election to receive COBRA continuation coverage and, if applicable, an independent election (a) to receive COBRA continuation coverage that is limited to core coverage and (b) to switch to another group health plan during an open enrollment period. However, if a qualified beneficiary who is either a covered employee or the spouse of a covered employee makes an election to provide any other qualified beneficiary with COBRA continuation

coverage (whether for core coverage only or core plus non-core coverage), the election shall be binding on that other qualified beneficiary. An election on behalf of a minor child can be made by the child's parent or legal guardian. An election on behalf of a qualified beneficiary who is incapacitated or dies can be made by the legal representative of the qualified beneficiary or the qualified beneficiary's estate, as determined under applicable state law, or by the spouse of the qualified beneficiary. The rules of this Q&A–37 are illustrated by the following examples:

Example 1: Assume that employee H and H's spouse are covered under a group health plan immediately before H's termination of employment (for reasons other than gross misconduct), the plan provides only core coverage, and the coverage under the plan will end as a result of the termination of employment. Upon H's termination of employment both H and H's spouse are qualified beneficiaries and each must be allowed to elect COBRA continuation coverage. Thus, H might elect COBRA continuation coverage while the spouse declines to elect such coverage. However, if H elects to provide COBRA continuation coverage for both of them, that election is binding on the spouse, and the spouse cannot decline COBRA continuation coverage. In contrast, H cannot decline COBRA continuation coverage on behalf of H's spouse. Thus, if H does not elect COBRA continuation coverage on behalf of the spouse, the spouse must still be allowed to elect COBRA continuation coverage.

Example 2: The facts are the same as in Example 1, except that coverage under the plan includes both core coverage and non-core coverage, and H and H's spouse have two dependent children who are also covered under the plan immediately before H's termination of employment. All four family members are qualified beneficiaries, each of whom must be offered the opportunity to elect COBRA continuation coverage either with or without non-core coverage. One possible result, therefore, is for the children to continue their full coverage while the parents continue only core coverage. This result can be achieved in a variety of ways, including separate elections by each family member, or a single election by H that binds the entire family.

Duration of COBRA Continuation Coverage

Question 38: How long must COBRA continuation coverage be available to a qualified beneficiary?

Answer 38: Except for an interruption of coverage in connection with a waiver as described in Q&A–35 of this section, COBRA continuation coverage that has been elected by a qualified beneficiary must extend for at least the period beginning on the date of the qualifying event and ending not before the earliest of the following dates: (a) The last day of the maximum coverage period (see Q&A–39 of this section); (b) the first day for which timely payment is not made to the plan with respect to the qualified beneficiary (see Q&A–48 of this section); (c) the date upon which the employer ceases to maintain any group health plan (including successor plans); (d) the first date after the date of the election upon which the qualified beneficiary is covered (i.e., actually covered, rather than merely eligible to be covered) under any other group health plan that is not maintained by the employer, even if that other coverage is less valuable to the qualified beneficiary than COBRA continuation coverage (e.g., if the other coverage provides no benefits for preexisting conditions); or (e) the date the qualified beneficiary is entitled to Medicare benefits under Title XVIII of the Social Security Act. However, a group health plan can terminate for cause the coverage of a qualified beneficiary receiving COBRA continuation coverage on the same basis that the plan terminates for cause the coverage of similarly situated active employees with respect to whom a qualifying event has not occurred. For purposes of the preceding sentence, termination for cause does not include termination based on a failure to make timely payment to the plan. (See Q&A–48 of this section regarding timely payment.)

Question 39: When does the maximum coverage period end?

Answer 39: The maximum coverage period ends (a) 18 months after the qualifying event, if the qualifying event that gives rise to COBRA continuation coverage election rights is a termination or reduction of hours; and (b) 36 months after the qualifying event, for any other type of qualifying event. The end of the maximum coverage period is measured from the date of the qualifying event even if the qualifying event does not result in a loss of coverage under the plan until some later date. See also Q&A–40 of this section in the case of multiple qualifying events. Nothing in section 162(k) or this section prohibits a group health plan from proving coverage that continues beyond the end of the maximum coverage period.

Question 40: Can the maximum coverage period ever be expanded?

Answer 40: No, with one exception. The exception involves a qualifying event that gives rise to an 18–month maximum coverage period and is followed, within that 18–month period, by a second qualifying event (e.g., a death or divorce). In such a case, the original 18–month period is expanded to 36 months, but only for those individuals who were qualified beneficiaries under the group health plan as of the first qualifying event and were covered under the plan at the time of the second qualifying event. No qualifying event can give rise to a maximum coverage period that ends more than 36 months after the date of the first qualifying event. For example, if an employee covered by a group health plan that is subject to COBRA terminates employment (for reasons other than gross misconduct) on December 31, 1987, the termination is a qualifying event giving rise to a maximum coverage period that extends for 18 months to June 30, 1989. If the employee dies after the employee and the employee's spouse and dependent children have elected COBRA continuation coverage and before June 30, 1989, the spouse and children (except anyone among them whose COBRA continuation coverage had already ended for some other reason) will be able to elect COBRA continuation coverage through December 31, 1990.

Question 41: If coverage is provided to a qualified beneficiary after a qualifying event without regard to COBRA continuation coverage (e.g., as a result of state or local law, industry practice, a collective bargaining agreement, or plan procedure), will such alternative coverage extend the maximum coverage period?

Answer 41: (a) The alternative coverage will not extend the maximum coverage period. The end of the maximum coverage period is measured solely from the date of the qualifying event, as described in Q&A–39 and Q&A–40 of this section.

(b) If the alternative coverage does not satisfy all the requirements for COBRA continuation coverage, the group health plan covering the qualified beneficiary immediately before the qualifying event is not in compliance with section 162(k) unless the qualified beneficiary receiving the alternative coverage was also offered the opportunity to elect COBRA continuation coverage and rejected COBRA continuation coverage in favor of the alternative coverage. At the end of that alternative coverage, the individual need not be offered a COBRA election. However, if the individual is a covered employee and the spouse or a dependent child of the individual would lose that alternative coverage as a result of a qualifying event (such as the death of the covered employee), the spouse or dependent child must be given an opportunity to elect to continue that alternative coverage, with a maximum coverage period of 36 months measured from the date of that qualifying event.

(c) If the alternative coverage does satisfy the requirements for COBRA continuation coverage, it can be credited toward satisfaction of the 18- or 36-month maximum coverage period. Moreover, in the case of a covered employee who receives more than 18 months of alternative coverage that satisfies the requirements for COBRA continuation coverage, if the spouse or a dependent child of the covered employee loses coverage as a result of a second qualifying event (such as the death of the covered employee) that occurs after the 18–month period, that spouse or dependent child need not be given an election to continue coverage.

Question 42: How can an event that occurs before a group health plan becomes subject to section 162(k) affect the maximum coverage period when a later, qualifying event occurs?

Answer 42: (a) If there are two events that satisfy the conditions set forth in paragraph (b) of this Q&A–42, then the first event is treated as though it were a qualifying event that occurred on the date that the plan became subject to section 162(k) (i.e., with a maximum coverage period that began on that date), so that the second event is not merely a qualifying event but a second qualifying event. This treatment applies solely for purposes of determining the maximum coverage period under Q&A–39 through Q&A–41 of this section in connection with that second qualifying event. It does not give rise to any right to elect COBRA continuation coverage in connection with the first event.

(b) The conditions referred to in paragraph (a) of this Q&A–42 are as follows: (1) The first event is listed in paragraph (b) of Q&A–18 of this section (regarding what is a qualifying event) but occurs before the date that the plan becomes subject to section 162(k), (2) the plan provides coverage to a qualified beneficiary after the first event that continues to or beyond the date that the plan becomes subject to section 162(k), and (3) a second event then occurs and is a qualifying event.

(c) The rule of this Q&A–42 is illustrated by the following examples:

Example 1: Assume that a group health plan became subject to section 162(k) on January 1, 1987. Employee F, who was covered by the plan, voluntarily terminated employment on January 1, 1986, and was given employer-paid coverage that would continue for 5 more years. F's spouse was also to be covered for the 5 years, except that the spouse's coverage would terminate upon divorce or F's death. F dies on January 1, 1988. F's death is a qualifying event, so F's spouse can elect COBRA continuation coverage (unless the election is precluded for some independent reason, such as the spouse's entitlement to Medicare benefits). F's termination of employment on January 1, 1986, is treated as though it were a qualifying event that occurred on January 1, 1987. F's death is thus a *second* qualifying event, for which the spouse's maximum coverage period ends on January 1, 1990 (i.e., 36 months after the first qualifying event). The spouse can thus elect up to 24 months of COBRA continuation coverage.

Example 2: Assume the same facts as in Example 1, except that F's death occurs after January 1, 1990. The plan does not have to give F's spouse an opportunity to elect COBRA continuation coverage.

Question 43: Must a qualified beneficiary be given the right to enroll in a conversion health plan at the end of the maximum coverage period for COBRA continuation coverage?

Answer 43: If a qualified beneficiary's COBRA continuation coverage under a group health plan ends as a result of the expiration of the maximum coverage period, the group health plan must, during the 180-day period that ends on that expiration date, provide the qualified beneficiary the option of enrolling under a conversion health plan if such an option is otherwise generally available to similarly situated active employees under the group health plan. If such a conversion option is not otherwise generally available, COBRA does not require that it be made available to qualified beneficiaries.

Paying for COBRA Continuation Coverage

Question 44: Can a qualified beneficiary be required to pay for COBRA continuation coverage?

Answer 44: Yes. For any period of COBRA continuation coverage, a group health plan can require a qualified beneficiary to pay an amount that does not exceed 102 percent of the applicable premium for that period. The "applicable premium" is defined in section 162(k)(4) of the Code. A group health plan can terminate a qualified beneficiary's COBRA continuation coverage as of the first day of any period for which timely payment is not made to the plan with respect to that qualified beneficiary (see Q&A–38 of this section). For the meaning of "timely payment," see Q&A–48 of this section.

Question 45: After a qualified beneficiary has elected COBRA continuation coverage under a group health plan, can the plan increase the amount that the qualified beneficiary must pay for COBRA continuation coverage?

Answer 45: Yes, if the applicable premium increases. However, the applicable premium for each determination period must be computed and fixed by the plan before the determination period begins. A determination period is any 12-month period selected by the plan, but it must be applied consistently from year to year. Thus, each qualified beneficiary does not have a separate determination period beginning on the date (or anniversaries of the date) that COBRA continuation coverage begins for that qualified beneficiary.

Question 46: Must a qualified beneficiary be allowed to pay for COBRA continuation coverage in installments?

Answer 46: Yes. A group health plan must allow a qualified beneficiary to pay for COBRA continuation coverage in monthly installments. A group health plan can also allow qualified beneficiaries the alternative of paying for COBRA continuation coverage at other intervals (e.g., quarterly or semiannually).

Question 47: Can a qualified beneficiary choose to have the first payment for COBRA continuation coverage applied prospectively only?

Answer 47: No. The first payment for COBRA continuation coverage is applied to the period of coverage beginning immediately after the date that coverage under the plan would have been lost on account of the qualifying event. Of course, if the group health plan allows a qualified beneficiary to waive COBRA continuation coverage for any period before electing to receive COBRA continuation coverage, the first payment is not applied to period of the waiver.

Question 48: What is timely payment for COBRA continuation coverage?

Answer 48: (a) If a qualified beneficiary's election of COBRA continuation coverage is made after the date of the qualifying event, timely payment for any COBRA continuation coverage during the period before the date of the election means payment that is made to the plan within 45 days after the date of the election. Timely payment for any other period of COBRA continuation coverage is governed by paragraph (b) of this Q&A–48.

(b) In general, timely payment for a period of COBRA continuation coverage under a group health plan means payment that is made to the plan by the date that is 30 days after the first day of that period. However, payment that is made to the plan by a later date is also considered timely payment if either (1) under the terms of the plan, covered employees or qualified beneficiaries are allowed until that later date to pay for their coverage during the period, or (2) under the terms of an arrangement between the employer and an insurance company, Health Maintenance

Organization, or other entity that provides plan benefits on the employer's behalf, the employer is allowed until that later date to pay for coverage of similarly situated employees during the period.

Lawrence B. Gibbs,
Commissioner of Internal Revenue.

J. Roger Mentz,
Assistant Secretary of the Treasury.

[FR Doc. 87-13366 Filed 6-10-87; 12:21 pm]
BILLING CODE 4830-01-M

Group Health Insurance Continuation:

A New Law That May Help You Keep Your Health Insurance When Your Family or Work Status Changes

After July 1, 1986, many Americans who would otherwise lose their group health insurance coverage because of unemployment, divorce, or the death or retirement of a spouse will be able to keep their insurance—by paying their own premiums.

Older Women's League

An Introduction

Most Americans with private health insurance are covered through an employer. As a covered worker or family member, you have health coverage as long as you are employed or are related to an employed worker. But if your family or work status changes, you often lose your health insurance, too.

Women often lose health insurance coverage when they divorce, are widowed, or their husbands lose a job or retire. An estimated five million American women age 40 to 65 have no health insurance whatsoever.

Public Law 99-272, enacted in April 1986, will help many individuals retain their health insurance when work or family status changes.

This new federal law begins to take effect July 1, 1986. It may help you.

This brochure explains how to take advantage of your expanded right to continue group health insurance. It is not intended to provide legal advice. If you are divorcing, consult a lawyer before making decisions that may affect eligibility for health insurance continuation.

This new law will **NOT** help you if you have already lost your health insurance before it takes effect.

What Group Health Insurance Continuation Means For. . . .

Widows and Dependent Children

If you have health insurance through your spouse's employer, you and your children can continue that coverage for three years if your spouse dies after the group health insurance continuation law takes effect. The employer should notify the health plan when a worker dies; **check with the personnel office** to confirm this has been done. Within two weeks, the plan must notify you of your right to continue coverage. **You MUST respond** within 60 days if you wish to continue on the group health insurance plan.

Divorced or Separated Spouses and Dependent Children

If you have health insurance through your spouse's employer, you and your children can continue that coverage for three years if you divorce or are legally separated after the group health insurance continuation law takes effect. **Notify the health plan** of the change in marital status RIGHT AWAY. Within two weeks, the plan must notify you of your right to continue coverage. **You MUST respond** within 60 days if you wish to continue on the group health insurance plan.

One final note: Provision for health insurance may be included as part of a divorce decree; discuss this possibility with your lawyer. But remember that coverage ends if premiums are not paid, so **you should pay** the premium yourself and be reimbursed by your former spouse. Otherwise, late or missed payments could jeopardize your insurance.

Spouses and Dependent Children of Retiring Workers

If you have group health insurance through your spouse's employer and are not eligible for Medicare, you and your children can continue coverage for three years if your spouse retires after the group health insurance continuation law takes effect. **Check with the personnel office** to confirm that the employer has notified the health plan of the retirement. Within two weeks, the plan must notify you of your right to continue coverage. **You MUST respond** within 60 days if you wish to continue on the group health insurance plan.

Unemployed Workers and Dependents

If you have group health insurance through an employer, you and your dependents can continue that coverage for eighteen months if you become unemployed or your hours are cut after the group health insurance continuation law takes effect. This does not apply if you are terminated for "gross misconduct." The employer must notify the health plan of your termination. Within two weeks, the plan must notify you of your right to continue coverage. **You MUST respond** within 60 days if you wish to continue on the group health insurance plan.

Other Eligible Children

If you have group health insurance through your parent's employer, you can continue that coverage for up to three years if you become ineligible (for example, because of your age). Check with the plan to find out when you are no longer considered a "dependent child." **Alert the plan** as soon as you become too old to qualify. Within two weeks, the plan must notify you of your right to continue coverage. **You MUST respond** within 60 days if you wish to continue on the group health insurance plan.

Group Health Insurance Continuation

You are eligible to continue your current group health insurance coverage if you are: the widow/er or divorced spouse of a worker; the Medicare-ineligible spouse of a retiring worker; or if you or your spouse has been laid off, terminated (except for gross misconduct) or is working reduced hours. Dependent children are also covered.

The new law applies to private employers with 20 or more workers and to state and local government health plans.

You do not have to pass a physical examination, since you are already a member of the group plan. Your coverage simply continues, but you must pay the full monthly premiums —both the employer and employee portions, plus a 2% fee for administrative costs. Even so, most people will find that their current group health insurance plan is more affordable and provides better coverage than an individual policy.

The coverage ends if you fail to pay your premium, become eligible for other group coverage through employment, remarriage or Medicare, or if the employer ends group health insurance coverage for all workers.

The law is effective for health **plan years beginning after July 1, 1986.** The employer or health plan can tell you when your next plan year begins. If the plan year begins in August, the law takes effect for you in August 1986. If the plan year does not start until February, the law takes effect for you in February 1987. Some employers are voluntarily complying earlier than the law requires; check with your employer. For plans subject to collective bargaining, the law does not take effect until January 1987, or when the current bargaining agreements expire, whichever is later.

June 1986

Older Women's League

Wall Street Journal, June 29, 1987, p. 27

Firms Now Must Offer Health Insurance To Some Ex-Workers—but at What Price?

YOUR MONEY MATTERS

By Alexandra Peers
Staff Reporter of The Wall Street Journal

In the past, an employee who quit or was fired usually lost not only a paycheck, but also health insurance. Not anymore.

Under legislation passed last year—and which companies must comply with by tomorrow—an employee's health benefits no longer automatically end when the job is over. What's more, family members may be entitled to continued coverage, even if the employee dies or gets divorced.

But the regulations are chock-full of exemptions, restrictions and points of contention awaiting clarification by the Treasury and Labor departments. Many people still won't qualify for continued coverage, and in some cases those who do may face premiums higher than on policies they could buy on their own. The onus also is on the employees and their families to comply with many of the law's deadlines and procedures to ensure that the health insurance is maintained.

The new law is "a step in the right direction," says Robert Hunter, president of the National Insurance Consumer Organization, but "it's still not anything like complete protection."

Hope and Horror Stories

Even so, the law has generated great interest among people worried about loss of health coverage. Between last July, when the legislation was passed, and year's end, the Older Women's League, which lobbied for the bill, received 50,000 letters "from people who had questions, horror stories, or who had hope against hope that their problems would be covered," says Alice Quinlan, the league's public policy director.

The law requires that companies with at least 20 employees make medical coverage available at group insurance rates for as long as 18 months after the employee leaves—whether the worker left voluntarily, retired or was dismissed. The law also provides that, following an employee's death or divorce, the worker's family has the right to buy group-rate health insurance for as long as three years.

If the group-rate coverage expires before the ex-employee gets a new job with health benefits, the employer must offer additional coverage, although at a more expensive, individual rate.

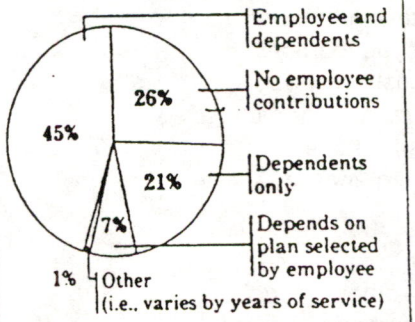
The continued-coverage law "will be a real benefit," says William O'Shaughnessy, insurance-risk manager for the St. Louis police. Spouses of officers who are retiring, for example, will have their option to buy health insurance at group rates extended to three years from six months.

For such group-rate coverage, employers can charge the former workers and their families the average cost of providing the health benefits plus a 2% administrative fee. In most cases, that still would be less than they would pay for arranging coverage on their own. But some may be better off looking for insurance outside the employer's continued group-rate plan.

"The amount the company can charge (for the group-rate plan) is 102% of 'x,' but what exactly is 'x'?" says Marjorie O'Connell, a lawyer with the Washington, D.C., firm of O'Connell & Kittrell. The individual can end up paying more than the coverage is worth, Ms. O'Connell says, because a company with several different medical plans—from basic benefits for part-time workers to coverage for hair transplants for directors—can average the overall costs when billing for continued insurance. Regulations clarifying how companies should figure the premium costs are expected to be announced by the federal government later this summer.

Medical Coverage

These percentages of surveyed companies require employee contributions to obtain medical coverage for:



Source: Hewitt Associates

The main concern about costs, however, comes when the former employee or family members convert to the individual-rate plan from group-rate coverage. The right to convert to the individual-rate plan "is not much of a privilege," says Mr. Hunter of the insurance consumers group. "It's often the right to convert to less comprehensive coverage at much higher rates."

Company-arranged coverage at individual rates is "absurdly costly," says Vincent Taormina, managing director of the benefits and compensation consulting group at the Coopers & Lybrand accounting firm. This is because such plans are often provided without requiring medical exams of the former employees or family members, as usually is required when applying for a new policy. "The assumption is that the employee, by not opting to subject himself to a medical exam, is a poor risk," Mr. Taormina says.

The people most in need of continued health coverage can't always afford such policies. A 60-year-old widow from Clearwater, Fla., for example, was offered medical coverage by her husband's former employer at an individual rate of $430 a month after her husband died, the Older Women's League says. That was $19 less than her entire monthly income from Social Security.

Not Everyone's Covered

Affordability, however, isn't the only concern for those seeking continued health insurance. For example, employees and their families aren't eligible if they have any other source of medical coverage, even if it's only Medicare or a private medical plan inferior to the employer's. The continued-coverage provisions also don't apply to federal agencies, employees discharged for "gross misconduct," or union workers whose contracts haven't expired since the law went into effect. Those union members will be included under their next contract.

Also, an employee's spouse may "have to take a number of special steps to ensure continued coverage" after a divorce, says Ms. O'Connell. Since family members lose all future insurance benefits if they aren't part of the health plan at the time of the divorce, the spouse might consider "getting a restraining order compelling the employee to maintain coverage" during divorce proceedings, she says.

Despite the loopholes, Congress did put some teeth in the law's enforcement. An employer that doesn't comply can be sued under the Employee Retirement Benefits Act and can be denied corporate tax deductions related to health benefits. If a company refuses to provide continued coverage, top officers and other highly compensated employees could face taxation of their own health benefits.

The law also will deter companies from dismissing certain employees, particularly elderly and ill workers, to get them out of the employer's insurance risk pool, Mr. Hunter says. "Now, at least there's some protection."

The Bite of COBRA

Employers feel threatened by a law that requires them to carry former employees on company health plans.

By Joan C. Szabo

Employers are wary of the bite of company health plan requirements in COBRA—the Consolidated Omnibus Budget Reconciliation Act of 1985, which was signed into law April 7.

"COBRA is one of the most dangerous intrusions on small business—I view it with considerable alarm," says Jerry Bartos, owner and president of Bartos, Inc., a small Dallas-based manufacturer of ventilation systems. That is because the law "makes a business person responsible for someone who is no longer in his or her employ," Bartos says.

Under COBRA, businesses with more than 20 employees that offer health insurance must continue coverage at group rates for up to 18 months for employees who retire, quit, switch from full-time to part-time status or are laid off. Those insured must pay the full cost of their insurance plus a 2 percent surcharge to cover administrative expenses.

Companies are required to continue coverage for three years, at the 102 percent rate, for an employee's spouse and dependents if the employee dies or becomes entitled to Medicare. The requirement also applies in event of a legal separation or divorce. On top of that, an employer must offer to provide the same three years' continued coverage to a dependent who reaches the maximum age for dependent coverage.

Continued coverage must be the same as that offered to "similarly situated" beneficiaries—individuals still employed by the company. Those eligible have at least 60 days to decide if they want it.

COBRA takes a deep gouge out of employers who fail to meet its requirements. The penalty is loss of a company's entire tax deduction for contributions made to all health plans.

Employee benefit consultants say the complexity of COBRA's health coverage provision has sparked a rash of questions from employers. "We have been flooded with inquiries on how to comply," says Peter Panken, a senior member of Parker, Chapin, Flattau & Klimpl, a New York and Washington law firm with a large practice representing management in labor relations.

Dennis M. Corry, manager of benefit plans for the Quaker Oats Company, says that "COBRA is ill-defined, lacking both clarification and guidelines."

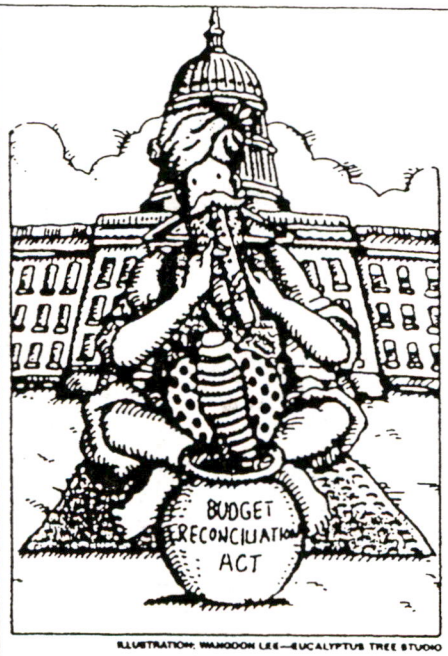


ILLUSTRATION: WAHOOON LEE—EUCALYPTUS TREE STUDIO

Many companies view the law's paper work requirements as an administrative nightmare. Under COBRA, employers must give written notice to each eligible employee and spouse of their right to continued health coverage. Written notice is also required when an employee or beneficiary becomes eligible for the continued coverage. The Labor Department has a model notice to help firms comply with the notification requirements.

Another major worry for employers is COBRA's potential cost. In addition to their expenses in processing the program, there is a possibility of higher health benefit premiums. Regulations are needed to explain how the cost of health insurance should be calculated, says Hewitt Associates, an employee benefit consulting firm in Lincolnshire, Ill.

"The 102 percent rate that companies are permitted to charge is not likely to cover the actual claim costs of people who decide to take coverage," says Peter J. Hutchings, who advises companies on their health benefits for Kwasha Lipton, an employee benefit consulting firm in Fort Lee, N.J. "The 102 percent is based on the average employee, but people who decide to continue coverage are more likely to anticipate needing medical care."

Quaker Oats' Corry says he "would not be surprised if the true cost of coverage is more than five times the premiums paid."

Employers may react to the possibility of higher rates by finding additional ways to trim health care expenses, such as asking employees to pick up more of the cost of insurance, experts say. Another cost-cutting step may include instituting a waiting period before health coverage kicks in for new employees, says consultant Linda Havlin of Hewitt Associates.

Dallas manufacturer Bartos says he has decided to drop all dependent coverage because of COBRA.

Though business views the law with trepidation, no one knows for sure how much COBRA will be used. "It remains to be seen how many people will take advantage of extended health benefits," Hutchings says. "In many cases, employees leaving one company will pick up coverage from their next employer or spouse's employer, which will almost always be less expensive for the former employee."

Meanwhile, companies are awaiting clarifying regulations from the Labor Department and the Internal Revenue Service to provide more guidance on COBRA. Until those rules are issued, employers are required to show good faith in complying with the law.

As they gear up to live with COBRA, a number of business people fear it is a harbinger of more federal regulation in the employee benefits area. One much-discussed bill in Congress that worries them would require most employers to offer up to 18 weeks of unpaid parental leave.

Another bill would require continued health coverage for former employees and their families for up to four months. More costly than COBRA, this proposal would require an employer to pay the same portion of the premiums paid before termination.

Many companies, says Hewitt's Havlin, see COBRA "as the beginning of a whole new wave of federally enacted social policies instituted by government through the employer." ■

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Washington Post, August 1986, pp. D1, D5

U.S. Begins Mandating Health Care

By Michael Abramowitz
Washington Post Staff Writer

Without much fanfare, the federal government has moved into a new era—the era of mandated health-care benefits.

Under a new federal law that went into effect last month, businesses with more than 20 employes who offer group health insurance must now continue the coverage for up to three years to widows, divorced spouses, and their dependents. Companies must offer continued coverage for up to 18 months for employes who have quit or been laid off.

Although the beneficiaries must pay the whole premium for this coverage, plus 2 percent to cover administrative costs, employers have complained that the law has proved a logistical nightmare.

David Glueck, who advises companies on their health benefits for Towers, Perrin, Forster and Crosby, said he has been inundated with calls about how to deal with the new law. Among the problems he cited are difficulties simply in keeping track of former employes, especially for restaurants and other companies with high employe turnover.

Another problem cited is that of "adverse selection"—the prospect that primarily unhealthy people will seek out coverage under the law. Donald C. Flagg, vice president for human resources at Nestle Enterprises Inc., estimated that the new law could raise the costs of health benefits by as much as 20 percent for some companies—a figure the law's supporters say is vastly overstated.

Whoever is right, more of these so-called "mandated benefits" appear to be on their way at the federal level. The extension of coverage provisions, part of last year's budget reconciliation act, are followed by more proposed legislation requiring businesses that offer health insurance coverage to include a range of extra benefits in their plans—from parental leave to preventive health care for children.

Proponents of the legislation say these initiatives are needed to address major gaps in the nation's health finance system, in particular the estimated 30 million-to-35 million Americans who are not covered by any insurance.

But company officials and business representatives are seeing red.

"It is scary as hell," said Flagg. "Congress is passing society's obligations onto business, which is where I don't think it should be."

The issue of mandated benefits has been argued at the state level for the past decade, with many states requiring employers to offer coverage for psychiatric care, alcohol and drug abuse, and other specific ailments. Some states have also mandated the continuation of coverage for certain groups such as laid-off workers or widowed spouses.

Health-care officials say the issue emerged at the federal level last year when Sen. John Chafee (R-R.I.) introduced a bill requiring businesses to include preventive health care for children in their health plans as a condition for keeping the premiums tax-deductible.

But it was the passage of the so-called "Cobra" legislation that struck a nerve among business lobbyists and representatives, who say the bill represents a forerunner to further federal incursions into their health plans. According to Cathy Amkraut, manager of public policy for the Washington Business Group on Health, whose members include many large companies, the trend to federal mandates can be seen in a number of recent initiatives on Capitol Hill:

- The so-called Access to Health Care Act, a recent bill sponsored principally by Sen. Edward M. Kennedy (D-Mass.) and Rep. Fortney H. Stark (D-Cal.). The bill, among other measures, would require employers to continue coverage of health insurance for four months after an employe is dismissed—and pick up the same portion of the premium as they did before the dismissal.

The bill also encourages states to establish "risk pools" to provide coverage for uninsured people. Under such pools, employers with more than 20 workers would have to make up any shortfalls if the premiums collected by the pools don't cover all claims. This part of the bill was approved last month by the House Ways and Means Committee.

- The Parental and Medical Leave Act of 1986, sponsored primarily by Rep. Patricia Schroeder (D-Colo). The bill, approved by two House committees, would require most employers to offer up to 18 weeks of parental leave and 26 weeks of medical leave. It is expected to come to the House floor this fall.
- Another bill sponsored by Kennedy and Orrin G. Hatch (R-Utah) requiring employers to provide coverage for technology dependent children for care at home equal to what is covered in the hospital.

Most of these measures have drawn sharp criticism from the business community. "Employers are becoming increasingly concerned that the voluntary employe benefit system is being dismantled by a patchwork quilt of state and federal mandates," said James A. Klein, a health lobbyist for the U.S. Chamber of Commerce.

Klein and other business spokesmen said the bills could well have an effect opposite to that intended, and cause smaller businesses to drop health coverage altogether.

But the mandated-benefit bills are drawing support, advocates say, out of a need to address critical public policy questions that haven't been adequately dealt with by the federal government. A good example is the problem of the uninsured, which has attracted increasing attention in the last year, they said.

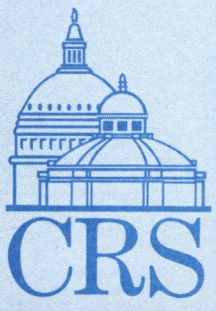
Order Code IB87168

CRS Issue Brief

Mandated Employer Provided Health Insurance

Updated June 1, 1990

by
Beth C. Fuchs
Education and Public Welfare Division



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Mandated Employer Provided Health Insurance

SUMMARY

Between 31 and 37 million Americans under the age of 65 lack health insurance. Recent estimates have drawn special attention to the working uninsured: over 80% of the uninsured are employed or live in families of workers.

The increased number of uninsured has occurred when changes in reimbursement policy by private insurers and the Federal Government have made it harder for hospitals to shift the costs of treating the uninsured to privately insured patients. Consequently, access to health care for persons lacking insurance is a growing concern. These developments have led to new congressional interest in the problems of the medically uninsured. Faced with substantial Federal budget deficits and diminished interest in Government-financed solutions, Congress has begun to look to employers as a potential source of expanding access to health insurance coverage.

Under one approach gaining some support in Congress, the Federal Government would mandate that employers provide health insurance coverage and/or specific health benefits to their employees and to their employees' families. There is, however, substantial controversy over this approach. Proponents argue that providing health insurance is an employer's responsibility. They say that the costs of providing care to uninsured workers are being shifted by health care providers to those employers who provide and pay for health insurance. Opponents of mandated employer-provided insurance argue that it is not an employer's responsibility to provide health insurance. They say that many employers, especially smaller ones, cannot afford to offer insurance. Opponents also argue that the added costs of health insurance would reduce employers' ability to compete, harming the overall national economy.

As a result of past actions by Congress, employers who offer health insurance have to conform to specific requirements affecting the nature of their health insurance plans and the entitlement to those plans. Most larger employers have to offer their employees the option of becoming members of federally qualified Health Maintenance Organizations. Also, employers are prohibited from discriminating in employee benefit plans on the basis of disabilities arising on account of pregnancy. Certain employers have to offer Medicare-eligible workers and their spouses the option to elect the employer's health plan as their primary source of insurance. Finally, certain employers required to make available continued health insurance coverage to qualified employees and their families who would otherwise lose coverage as a result of specific events.

In the 101st Congress, bills have been introduced to expand access to health insurance by mandating that employers provide basic health insurance. One such bill, the "Basic Benefits for All Americans Act of 1989" (S. 768) has been voted out of Committee and is awaiting action by the Senate. Other proposals, placing new requirements on employers, may also be considered.

ISSUE DEFINITION

Most Americans have health insurance coverage through private group plans offered by their employer or through the two major Federal Government financed programs, Medicare and Medicaid. A much smaller number of Americans purchase individual policies through the private health insurance market. However, between 31 and 37 million Americans have no health insurance coverage. Moreover, the percentage of uninsured Americans has been climbing, increasing by some estimates by as much as 20% for the under age 65 population between 1979 and 1986. Recent U.S. Census Bureau estimates have drawn special attention to the working uninsured: over 80% of the uninsured are employed or live in families of workers. For these Americans, employment or connection to employment through a working family member has failed to result in coverage under a health insurance plan.

The increased uninsured population has occurred when changes in the reimbursement policies of private insurers and the Federal Government have made it more difficult for hospitals to shift the costs of treating the uninsured to privately insured patients. Consequently, there is growing congressional concern about decreased access to health care for persons lacking insurance. In search of a solution that will not result in major Federal spending, Congress has turned to employers as a potential source of expanding access to health insurance coverage. In past years, Congress has mandated that employers who offer health insurance to their workers must meet specific requirements affecting the nature of their health insurance plans and the entitlement to those plans. In the 101st Congress, legislation is being considered to mandate that employers provide basic health insurance to their employees and to require that employers provide specific health benefits in their insurance plans. The Pepper Commission has also recommended a "job-based" approach to increasing access to health insurance that includes a mandate on larger employers to provide health insurance or contribute a portion of payroll toward the cost of covering employees and dependents in a public insurance plan. (The Pepper Commission proposal is described in more detail in CRS Issue Brief 90005, Health Insurance, Janet Kline, Coordinator.) These proposals are stimulating substantial congressional debate.

BACKGROUND AND ANALYSIS

Uninsured Population

In 1987, between 31 and 37 million Americans did not have any health insurance. [Variations in estimates of the uninsured are explained by the different questions and methods of sampling used in the surveys.] Estimates from the March 1988 Current Population Survey (CPS) of the U.S. Census Bureau place the number at 31.3 million; estimates from the National Medical Expenditure Survey of the National Center for Health Research place the number at 37 million. In the late 1970s, between 13% and 14.5% of the under-65 population were uninsured. This number increased to 17.7% in 1984 and fell back to 17.5% in 1986. Estimates vary, and some studies report that the number of medically uninsured peaked during the economic recession of the early 1980s, and is now on a downward trend.

The effects on an individual of not having health insurance are not well documented. What is known is that the uninsured are less likely to use health services and are more likely to be in poorer health than the insured population. The 1986 National Access Survey (done for the Robert Wood Johnson Foundation) reports, for example, that the uninsured had approximately 40% fewer ambulatory visits and 19% fewer hospitalizations than the insured. Of those individuals surveyed who had chronic illnesses, 20% of the uninsured failed to see a physician or other provider over the course of a year, compared to 17% of the insured.

While data on the health consequences of lacking insurance are scarce, several studies do provide information on who make up the uninsured population. They indicate that low-income households are more likely to lack health insurance than those with middle or high incomes. They also indicate that the vast majority of uninsured are employed or live in families where the head of the household is employed. Most recent studies using Census Bureau data report that at least 80% of the uninsured live in families where someone is employed.

Working Uninsured

Largely as a result of labor union pressures for better employee benefits, and Federal tax incentives that allow employers to deduct the costs of providing health benefits to their employees, employer-related health insurance became increasingly commonplace after World War II. Today, after paid vacations, it is the most common fringe benefit offered by employers. For the nine out of ten Americans with private group insurance, that insurance is provided in the employment setting. As a result (and in contrast to other western nations where health and pension benefits are provided through public programs), workers in the United States have grown to rely on employer-provided benefits for these basic protections. However, as the following statistics reveal, not all employers offer health benefits and, when offered, not all employees accept them.

Some analysts argue that the decline in coverage is due to the shifting of our economy from jobs that carry health insurance to ones that do not. It is true that while civilian, nonagricultural jobs increased by about 7% between 1982 and 1985, the number of jobs with health insurance provided by an employer increased by less than 5%. However, more important may be changing demographics. For example, there appears to be an increase in the number of young adults without health insurance living in households in which the parents have insurance. In addition, dependent coverage has declined.

EBRI's May 1988 analysis of CPS data on the working uninsured reveal that in 1986, 18.1 million workers reported no coverage from an employer plan. Of that number, 10.9 million were the head of a family (meaning the family member with the greatest earnings or an individual without a family). Another 7.2 million were other family workers and not the head of the household. The majority of uncovered workers were low wage earners. In 1986, 74% of all uninsured workers earned less than $10,000; 93% earned less than $20,000. About 35% of all uninsured workers earned, on average, less than the Federal minimum wage in 1986; 50% of all uninsured workers earned less than 125% of the minimum wage. Most of these individuals worked full-time.

It is also useful to look at the working uninsured according to their primary source of employment. According to EBRI, workers in certain employment sectors are much more likely to lack health insurance coverage than the average American worker under age 65. These include workers in agriculture; retail trade; services (business, repair, entertainment and personal); and construction. Also included in this category are the self-employed. Workers in other employment sectors (including manufacturing, finance, transportation, and wholesale trade) lack insurance coverage only one-third to one-half as often as workers in the above employment sectors.

Move Toward Mandated Health Benefits

Since the early years of this century, national health insurance has been a hotly debated issue in the United States. While in the late 1960s and 1970s, the debate revolved around whether to enact a program of universal national health coverage, in the 1980s the emphasis has been on incremental expansions of health insurance coverage. Proposals have focused on expanding coverage for specific segments of the population (such as laid-off workers, low-income elderly, and children) and for people who, because of a major pre-existing health condition, are unable to obtain health insurance through the private market. Faced with substantial Federal budget deficits and an apparent diminished interest in Government-financed solutions, Congress has begun to look to employers as a potential source of expanding access to health insurance coverage.

One approach gaining some support in Congress falls under the general heading of employer mandates. Under this approach, the Federal Government would mandate that employers (private employers as well as State and local governments) provide insurance coverage and/or specific health benefits to their employees and, in some cases, also to their employees' families. This approach is consistent with the current reality that in the United States, health insurance for all but the old, disabled, and very poor, is primarily obtained through an employer's group plan.

In the 99th Congress, legislation was enacted that required certain employers to offer continued health insurance coverage to their employees who would otherwise lose coverage for certain reasons. Also, certain employers were required to offer their Medicare-eligible disabled workers primary coverage under the employers' health insurance plans. In the 100th Congress, legislation was considered to mandate that employers provide basic and/or catastrophic health insurance coverage. These proposals are being considered again in the 101st Congress.

Issues Related to Mandating Employer-Provided Health Insurance

The debate over mandating that employers provide health insurance raises philosophical issues such as the nature of an employer's obligation to his or her employees, and whether it is appropriate for the Federal government to require that employers offer insurance. In addition, it raises questions about the potential economic effects of mandates on employers as well as on the health of the national economy.

Question of Employer Responsibility

Proponents of mandatory employer-provided health insurance argue that employers have a basic obligation to ensure that their employees have access to health insurance just as they have an obligation to provide a liveable wage. They assert that a minimum health benefits law should be established in the same manner as the Federal Government has established a minimum wage law. They say that it will ultimately lower the Nation's health bill because more people will have access to health care. In addition, they argue that requiring employers to provide coverage is in keeping with the Nation's heavy reliance on employment-related insurance. They further assert that relying on private rather than government-provided insurance builds upon our Nation's tradition of leaving health insurance to the competitive market place.

Proponents also argue that this approach will increase equity across employers and taxpayers. Currently, health insurance premiums are priced to include not only the direct cost of providing health care services to the employer's workers, but also other costs borne by the providers of health care for uninsured or underinsured individuals, a substantial portion of which are uninsured workers. Employers who are paying for health care coverage for their employees are thus subsidizing those employers who are not paying for coverage.

Finally, proponents argue that employers who provide health benefits are also subsidizing other employers by insuring many of the latter's workers through family coverage. According to a CRS analysis (based on March 1987 CPS data), 23.6 million working Americans receive coverage through employers for whom they are not directly working. Moreover, individuals who are not offered insurance by their employers are paying some of the $37 billion in taxes that are used to subsidize (through tax expenditures) health insurance for other, generally higher-paid workers.

The opponents of mandatory employer-provided health insurance counter by arguing that employers have no inherent obligation to provide health benefits. They assert that the individual has a responsibility to purchase insurance in the private market. For those individuals who cannot afford to pay for health insurance, then the public sector should provide a minimum level of health care. Moreover, opponents argue that an employer's decision to provide insurance or to provide a specific set of health benefits should not be dictated by the Government. Rather, it is labor-management negotiations or free-market competition among insurers vying for employers' business that should determine whether employers provide insurance and if so what health services should be covered under the policy. Such reliance on the marketplace will also ensure greater efficiencies in the supply and demand of health coverage and services, thus helping to hold down costs.

There are also those who reject mandates because they would, in their view, undermine the voluntary nature of employer-provided health insurance. They argue that the majority of employers already provide coverage; it is a benefit that these employers have privately chosen to provide in a form that is most appropriate to their own employees. Some employers who already insure their employees argue that a Federal law mandating that employers provide insurance (particularly if that law were to require a basic minimum level of benefits) would result in higher employee benefit costs and new administrative burdens.

Critics of mandated employer-provided coverage also argue that such a policy might increase the costs of labor to the point where companies, especially smaller ones, would reduce their labor force or reduce wages. Health insurance is a relatively expensive benefit. The Small Business Administration (SBA) reports average employer health care costs totalled $1,500 (roughly 75 cents per hour) per worker in 1986. For the 35% of uninsured workers who are paid less than the minimum wage ($3.35 in 1987), the added hourly cost of a health insurance benefit could be prohibitive, even if the employee were required to pay a share of the premium. Although a mandated insurance package might be less comprehensive and therefore less expensive than the average policy cited by the SBA, it could still produce reductions in the employment of low wage workers as employers attempt to adjust to higher labor costs.

Mandated Employer-Provided Insurance and Competitiveness

In addition to the debate about employer responsibility, there is a different set of issues relating to the potential effects of mandating benefits on employers' ability to compete in domestic and world markets. Much of the analyses of these effects is speculative; however, the basic arguments tend to be articulated as follows.

Opponents of mandated employer-provided health coverage say that mandated insurance would drive up the cost of doing business and reduce the ability of firms to compete, both in the domestic and world markets. Industries that compete against foreign manufacturers (especially those from certain Third World nations) are competing against employers who do not as a rule provide health and other fringe benefits. This helps foreign manufacturers to hold their prices down. Small employers, especially, believe that mandating health insurance coverage might cause them to lose whatever competitive edge they may have since they would have to offset the cost of the new benefits by raising their prices. While many smaller firms do not directly engage in international trade, some proportion of them are suppliers to large companies that do compete internationally. Higher costs for a supplier affect the costs of the purchasing firms: if health insurance coverage were required, small employers might pass the cost of the coverage onto their clients. This reasoning is also extended to domestic competition.

Proponents of mandated benefits dismiss the competitiveness argument as invalid or not compelling. In their eyes, it is not a real issue because the companies that are struggling to maintain their competitive edge (such as the auto manufacturers) are the very companies that already provide health insurance. The majority of the working uninsured are not found in the transportation and manufacturing industries but in the service and retail trade industries, which are comparatively unaffected by foreign competition. It is these latter industries that have experienced the most growth since 1979: the services industry is projected by the Bureau of Labor Statistics to increase from about 21% of total U.S. jobs in 1979 to over 26% in 1995; the retail trade industry is projected to increase from 22% to 23% over the same period. Manufacturing and transportation, which have traditionally covered most of their workers, are predicted to decline. These statistics noted, mandated benefits proponents conclude that there are more critical variables, such as exchange rates, undermining American competitiveness than the cost to American firms of their employee benefit packages.

Small Employers and Mandated Employer-Provided Health Insurance

It is often assumed that smaller employers are less likely to offer health benefits because of the high costs of premiums, administrative burdens and the perception that workers prefer cash wages to benefits. Estimates place the costs of insurance for small employers at anywhere from 10% to 40% higher than for large employers. The SBA reports that very small firms that do not offer health benefits spend about 7% of payroll on fringe benefits. Those which do offer coverage spend 10%.

According to the SBA, in 1986, 46% of firms with fewer than 10 workers offered health benefits, compared to 78% with 10 to 24 workers, 92% of firms with 25 to 99, 98% of firms with 100 to 499, and 100% of firms with 500 or more workers. 84% of all workers who worked for employers without health plans worked in firms with less than 25 employees.

Based on surveys and other studies, the SBA has concluded that smaller employers tend not to offer health insurance because they (1) face higher per worker premiums since the risk for insurers is spread over fewer persons; (2) do not benefit to the same extent as larger firms from the tax advantages associated with offering health insurance; (3) experience higher fixed costs in choosing and administering a health plan; (4) have relatively higher worker turnover rates and a greater use of part-time and seasonal employees which increase their administrative fees relative to the fees charged for larger firms; and (5) tend to have narrower profit margins from which to pay relatively higher premiums.

Associations representing small employers use such findings to argue that forcing small employers to offer health insurance will result in higher prices, lower wages, more business failures and fewer jobs. They contend that small firms simply cannot spend more of their receipts on employee benefits.

Another argument used against mandated coverage for small employers is that low-wage workers prefer to receive cash benefits or are already covered indirectly through a family member's insurance policy, and should not be forced to accept reduced earnings. However, an SBA survey of employers found that 14% of eligible workers in small firms (less that 10 employees) which offer coverage turn it down, compared to the 13% average across all firms.

Many proponents of mandated coverage agree that small employers might be adversely affected if they were required to offer (as well as pay some portion of) health insurance. They suggest, however, that potential problems for small employers could be reduced through mechanisms designed to lower both the costs and the administrative burdens of offering health insurance. These mechanisms are generally designed to pool large numbers of small employers in one large group, enabling them to obtain health insurance at lower costs. For example, the Council of Smaller Enterprises (COSE) in Cleveland, Ohio, arranges with a number of insurance companies group health insurance for about 8300 firms, which in turn provide insurance to more than 120,000 employees. COSE is able to negotiate less expensive policies than would otherwise be available to these employers if they sought the insurance on their own.

Such pooling mechanisms have been employed with mixed success. Observers say that they are not as effective for the smallest employers, which are still subject to medical underwriting. They also tend not to attract those employers who have never offered coverage. In addition, their effectiveness in holding down premium rates is limited by the volatility of the small group insurance market. However these problems largely could be eliminated if employers were required to participate in the pool.

Underinsurance and Catastrophic Coverage

Some analysts advocate that an appropriate compromise between the two extremes of doing nothing and mandating that all employers offer health insurance is to require that all employers offer coverage under a catastrophic illness policy. These policies provide coverage for only very large medical expenses after the beneficiary has paid a large deductible; the premium cost of such coverage is, however, generally lower than for more comprehensive policies. A catastrophic illness policy would ensure protection of individuals against the devastating financial burdens of a major illness but would be less costly for employers to offer. On the other hand, such an approach would not address the need of the medically uninsured for basic health services.

History of Federal Employer Mandates

The Federal Government has traditionally left the regulation of insurance to the states. According to Blue Cross and Blue Shield Association, there are over 680 State-mandated benefit laws governing health insurance. They include specific services (e.g., maternity coverage and newborn care), the services of specific providers (e.g., dentists and chiropractors), as well as requirements that plans provide for continuation and conversion options. The States vary in the numbers and types of mandates. Some observers in the business and insurance communities contend that these mandated benefit laws are largely responsible for the high costs of health insurance. Advocates of State mandates say that they increase access to needed health services and encourage greater freedom of choice of providers, which in turn promotes competition and lowers health care costs.

While the business of insurance has been left largely to the States to regulate, employee welfare benefit plans are governed by the Employee Retirement Income Security Act (ERISA), a Federal law enacted in 1974. (Hawaii is an exception. ERISA was amended to allow Hawaii to continue its law requiring employers to provide health insurance coverage.) Included under employee welfare benefit plans are self-insured health plans, where the employer assumes the risk for paying claims, instead of paying premiums to an insurance company which in turn assumes the risk. Thus, while traditionally insured companies are affected by State mandates, self-insured companies are regulated by ERISA. ERISA regulates such aspects of welfare benefit plans as plan disclosure, but until recently, employers under ERISA were relatively free to structure plans as they desired or, if their employees were represented by a union, through the collective bargaining process. As discussed below, this changed with the enactment of Title X of the Consolidated Omnibus Budget Reconciliation Act (COBRA, P.L. 99-272).

In the 1970s, changes were made in Federal law to mandate that employers offering health insurance meet specific requirements. For example, the Health Maintenance Organization Act of 1973 (P.L. 93-222) requires that certain employers with 25 or more employees offer a health maintenance organization (HMO) option in their health plan if a qualified HMO exists in their area. In 1978, Congress amended the Civil Rights Act to extend the prohibition against sex discrimination in employment to include discrimination on the basis of pregnancy, child birth, or related medical conditions (P.L. 95-555). As a result, larger employer health plans must treat women affected by these conditions similarly to other employees, based on their ability or inability to work.

Federal proposals mandating employers to provide coverage date back to the Nixon Administration. More recently, the Carter Administration developed legislation to require employers to provide basic health insurance as an employee benefit. The Carter proposal would have also expanded Federal programs to include those who remain uncovered under employer plans. It was criticized by representatives of small business who argued that requiring them to provide insurance would add significantly to their labor costs and threaten their viability. It also fell victim to the absence of consensus among other health policy actors.

Federal mandates on employers who provide health coverage have continued into the 1980s. In addition, new efforts have been made to broaden the scope of the mandates to those employers who do not already offer health insurance.

Title X of COBRA

The passage of Title X of the Consolidated Omnibus Budget Reconciliation Act (COBRA) in April 1986, marked a major departure in Federal law and regulation of employers' welfare benefit plans. It was the first time that the Federal Government mandated a specific benefit in employee welfare benefit plans. While COBRA does not mandate that employers provide health insurance, it does require that employers with 20 or more employees who do provide health benefits offer qualified employees and their families the option of continued health insurance at group rates when faced with loss of their coverage because of certain qualifying events. The qualifying events include termination or reduction in hours of employment, death, divorce, eligibility for Medicare, or the end of a child's dependency under a parent's health insurance policy. When a covered employee experiences termination or reduction of hours of employment, then the coverage of the employee and any qualified beneficiaries must continue for 18 months. For all the other qualifying events, the coverage for the qualified beneficiaries must be continued for 36 months. The employer's health plan may require the employee or beneficiary to pay the premium for the continuation coverage, but the premium may not exceed 102% of the otherwise applicable premium for that period. (See also CRS Issue Brief 87182, Private Health Insurance Continuation Coverage, by Beth C. Fuchs.)

In the Tax Reform Act of 1986 (P.L. 99-514), Congress included a number of technical corrections to Title X of COBRA. In the Omnibus Budget Reconciliation Act of 1986 (P.L. 99-509), Title X was expanded to require continuation coverage for retirees in cases where the employer files for bankruptcy. The Technical and Miscellaneous Revenue Act of 1988 (P.L. 100-647) made major changes in the penalties, and the Omnibus Budget Reconciliation Act of 1989 (P.L. 101-239) extended

continuation of coverage from 18 to 29 months for certain disabled workers and their families. (See CRS Issue Brief 87182.)

Medicare Working Aged and Working Disabled Secondary Payer Requirements

A different type of employer mandate was legislated through changes in the Medicare program and amendments to the Age Discrimination in Employment Act of 1967. Prior to 1982, employers generally used Medicare coverage as the basic health insurance for their Medicare-eligible employees supplemented by an employer-provided policy which filled in gaps in the Medicare coverage. This tended to ensure that health care costs for their older workers were confined to supplemental as opposed to basic health care coverage. In 1982, as part of the Tax Equity and Fiscal Responsibility Act (TEFRA, P.L. 97-248), Congress adopted a proposal by the Reagan Administration to require that private employers with 20 or more employees offer their employees and their employees' spouses, age 65-69, their health insurance plan, which would be the primary payer for all claims. This provision was adopted to reduce Medicare expenditures by shifting the health care costs of older workers onto employers. The "working aged" or "secondary payer" requirement was expanded through subsequent laws. The Deficit Reduction Act of 1984 (DEFRA, P.L. 98-369) expanded the spousal coverage to include all beneficiaries 65-69 with working spouses under age 65. COBRA, (P.L. 99-272) made Medicare benefits secondary to those payable under employer group plans for employed individuals age 65 or over, and the spouses age 65 or older, of any employed individual regardless of age. OBRA of 1986 (P.L. 99-509) included a Reagan Administration proposal requiring employers with 100 employees or more to offer their disabled workers and their spouses the option of coverage under their employers' health plan as the primary insurance policy.

Bowen Catastrophic Proposal

In November 1986, Otis Bowen, Secretary of Health and Human Services, released a report to President Reagan on catastrophic illness expenses. This report was in response to the President's directive in his Feb. 6, 1986, State of the Union address that the Secretary report to him with recommendations on "how the private sector and Government can work together to address the problems of affordable insurance for those whose life savings would otherwise be threatened when catastrophic illness strikes."

While the Bowen report discussed options to encourage employers to provide catastrophic coverage, it recommended that States require that such coverage be offered in all employment-related plans. It specified that employers should not be required to finance such coverage, and also recommended the extension of full tax deductions for health insurance to the self-employed and unincorporated businesses (currently at 25%) as long as coverage is included for catastrophic expenses.

Although the Reagan Administration promoted Secretary Bowen's proposals for restructuring Medicare to cover catastrophic illness expenses, it did not endorse the recommendations in the Secretary's report for mandating catastrophic illness insurance under employer-provided health benefit plans. Some of these options were incorporated in legislation introduced in the 100th Congress, such as H.R. 2300

(Gradison), which would have denied the tax deduction for employer-provided health insurance to employers who failed to provide catastrophic coverage.

Types of Mandated Coverage Proposals

A variety of approaches to mandating coverage are incorporated in legislation that has been introduced in recent years. While most are aimed at expanding access to basic health insurance by mandating that employers provide health coverage, others seek also to define the nature of the benefits to be offered. There are also proposals that require employers to provide their existing benefit packages to employees, laid-off employees, retirees and/or dependents who experience a change in job or family status. Finally, other proposals require employers who already offer insurance to offer specific benefits, such as well-baby care.

Defining the Application, Nature and Scope of Mandated Health Benefits

One of the controversies in providing for any Federal mandate is whether or not it should apply to all employers, and if not, where the limits should be drawn. The Medicare working aged and COBRA Title X provisions exempt employers with fewer than 20 employees, although the Medicare working disabled provisions enacted in OBRA of 1986 (P.L. 99-509) apply to only those employers with 100 or more employees. Congress has been wary of applying mandates to smaller employers largely because of concerns that they are not as easily absorbed by such firms and could create economic hardships. Congress has also excluded the Federal Government and religious organizations from certain provisions.

The debate over mandated benefits is influenced by concerns about the lack of coverage as well as about concerns that working Americans are not adequately protected against the costs of a catastrophic illness. Consequently, there are proposals to require that employers provide basic hospital and medical insurance as well as those that would mandate only catastrophic illness protection. A more complex issue is whether the mandate should specify the nature of health benefits to be offered by employers. Again, the proposals vary in their approach. Some, such as the Kennedy-Waxman proposal in the 101st Congress (S. 786, H.R. 1845), require a minimum level of benefits in the health insurance package. However, an actuarial equivalency provision allows employers to offer different mixes of benefits and employee cost-sharing requirements. Other bills have left the nature of the benefit package unspecified. There have also been narrowly defined proposals that mandate that employers who already provide health insurance include within their benefit package specific services, such as coverage for pediatric preventive health care. (See S. 968 and H.R. 1449, in the 100th Congress.)

Defining the Population to be Covered and the Duration of Coverage

Whichever approach is pursued, it is necessary to define the beneficiaries who would receive the mandated health coverage. The employer's responsibility could be limited to active full time employees, or expanded to include any or all of the following: part-time employees, seasonal employees, retired employees, spouses, widowed and/or divorced spouses, dependent family members, and employees who

have terminated their employment, either voluntarily or involuntarily. Title X of COBRA and its subsequent amendments provide an example of a broad definition of beneficiaries.

In the same vein, some proposals are directed at ensuring that employers offer health benefits beyond the point at which the employee (and his/her dependents) has an immediate connection with the employer. In the past, Congress has considered proposals to require that employers pay for the continued group coverage of laid-off employees for a defined period of time. In this case, the benefit package may or may not be defined. Such continuation of coverage mandates may extend to laid-off or otherwise terminated employees, retirees of the firm and dependent spouses and dependents of such employees.

Defining the Liability of Employers and Employees

The proposals to mandate employer-provided insurance also generally define the limits of the employer's financial obligation to pay for those benefits. In Title X of COBRA, Congress authorized employers to require the employee to pay for the continued health coverage, plus a small fee to cover the employer's administrative costs. In other proposals, the focus is to keep the employee's costs for coverage low by requiring employers to pay a large portion of the premium. The Kennedy-Waxman plan in the 101st Congress (S. 768, H.R. 1845), for example, requires that the employer pay 80% of the employee's insurance premium (and 100% for low-income employees) which in turn is deductible from the employer's taxes as a cost of doing business. H.R. 2563, in the 101st Congress, prohibits employers from reducing their premium shares for certain part-time workers.

LEGISLATION

H.R. 43 (Clay)

Requires that certain contracts between the U.S. and private contractors contain provisions requiring the contractor to provide certain pension and health benefits to its employees. Introduced Jan. 3, 1989; referred to Committee on Education and Labor.

H.R. 1845 (Waxman)

Basic Health Benefits for All Americans Act. Amends the Public Health Service Act, Fair Labor Standards Act, Title XIX of the Social Security Act, and Employee Retirement Income Security Act to require that employers enroll employees in a health plan that covers specified health services and provides protection against catastrophic illness expenses. Also requires that State Medicaid programs provide health benefits on a phased-in basis to people in poverty and near poverty, and to all other individuals not covered by employer plans. Requirements for employer-based plans similar to S. 768 (see below). Introduced Apr. 12, 1989; referred to Committees on Education and Labor and on Energy and Commerce.

H.R. 2563 (Schroeder)

Part-time Temporary Workers Protection Act of 1989. Amends the Employee Retirement Income Security Act to prohibit a reduction in employer-provided premiums for employees solely because the employee works less than full-time with

less than 30 hours per week, allows employer to reduce the premium contribution to not less than a ratable portion of the premium ordinarily provided in the case of an employee who completes 30 hours of service per week. Introduced June 6, 1989; referred to Committee on Education and Labor.

H.R. 4070 (Grandy)

Universal Health Benefits Empowerment and partnership Act of 1990. Amends ERISA, the Internal Revenue Code, and the Public Health Service Act to provide for universal and more affordable coverage under group, State, or alternative health benefit systems. Requires employers to offer coverage for eligible individuals under basic group health plans or group health payroll deduction plans. Introduced Feb. 22, 1990; referred to Committees on Education and Labor, Ways and Means, and Energy and Commerce.

S. 768 (Kennedy)

Basic Health Benefits for All Americans Act. Amends the Public Health Service Act, the Fair Labor Standards Act, and ERISA to require that employers enroll employees in a plan that covers specified health services and provides protection against catastrophic illness expenses. Also requires that States establish programs to provide health benefits on a phased-in basis to people in poverty and near poverty, and to all other individuals not covered by employer plans. Failure of an employer to provide insurance would result in eligibility loss for grants, contracts, loans or loan guarantees under the Public Health Service Act or civil penalties under the Fair Labor Standards Act. Provides that an individual may sue in Federal court for injunctive relief. Under employer plans, limits the deductible to $250 per person ($500 per family) and copayments to 20% of the cost of any service (excluding certain services for which copayments are prohibited and other services for which different copayments are specified). Except part-time employees, limits the employee's share of the premium to 20% of the cost of coverage, and requires the employer to cover the full cost of at least one health plan for low wage workers. Provides that employers may provide benefits that are equivalent on an actuarial basis to those specified, and that new employers with 10 or fewer employees may provide a "tailored" plan, i.e., a plan that has one-half the actuarial value of benefits of a health benefit plan. Certain part-time employees may waive enrollment in the employer's plan, but the employer must pay what he/she otherwise would have paid for the employee's health plan to the State or Federal entity providing coverage to non-working persons. Employers without a plan meeting the minimum benefit standards are required to join regional insurance pools to be established by the Secretary of Health and Human Services that provide health benefits at community rates. Provides for a Federal subsidy for small businesses where compliance costs exceed 5% of gross revenues. Provides for Federal and State financing of the State programs, and specifies benefit package and cost-sharing. Introduced Apr. 12, 1989; referred to Committee on Labor and Human Resources. Hearings held May 1 and June 23, 1989. On July 12, 1989, the Committee voted to report an amended version of S. 768 to the Senate.

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"Falling Through the Safety Net," Washington Post, December 2, 1986, Health Section, pp. 12-16

By John K. Iglehart
Special to The Washington Post

In a land of medical plenty, where the government says there is a surplus of physicians and hospital beds, roughly 37 million Americans lack the health insurance necessary to get the sometimes very costly care they need.

A certain percentage of Americans have always coped without health insurance and have survived by relying on charity care, but now the number of uncovered people in the United States has increased approximately 40 percent since 1980 and no resolution of this major social problem is in sight.

In the new economic conditions of the 1980s, which are turning medicine into a competitive marketplace, there is no one culprit behind the swelling ranks of the medically indigent. Rather, a number of forces in the private and public spheres of health care are redefining the limits of society's benevolence toward the most vulnerable segments of the population.

At the top of the list is the Reagan administration's determined effort to slow the growth of federal spending on medical care [illegible]educe the scope of the government's so-[illegible]genda. Indigent care, Dr. William L. [illegible]oper, administrator of the Health Care Financing Administration, said recently in an interview, "is strictly a state problem." For one thing, Roper declared in his conversation with State Health Notes, "the federal government is broke, far more so than the states in the aggregate."

For their part, state governments have tightened sharply the criteria for being eligible for Medicaid, the major program that finances care for the poor. As a consequence, fewer than half of the people whose incomes fall below the official poverty line ($8,800 annual income for a family of three in 1986) meet the program's arbitrary and often confusing eligibility standards.

These tight-fisted policies also extend to the private sector. Commercial health insurors are less willing to subsidize the cost of charity hospital care. And employers, worried about rising labor costs and increased competition in international markets, are less willing to support charity care through higher premiums on their own workers.

Health-care providers themselves—the nation's 5,800 private hospitals and 520,000 practicing physicians—are also adding to the problem. While the total cost of care contin[illegible]to mount at a rate well in excess of the [illegible]umer price index, the public perception is that doctors and hospitals are getting financially squeezed and that's why they can't provide as much charity care. As Prof. Uwe E. Reinhardt of Princeton University, a health economist, discussed in an interview:

"Newspapers headline their health cost stories [with] 'Physicians' Payments Cut,' leaving the impression that American society has drastically reduced the money flow to its health-care providers, forcing them to reduce commensurately the care they render.

"Actually, there has been no such reduction in the aggregate money flow. On the contrary, that flow has increased apace since 1980, whether one measures it in current dollars, in constant-purchasing-power dollars, or by the percentage of the gross national product devoted to health care," he said.

All this is setting the politics of health care on a collision course. On one hand, the total medical bill is still going up, although at a slower rate than in the inflationary period of the 1970s. On the other hand, more Americans are finding themselves without access to medical care because they can't pay for it.

The federal government may address a portion of this problem next year when it considers whether to extend Medicare benefits to include protection against illnesses of a catastrophic nature. But this would affect only the elderly, who already enjoy relatively broad health-care benefits under Medicare.

A federal problem? A state problem? An individual problem? As policymakers debate those questions, more Americans are finding themselves without access to medical care. They're falling through the cracks.

At the same time, two recent developments are likely to exacerbate the problem of the uninsured: enactment of an immigration bill that grants amnesty to some of the nation's estimated 3 to 6 million illegal residents, and the emergence of AIDS as a major public health crisis. State and local governments are worried that Congress' plan to pay some $4 billion over four years to provide services for newly legal immigrants will fall far short of covering potential medical costs. And AIDS victims, many without insurance, will consume a substantial sum of the limited resources of large public hospitals.

New Medical Marketplace

It used to be that hospitals would cover the cost of patients with little or no health insurance by increasing the bill to well-insured patients and thereby shift the burden of charity care to those able to pay. But this Robin Hood approach is falling victim to a new way of looking at medical care.

The new vision, which the Reagan administration and many private third-party payers are pressing, is essentially to recast medical care as an economic product rather than a social good, to consider it as a commodity purchased like an automobile or a refrigerator, rather than a service available to all in need.

The shift to a more competitive health system, intended to strip away built-in subsidies for charity care, now makes the uninsured more vulnerable and often poses an ethical dilemma for hospitals and physicians as well.

On philosophical and practical grounds, arguments favoring the redefinition of medical care as a product make some sense, as the proliferation of health maintenance organizations and other competitve health programs attest. But according to congressional and industry experts, the growing problem of indigent care threatens to become the Achilles' heel of the new medical marketplace. To make competition in health care work, they say, government must factor into its thinking the reality that a significant segment of the population is unwanted in any price-sensitive system, unless their care is somehow subsidized.

There is a strong consensus on that care of indigent patients is becoming a crisis. Supporters of the Reagan administration's determined bid to transform the delivery of American medical care through market principles find themselves in agreement with those who would prefer to rely on regulatory policies legislated by Congress and state governments.

"As we create a price-sensitive health care marketplace, accommodations must also be made," Sen. Dave Durenberger (R-Minn.), one of the congressional champions of this approach, said at the opening of a 1984 hearing on medical care for the disadvantaged. "These accommodations are necessary on moral as well as on economic grounds to assure access to quality services for all who need health care."

Michael D. Bromberg, executive director of the Federation of American Health Systems, expressed a similar notion in an inter-

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view. The federation includes the for-profit hospital companies in the vanguard of health interests pressing market approaches.

"Without closer government attention to the growing problem of the uninsured—through action, not more talk—the encouraging progress health care providers have made to become more efficient through market approaches stands seriously threatened," said Bromberg. "The administration simply refuses to accept that political reality."

Bromberg's organization, along with a diverse range of other private sector groups, including the AFL-CIO, American Medical Association, the Catholic Health Association, the U.S. Chamber of Commerce and the Business Roundtable, have discussed the issue of indigent care several times over the last year. Convened under the aegis of Project HOPE, a private health policy and education foundation in Virginia, the groups have agreed that additional federal and state government action, as well as private sector initiative, is needed to address the issue.

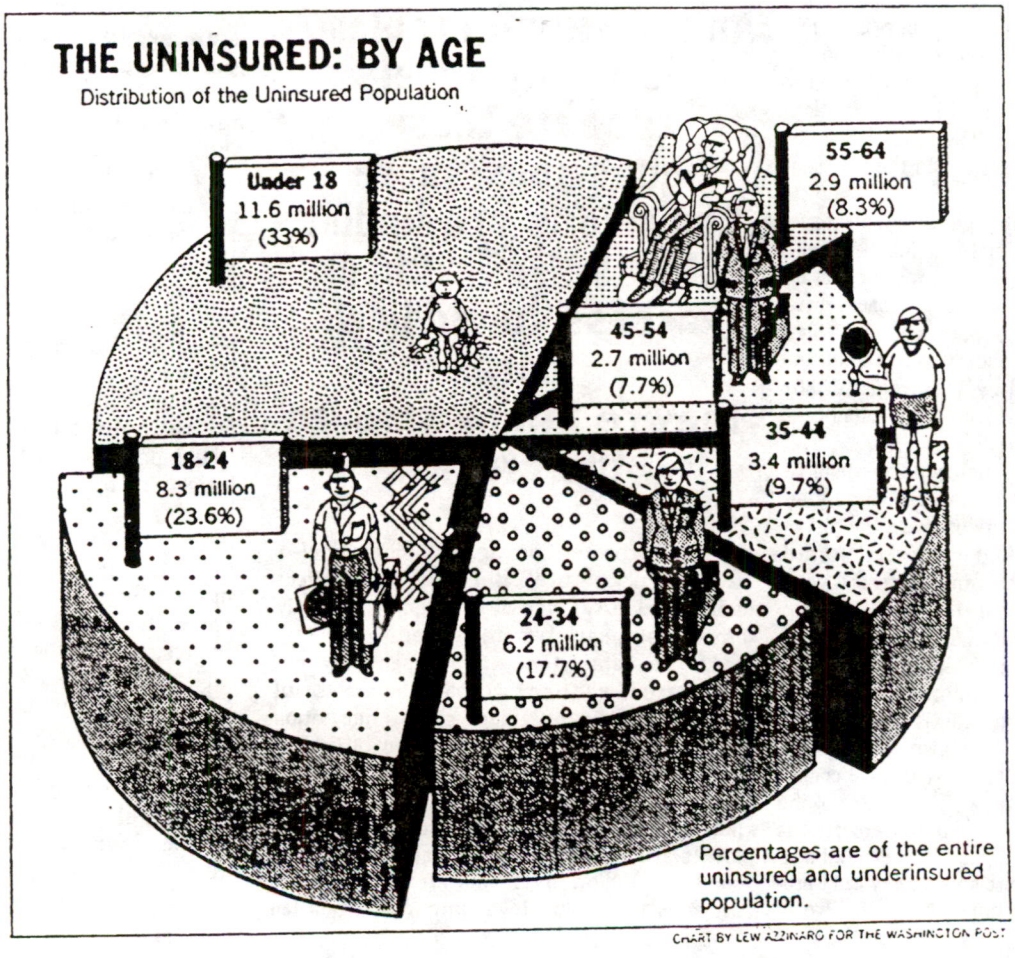
"Given the vast differences in the philosophical outlooks of these organizations, we were frankly surprised at the unanimity of their views on both the seriousness of the problem and the appropriate strategies for seeking solutions," said health economist Gail R. Wilensky, who is vice president of Project HOPE.

Who Is Medically Indigent?

All of the philosophical discussions about the delivery of health care through market or regulatory means is largely irrelevant for people who lack adequate health insurance and are hurting. Consider, for example, the cases of three individuals whose experiences were cited in a "Study of Hospital Care for the Medically Indigent" prepared by the District of Columbia Hospital Association.

- A self-employed carpenter without health insurance avoids seeing a physician about continuing abdominal pain in an effort to save money for some needed new clothing for his family. Finally, he is rushed to a hospital for emergency surgery. Now, in addition to having no health insurance, he has no income until he returns to work and no way to pay his hospital bills.
- A pregnant, unmarried teen-ager does not seek prenatal care because she cannot afford it on her part-time salary. She delivers a premature, low-birth weight baby who spends the first several weeks of life in a high-cost neonatal intensive care unit, generating thousands of dollars of unpaid bills.
- A Central American couple, both of whom are illegal aliens, avoid having their infant son immunized because they fear being asked for identification at the free public clinic and cannot pay for private care. The boy contracts whooping cough and is hospitalized in serious condition.

As these examples illustrate, the indigent health care problem strikes a heterogeneous population of Americans, including young people, working people, poor people, the homeless, illegal aliens and many other ordinary citizens who find themselves in circumstances that make them economically vulnerable to the threat of serious illness.



"Although it seems impossible in this day of the artificial heart and organ transplants, 37 million Americans are without the insurance coverage necessary to pay for a broken arm, an appendicitis, or the birth of a baby," Durenberger said last June at a hearing before the Senate Governmental Affairs Subcommittee on Intergovernmental Relations, which he chairs. "Thirty-seven million people represents a population nine times the size of my home state of Minnesota. It is more people than live in the States of New York and California combined."

According to a recent study by the Urban Institute, a key and somewhat surprising characteristic of the nation's uninsured is that two thirds of the adults—some 15.1 million people—are in the labor force. More than half of the uninsured adults are employed and some 12 percent are temporarily without a job and are considered part of the work force.

Researchers Margaret B. Sulvetta and Katherine Swartz, who prepared the study for a National Health Policy Forum at George Washington University, based their estimates of the uninsured population largely on data from the Census Bureau's Current Population Reports and the Current Population Survey.

Sulvetta and Swartz estimated that the remainder of of uninsured adults are either unemployed (2.8 million), unable to work (2.1 million), attending school (1.7 million) or are women with children at home (3.6 million).

The risk of being uninsured is greatest for people whose family incomes are below the poverty line. Young adults and children make up the the most vulnerable age groups. And the risk of being medically indigent is higher for blacks and other minorities than for whites.

The Politics of Indigent Care

A predictable cycle has developed in Congress on the issue of the medically uninsured. The highest degree of interest in legislating a solution comes during periods of rising unemployment. That's because most people—more than 65 percent of all Americans—are insured through their places of work. (Another 12.3 percent purchase their own private insurance. Only 12.8 percent of the population have public coverage from Medicaid, Medicare or Champus, the military health program.)

Several times over the past decade, Congress has seriously considered legislation that would extend health insurance benefits to the unemployed. The last time was during the economic recession of the early 1980s. But each time, the measures have failed.

Currently, only a relative handful of legislators have demonstrated an ongoing interest in addressing the broader issue of indigent care: principally Durenberger and fellow Republicans Sen. John Heinz of Pennsylvania and Rep. Bill Gradison of Ohio and Democrats Sen. Edward M. Kennedy of Massachusetts and Reps. Fortney H. (Pete) Stark and Henry A. Waxman of California. While they have raised the level of public concern, they have so far failed to budge

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the Reagan administration and its refusal to discuss the matter seriously.

But Congress, well intentioned if not well organized, has begun to recognize the need to restrain some types of economically motivated behavior, produced by competitive health care markets.

A new federal law, for example, which took effect in 1984, now requires states to expand their Medicaid programs to include pregnant women and children under the age of 5 in families that meet the eligibility criteria of public assistance.

The Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985 prohibits hospitals from refusing emergency treatment to persons without health insurance, a response to the problem of private hospitals' "dumping" uninsured patients on public hospitals.

COBRA also mandates that employers permit laid-off workers and their divorced spouses, widows and dependent children to retain group health insurance coverage for four months if the person covered pays the full premium. (The problem, however, for many in this situation is that they can't afford the premium.)

Last May, Durenberger, Gradison, Heinz, Kennedy, Stark and Waxman introduced legislation in the House and Senate that would extend even more assistance to uninsured and other groups with high medical risks.

The legislation would require states to establish pools of comprehensive insurance for all residents, regardless of their health status. Nine states—Connecticut, Florida, Indiana, Minnesota, Montana, Nebraska, North Dakota, Rhode Island and Wisconsin—already offer similar pools to their residents.

This legislation would also finance hospital care for the uninsured, provide incentives for small businesses to offer health insurance to their employes, and require employers to continue paying health premiums for laid-off workers for four months.

In 1983, a report of the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, appointed under President Carter, concluded that society has an ethical obligation to ensure equitable access to medical care for all. Since then, this view has been increasingly embraced by both the conservative and liberal wings of the medical and political communities.

Although the combination of private and public health insurance offers protection against the financial consequences of illness for most Americans, these efforts fall considerably short of providing universal access to health care for all Americans.

The Reagan administration clearly favors less government action and lower taxes rather than a more interventionist strategy that would seek to deal with social problems through expanded or redistributed public support. The issue of how to provide care to some 37 million uninsured people lies at the heart of the matter. ■

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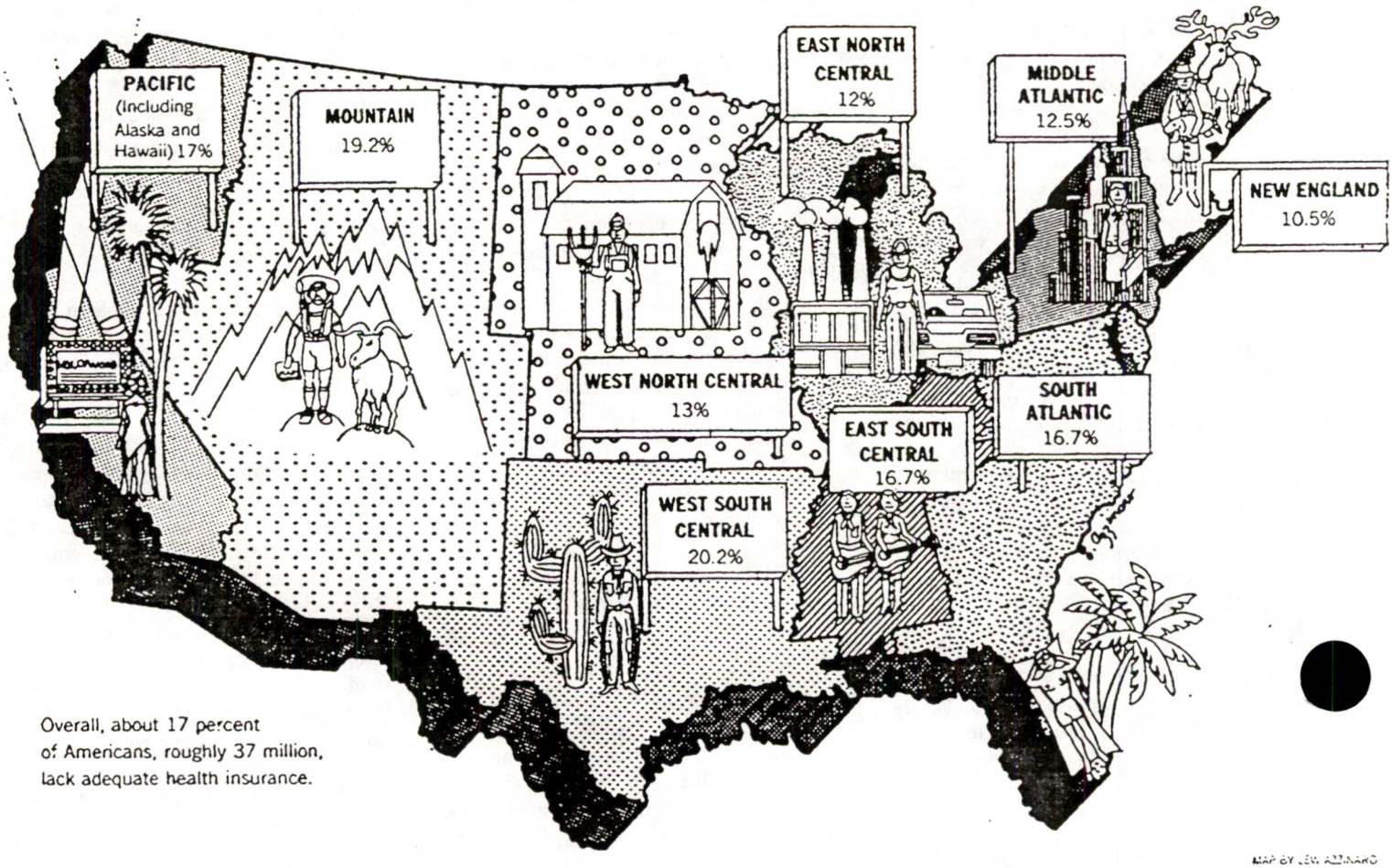
THE UNINSURED: BY REGION

Percentage of Each Area's Population That Lacks Adequate Health Insurance



Overall, about 17 percent of Americans, roughly 37 million, lack adequate health insurance.

MAP BY LEW AZZINARO

The Canadian Solution: Guaranteed Care, Less Flexibility

Unlike the United States, Canada has made it a health policy priority to guarantee its population of 25.5 million universal access to care.

Canada has accomplished this by granting its federal and provincial governments extensive powers to constrain medical costs so that universal access to care does not generate expenditures that would be considered exorbitant by public officials and the electorate.

As Vickery Stoughton, an American who is president of Toronto General Hospital, said in an interview: "Canadians are simply more comfortable than are Americans with granting government a central role in the financing of medical care. While virtually all of Canada's physicians are private practitioners, they provide services under a payment schedule negotiated with the provincial governments."

In 1971, Canada and the United States spent almost the same percentage of their respective gross national products (GNPs) on health care—a little more than 7 percent. Fifteen years later, in 1985, Canada devoted $38.5 million (Canadian dollars), or 8.6 percent of its GNP, to health care, while the United States spent $425 billion, or 10.6 percent of its much larger GNP, for the same purpose.

At the same time, there is a remarkable egalitarian quality about Canadian health care compared with that in the United States. There are no hospitals, for example, that serve a primarily poor clientele, even in Toronto, the nation's largest urban center.

"There is absolutely no way you can tell a patient's economic standing when he is a patient in a Canadian hospital," Stoughton said. The only economically related question patients are asked on admission is whether they have supplemental private insurance that would entitle them to a semiprivate or private room.

Yet there is a price that Canada pays for delegating so much authority to provincial governments to administer its health plans. Decision-making is more bureaucratic and inflexible. What's more, innovation with new ways of providing health care is far less prevalent than in the United States.

For example, health maintenance organizations, which have proliferated in the United States as an effective way to constrain health spending while still providing comprehensive care, are virtually unknown in Canada, with the exception of a few plans in Ontario.

— John K. Iglehart

Los Angeles Times, July 21, 1987, part II, p. 4

Worth Doing

Sen. Edward M. Kennedy's legislation mandating health insurance for all working Americans has picked up some significant support from American business in initial hearings in Washington. That is a welcome balance to the stubborn opposition from the U.S. Chamber of Commerce to any federal mandate.

Francis R. Carroll, president of the Small Business Service Bureau representing more than 35,000 small businesses, emphasized in his testimony that "this bill is an important step toward making health insurance affordable for small business owners and their employees." And he underscored three critical elements that critics sometimes ignore: "It is not bureaucratic. It is not a mandate for socialized medicine. Instead, it builds on the strength of America's private-sector health-insurance system."

Among the other advocates were spokesmen for two major corporations, American Airlines and Chrysler, both deeply concerned about the disadvantages imposed on their companies by the present system through which the companies that provide health insurance also indirectly subsidize the health care of workers of enterprises that provide no protection.

Robert L. Crandall, chairman and president of American Airlines, said that his airline had been placed in a difficult competitive situation since Continental Airlines used the bankruptcy law to abrogate its labor contracts and subsequently "reduced or eliminated most employee benefits, including company-paid health benefits." He said that "as a result of the reorganization Continental's wage and benefit costs are now about half those of many other airlines."

Walter B. Maher, director of employee benefits at Chrysler, insisted that "companies like Chrysler, which have already assumed a significant financial responsibility to provide health coverage, thereby alleviating pressures on public systems, should not be allowed to be a dumping ground for other companies' health bills."

Dumping is precisely what is happening as a growing number of Americans, now 37 million, find themselves without any form of health insurance, even though most of them have jobs. Their illnesses go untreated until they are so critical that the people enter hospitals through emergency rooms and, faced with staggering costs, leave with unpaid bills—bills that ultimately must be funded by overcharging other patients or collecting public and private money.

Under the Kennedy proposal, all employers would be required to provide minimum health insurance. The insurance would be made available to small businesses at prices competitive with the lower costs that are now paid for large groups through the creation of competing regional insurance pools.

Opponents of the measure argue that it, like an increase of the minimum wage, would result in business failures and overall reduced employment. Karen Davis, chairman of the Department of Health Policy and Management at the Johns Hopkins School of Hygiene and Public Health, argued that the advantages would outweigh the disadvantages. "There is some evidence that suggests a 10% increase in labor costs might result in a 1% decline in employment," she testified. But she argued that the plan outlined by Kennedy would not be "excessively burdensome" and would be concentrated on a sector of the labor force where job loss is less likely because it is shrinking. Furthermore, arguments that these reforms would affect the international competitiveness of American companies are exaggerated, because most of the companies that would be affected are in the service sector—not engaged in exports.

As Kennedy has pointed out, the majority of businesses—including small enterprises—already provide health insurance equal to or better than the basic protection that would be mandated by the legislation. Essentially, he added, the legislation "simply extends the current American system of employment-based health insurance to millions of families that are now unfairly excluded." That is something worth doing.

Insuring All Employees Could Kill the Company

By Anthony Gajda

The minimum health insurance legislation that the Senate Labor and Human Resources Committee is now considering would cover the estimated 25 million workers and dependents currently without health insurance, people greatly in need of some sort of help. But the price of this legislation would likely be business shutdowns and layoffs that would throw many people out of their jobs. In attempting to solve the problem of how to relieve the pain and suffering of millions of people not covered by health insurance, the legislation would cause unacceptable pain and suffering of its own.

The Minimum Health Benefits for All Workers Act of 1987, sponsored by Sen. Edward Kennedy (D., Mass.), would require employers to provide employees who work 17½ or more hours a week and their dependents with insurance for hospital, medical, surgical, maternity and well-baby care on both an in-patient and outpatient basis. Employers would have to pay 80% to 100% of the costs. By the most optimistic estimate, the cost of this minimum level of health insurance would average $1,186 per employee per year, or a first-year total cost of more than $25 billion.

Act of Faith

Some large employers, including American Airlines and Chrysler, support the legislation, arguing that companies and governments now providing health insurance are indirectly paying the health-care bills of employees who do not have health insurance. If hospitals and doctors cannot collect their fees from patients who are uninsured, they simply raise the fees that they charge to patients with insurance. While this argument seems reasonable, it takes an act of extraordinary faith to expect that hospitals and doctors are going to reduce their fees if uninsured patients suddenly become insured.

Other supporters argue that small business, by not providing its employees with health insurance, is failing to pay its fair share of health-care costs. The implication is that this problem can be solved by the minimum health insurance bill. Unfortunately, the dynamics are much more complicated than that.

Small businesses are frequently in the retail trade and services industries, typically paying minimum or low wages. At the minimum wage, an employee working 35 hours a week earns $6,097 a year. An employee working half-time, or 17½ hours a week, earns $3,048.50. At the minimum wage, the annual cost of $1,186 for the minimum health insurance plan will be equal to 19% of payroll for full-timers and 39% of payroll for those who work half-time.

In light of these costs, it is difficult to accept that the proposed legislation creates a program that, according to Sen. Kennedy, "small business cannot only live with—it can prosper under." Some large employers also will find it difficult to absorb the cost of the legislation. An estimated 4.3 million uninsured workers are in companies with 1,000 or more employees.

At the minimum wage, the annual cost of $1,186 for the health insurance plan will be equal to 19% of payroll for full-timers and 39% for those who work half-time.

Companies—large and small—that now do not provide health insurance for their employees are likely to react in a number of ways if the legislation is enacted:

- Some marginally profitable or even unprofitable concerns will view the cost of minimum health insurance as the last straw and will close. Others will provide the insurance, become unprofitable and close. In both instances, there will be a loss of jobs.
- Some companies will replace part-timers with full-timers. While this response may minimize the employer's insurance costs, his total cost of doing business could increase. Companies that now provide health insurance to their full-time employees but not to their part-time employees may simply change work schedules so that part-time employees work less than 17½ hours a week. Again, in both cases the result will be that some part-timers will lose their jobs—or at least some of their wages.
- Other employers will simply reduce their workforce to the point at which the additional cost of mandated health insurance is offset by reductions in payrolls. Again, the result will be job losses.
- The higher labor costs associated with the legislation will cause some companies to replace labor with technology. The result? Job losses.

It will not matter that some employees, such as teen-agers covered by their parents' health insurance or adults covered by their spouses', do not want the minimum health insurance. They will be covered.

It will not matter that some employees making over $4.19 an hour will not want to pay the typical $20 a month for their share of health-insurance costs. They will have to pay it.

Of course, all this presupposes that the employers and employees are totally committed to complying with the law as it is enacted. Some small employers may join the underground economy by paying workers cash to avoid offering the insurance. If so, tax revenue will be lost.

It is quite possible that large firms that have been providing health insurance to their employees and retirees will see smaller increases in the cost of their health insurance. But that is likely to be a short-term effect. In the longer term, the injection of $25 billion or more a year into the health-care system probably will increase the price we pay for health care.

The minimum health insurance mandate may set off an era of steep increases like the one we saw after the implementation of Medicare and Medicaid. And those increases may dwarf any savings that large firms may gain initially from no longer having to subsidize the cost of health care for the uninsured.

Some will say these fears are unfounded, that the oversupply of health-care providers is sufficient to absorb the additional demand. That probably would be true if unemployment among physicians were 10% or 15%. But when was the last time someone tried to make an appointment with a doctor and was told to "come right over, we're kind of slow today"?

While a case can be made that there are enough empty hospital beds to absorb the additional demand, there are three reasons that prices are likely to go up.

First, hospitals, unlike physicians, are not mobile and cannot follow population movements. In many areas of the country, populations have shifted away from neighborhoods and communities in which hospitals are situated. While the Kennedy proposal might fill beds in hospitals in older neighborhoods and communities, it would probably exacerbate demand and raise costs in newer areas already short of hospital beds.

Second, the hospital industry has been scaling down operations to accommodate the reduced demand resulting from cost-containment efforts in both the public and private sectors. The increased demand from those obtaining the minimum benefits will require the industry to begin to bid up wage rates in order to attract nurses and other health workers to hospitals.

Third, hospitals have reorganized in order to market outpatient services, such as outpatient surgery and home health care, the prices of which are not regulated by state or federal agencies. Revenue from these outpatient services is then used to subsidize losses from inpatient services, the prices of which are frequently regulated. It is likely that hospitals will optimize the mix of regulated and unregulated services to maximize revenue and that the increased general demand for unregulated services will boost prices.

Economic Impact

Congress should carefully study the economic impact of the Kennedy legislation. Health care now accounts for 10.9% of gross national product: The proposed legislation would raise it to 11.4% of GNP. Congress should say what the actual cost of the Kennedy legislation, as well as catastrophic care, Medicare and other pending health-care legislation would be in terms of increased health-care prices, job losses and other dislocations in the economy. Businesses that are paying for this legislation and workers whose jobs may be affected by it deserve to know how much this approach to providing needed health insurance will really cost.

Mr. Gajda is a principal of William M. Mercer-Meidinger-Hansen Inc., a leading employee benefit and compensation consulting firm.

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CRS Report for Congress

Access to Health Care: Selected References, 1988-1989

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Bibliographic Specialist, Education and Public Welfare
Library Services Division

December 1989

Congressional Research Service • The Library of Congress

ACCESS TO HEALTH CARE: SELECTED REFERENCES, 1988-1989

SUMMARY

This bibliography contains references from the Public Policy Literature Data Base of the Library of Congress. The focus of the selected references is on the accessibility of all Americans to adequate medical care regardless of the individual ability to pay. The groups that require improved access include the homeless, the aged, children, and minorities. In addressing the issue of access the material included in this bibliography discuss private health insurance, national health insurance, patient dumping, indigent care, and closing of hospitals.

ACCESS TO HEALTH CARE: SELECTED REFERENCES, 1988-1989

Access to medical care for Black and white Americans. JAMA [Journal of the American Medical Association], v. 261, Jan. 13, 1989: 278-281. LRS89-2506

"A 1986 national survey of use of health services shows a significant deficit in access to health care among black compared with white Americans. This gap was experienced by all income levels of black Americans. In addition, the study points to significant underuse by blacks of needed medical care."

Battistella, Roger M. Weil, Thomas P.
National health insurance reconsidered: dilemmas and opportunities. Hospital & health services administration, v. 34, summer 1989: 139-165. LRS89-3500

"The authors conclude that government intervention in the health sector is bound to expand rather than contract because centralization is the key to reconciling otherwise divergent political demands for spending controls and greater equality of access to quality care for the increasing number of uninsured or underinsured persons."

Bishirjian, Terry.
Rural health care in the 1990s: decade of decision and change. Appalachia, v. 22, spring 1989: 31-37. LRS89-5321

Addresses the challenges facing Appalachian health care in the near future: costs, competitiveness, accessibility, affordable insurance, skilled medical professionals, geographical barriers.

Cancer and the poor: a report to the nation; findings of regional hearings conducted by American Cancer Society. Atlanta, American Cancer Society [1989] 33, 52 p. LRS89-6564

Reports findings from May-June 1989 hearings in Georgia, Mississippi, New Jersey, Missouri, Texas, California, and Arizona in which people from 47 States and territories testified about high mortality rates and access to health care for poor persons who develop cancer.

Cleeton, David L.

The medical uninsured. Public finance quarterly, v. 17, Jan. 1989: 55-83. LRS89-743

Argues "that the present design of public asistance programs creates a market failure by ruling out limited ceiling coverage for individuals who consider public assistance programs to provide at least partial coverage against losses. This is particularly relevant to the state Medicaid needy programs and their spend-down provisions."

Cost and effects of extending health insurance coverage. Washington, G.P.O., 1989. 176 p. LRS89-3043

At head of title: Committee print.

"Education and Labor serial no. 100-EE; Energy and Commerce serial no. 100-CC; Special Committee on Aging serial no. 100-P"

"Prepared for the Subcommittee on Labor-Management Relations and the Subcommittee on Labor Standards of the Committee on Education and Labor and the Subcommittee on Health and the Environment of the Committee on Energy and Commerce, House of Representatives and the Special Committee on Aging, United States Senate by the Congressional Research Service, Library of Congress."

Crisis in the U.S. Health Care System: how should government and industry respond? Washington, MAPI, 1989. 31 p. (MAPI policy review PR-108) LRS89-6548

"Examines the current U.S. system of health care delivery and its problems. The mandated benefit proposal, as contained in S. 768, is then reviewed, and finally, alternative approaches to improving access to health care without further escalation of costs are discussed."

Davis, James E.

National initiatives for care of the medically needy. JAMA [Journal of the American Medical Association], v. 259, June 3, 1988: 3171-3173. LRS88-4839

"The provision of medical care to the underserved, the underprivileged, and the financially needy is a compelling concern of medicine, perhaps the most perplexing problem that confronts the medical profession today."

Duncan, R. Paul.

Inpatient transfers and uncompensated care. Hospital and health services administration, v. 33, summer 1988: 237-248. LRS88-5073

Differentiates between "the concepts of patient transfer and dumping and presents an empirical examination of a sample of inpatient transfers including descriptions of patient, hospital, episode, and compensation characteristics."

Enfield, Lisa M.

Patient dumping in the hospital emergency department: renewed interest in an old problem. American journal of law & medicine, v. 13, no. 4, 1988: 561-595. LRS88-14978

"We conclude that the currently proposed solutions to patient dumping will have limited effectiveness without more specific incentives for the provision of health care to the medically indigent."

Estes, Carroll L.

Aging, health, and social policy: crisis and crossroads. Journal of aging & social policy, v. 1, 1989: 17-32. LRS89-7783

"In the 1980s, significant and growing problems of uninsurance and underinsurance for health care have re-emerged. Simultaneously, state Medicaid programs are characterized by their increasing variation and inequities, while there has been a decline in access for the poor. The future of aging policy will be decided in the context of four socio-demographic realities: (1) population aging (2) trends in mortality and morbidity (3) the relationship between income and health, and (4) aging as a woman's issue."

Friedman, Emily.

Are risk pools being oversold as a solution? Hospitals, v. 62, Nov. 5, 1988: 100-104. LRS88-10248

Charts characteristics of current State health insurance risk pools. Assesses finance and feasibility of State plans to provide health insurance coverage to those unable to get access to other health insurance. Includes a report on public opinion of hospital responsibility for the care of the uninsured by Jane Edgar of the Arthur D. Little, inc.

Ginzberg, Eli.

Medical care for the poor: no magic bullets. JAMA [Journal of the American Medical Association], v. 259, June 10, 1988: 3309-3311. LRS88-5163

"The thrust of my analysis has been to highlight the inherent limitations in a nonegalitarian society of continental proportions to establishing a single acceptable level of care for all its population and the inability to achieve this goal by passing more laws and appropriating more money, although some new laws and more money are definitely needed."

Goodman, John C. Robbins, Gary. Robbins, Aldona.
Mandating health insurance. Dallas, National Center for Policy Analysis, 1989. 21, 14 p. LRS89-1542

Argues against proposals for mandated health insurance and concludes that "it would be far less expensive to subsidize unpaid hospital bills from public funds. And close inspection of the market for health insurance reveals that existing government regulation is a major cause of the rising number of people without health insurance. Before enacting new regulations, we should first repeal old ones and give market forces a chance to work."

Haislmaier, Edmund F.
The health care quagmire. Consumers' research, v. 72, Sept. 1989: 10-16. LRS89-7745

"There is a growing concern in America that the nation's health care system needs intensive care. The most obvious problems are the rapid escalation in the cost of medical care and, in part as a result of such high costs, the fact that many Americans effectively are denied access to necessary medical treatment."

Minimum Health Benefits Act: mandating new problems. Washington, Heritage Foundation, 1988. 15 p. (Issue bulletin no. 136) LRS88-3154

"There is a real danger, however, that this [minimum health benefits] legislation would do more harm than good. While these proposals might help some workers and employers, they still would leave many Americans unprotected and, at the same time, would destroy jobs and drive health care spending and costs even higher, to the detriment of all Americans and the U.S. economy."

Hansen, Karen.
A painful prescription. State legislatures, v. 14, Nov.-Dec. 1988: 20-21. LRS88-12431

"In this country, good medical care is available for the rich and the middle class. For the poor and near poor it is being rationed, by design or by default."

Health insurance and the uninsured: background data and analysis. Washington, G.P.O., 1988. 172 p. LRS88-14353

At head of title: Committee print.

"Education and Labor serial no. 100-Z; Energy and Commerce serial no. 100-X; Special Committee on Aging serial no. 100-1"

"Prepared for the Subcommittee on Labor-Management Relations and the Subcommittee on Labor Standards of the Committee on Education and Labor and the Subcommittee on Health and the Environment of the Committee on Energy and Commerce, House of Representatives and the Special Committee on the Aging, United States Senate by the Congressional Research Service, Library of Congress."

Healthy children: investing in the future. Washington, Office of Technology Assessment, for sale by the Supt. of Docs., G.P.O., 1988. 301 p. LRS88-5975

Partial contents.--Children's access to health care.--Prevention of childhood illness: selected topics.--Prenatal care.--Newborn screening.--Wellchild care.--Prevention of accidental childhood injuries.--Prevention of child maltreatment.

Hegarty, Stephen H. Kinzer, David M.

Mandated coverage: Massachusetts' ordeal. Hospitals, v. 62, July 20, 1988: 66-73. LRS88-6519

"A Massachusetts law, signed in April 1988, provides health coverage to all of that state's uninsured citizens. The law is a U.S. 'first' in the sense that it promises coverage to all citizens, regardless of their employment status. The law, which will not be fully phased in until 1992, is a complex one that not only addresses the uninsured issue but also redesigns a regulatory system that for some years has made the state's hospitals--voluntary and governmental--subject to overall revenue controls."

Hospital closures and access to medical care. Lexington, Ky., Council of State Governments, 1989. 11 p. (CSG backgrounder 078901) LRS89-7029

"There is much debate concerning the economics of our nation's health care system, and whether these hospital closings are the result of unfair regulation practices, the health industry's own glut, or poor fiscal management. The purpose of this paper is not to argue these points, but to address the occurrence of hospital closings as a concern for state and local officials who must deal with the consequences as they affect public access to medical care."

Inequities in health services among insured Americans: do working-age adults have less access to medical care than the elderly? New England journal of medicine, v. 318, June 9, 1988: 1507-1512. LRS88-5075

Concludes "that insured, working-age adults have less access to medical care than the elderly, and that poor, black, or Hispanic persons in this group are at risk for even greater problems with access to care."

Insuring the uninsured: options and analysis. Washington, G.P.O., 1988. 212 p. LRS88-14354

At head of title: Committee print.

"Education and Labor serial no. 100-DD; Energy and Commerce serial no. 100-BB; Special Committee on Aging serial no. 100-O."

"Prepared for the Subcommittee on Labor-Management Relations and the Subcommittee on Labor Standards of the Committee on Education and Labor and the Subcommittee on Health and the Environment of the Committee on Energy and Commerce, House of Representatives and the Special Committee on Aging, United States Senate by the Congressional Research Service, Library of Congress.

Jackson, Jesse L.

A prescription for America's health. State government news, v. 31, Dec. 1988: 6-8. LRS88-11806

Urges a national health program to support health care as a constitutional right. "A federally administered program is the only way to ensure adequate funding in poorer areas and to prevent regressive state governments from blocking access to care."

Koska, Mary T.

Alternate care: indigent care and overcrowding threaten EDs (emergency departments). Hospitals, v. 63, July 20, 1989: 66, 68, 70. LRS89-5934

Presents evidence that for a growing number of hospital emergency departments, "the constant flow of indigent patients and increasing instances of overcrowding," are straining the acute health care system.

Main, Karen.

1988 report on the medically indigent. Frankfort, Ky., Legislative Research Commission, 1988. 96 p. (Research report no. 236) LRS88-12401

Reports on Kentucky's problems involving "the uninsured and people whose insurance is insufficient for any reason, including exhausted benefits, exclusions on allowable procedures or types of care and pre-existing conditions." Includes reports on trends in other States' Medicaid programs for 1986 and 1987.

Man, Anthony.
Rural health care: closed hospitals only part of problem. Illinois issues, v. 15, May 1989: 12-15. LRS89-3490
"As the most visible symptoms of the ailments plaguing rural health in Illinois, hospital closings will continue to get lots of attention--the kind that spurs political and government activity."

Mueller, Keith J.
The role of policy analysis in agenda setting: applications to the problem of indigent health care in the United States. Policy studies journal, v. 16, spring 1988: 441-453. LRS88-6004
"This discussion of the shaping of policies concerning indigent health care is a call for more research concerning the shaping of state policies using the agenda setting approach to explain the roles played by various actors in shaping legislative suggestions. This approach can also explain the difficulty experienced in moving from general knowledge of a problem to actual policies."

Orr, Suezanne Tangerose. Charney, Evan. Straus, John.
Use of health services by Black children according to payment mechanism. Medical care, v. 26, Oct. 1988: 939-947. LRS88-11089
"The use patterns of approximately 2,600 black children, categorized according to type of insurance (Medicaid, private health insurance or no insurance), were analyzed. All children were enrolled in an urban pediatric primary care program that attempted to increase access to health care by poor children. Medicaid recipients used health-care services more than their counterparts who had private or no insurance. All groups received significant levels of preventive care."

Patricelli, Robert E.
Statement of the U.S. Chamber of Commerce on problems in access to affordable health insurance for small business. Washington, U.S. Chamber of Commerce, 1989. 7 p. LRS89-9164
Addresses the problem of rising costs of health care plans in the small business market.

Pincus, Carol R.
How your colleagues care for the uninsured. Medical economics, v. 65, Aug. 1, 1988: 60-65. LRS88-6439
A nationwide survey of doctors indicates that the uninsured can make up 15% of a physician's practice and in some depressed areas the numbers can be as high as 55%. Doctors cope by making special payment arrangements, offering credit, and referring patients to clinics. Some doctors require cash payments from uninsured patients.

Rosenbaum, Sara. Hughes, Dana C. Johnson, Kay.
Maternal and child health services for medically indigent children and pregnant women. Medical care, v. 26, Apr. 1988: 315-332.
LRS88-2435

"Millions of low-income children and women of childbearing age are completely uninsured. Medicaid, the nation's largest public health financing program for the poor, is an inadequate resource for uninsured families with children. By 1984, the program served only 46% of the poor and near-poor, down from 65% in 1976."

Russell, Louise B.
Proposed: a comprehensive health care system for the poor. Brookings review, v. 7, summer 1989: 13-20. LRS89-5107

Outlines a program that would make health care available to the poor, even those not now covered by Medicaid.

Sager, Alan.
Prices of equitable access: the new Massachusetts health insurance law. Hastings center report, v. 18, June-July 1988: 21-25. LRS88-5805

"Massachusetts's new health insurance law has been shaped by much more than presidential politics. Ten years of evolving policy on health insurance and hospital finance have exerted powerful influences. Ironically, enacting universal access required paying hospitals much more money for their currently insured patients. This costly compromise may destabilize the law's implementation."

Thorpe, Kenneth E. Siegel, Joanna E. Dailey, Theresa.
Including the poor: the fiscal impacts of medicaid expansion. JAMA [Journal of the American Medical Association], v. 261, Feb. 17, 1989: 1003-1007. LRS89-1801

"We estimate that expanding Medicaid coverage to all currently uninsured nonelderly persons below the federal poverty line would cost approximately $9 billion."

U.S. Congress. House. Committee on Education and Labor.
Subcommittee on Labor-Management Relations.
Oversight hearing on access to health insurance. Hearing, 100th Congress, 2nd session. June 9, 1988. Washington, G.P.O., 1988. 367 p. LRS88-12396

"Serial no. 100-94"

U.S. Congress. House. Committee on Energy and Commerce.
Subcommittee on Health and the Environment.
Health insurance coverage and reform. Hearing, 101st Congress, 1st session. Mar. 9, 1989. Washington, G.P.O., 1989. 137 p.
"Serial no. 101-18" LRS89-4792

Minimum health benefits for all workers. Hearings, 100th Congress, 2nd session on H.R. 2508. Apr. 14 and 15, 1988. Washington, G.P.O., 1988. 345 p. LRS88-12106

"Serial no. 100-174"

Includes discussion of the impact of the proposed bill on employers and businesses.

U.S. Congress. House. Committee on Government Operations. Human Resources and Intergovernmental Relations Subcommittee.
Equal access to health care: patient dumping. Hearing, 100th Congress, 1st session. July 22, 1987. Washington, G.P.O., 1988. 463 p. LRS88-1973

U.S. General Accounting Office.
Health insurance: a profile of the uninsured in Ohio and the nation; report to the Honorable Howard M. Metzenbaum, U.S. Senate. Aug. 30, 1988. Washington, G.A.O., 1988. 66 p. LRS88-8683

"GAO/HRD-88-83, B-232117"

"Data compiled annually by the Bureau of the Census to identify characteristics of the uninsured and changes in the uninsured population since 1982."

Health insurance: an overview of the working uninsured; report to the chairman, Committee on Finance, U.S. Senate. Feb. 24, 1989. Washington, G.A.O., 1989. 54 p. LRS89-1515

"GAO/HRD-89-45, B-230452"

Discusses "the characteristics of the working uninsured, [and] the kinds of employers that do not offer health insurance."

Long-term care for the elderly: issues of need, access, and cost; report to the Chairman, Subcommittee on Health and Long-Term Care, Select Committee on Aging, House of Representatives. Nov. 28, 1988. Washington, G.A.O., 1988. 54 p. LRS88-14243

"GAO/HRD-89-4, B-226097"

Provides information on "(1) the number of elderly estimated to need long-term care now and in the next century, (2) the types of available long-term care services and access to them, and (3) public and private expenditures to finance and deliver long-term care."

Congressional Research Service • The Library of Congress • Washington, D.C. 20540

Health: Long-Term Care for the Elderly
IP 402H

Why is the financing and delivery of long-term care services an important policy issue for Congress? There are several reasons. First, the nation has a rapidly growing elderly population. Second, studies show major increases in the need for institutional and community-based long-term care services in the future. Today approximately 1.3 million elderly persons are residents of nursing homes. For every elderly person residing in a nursing home, there are at least twice as many elderly persons living in the community requiring various kinds of care. Estimates for the future show that the nursing home population might be as high as 4.4 million persons by the year 2040, and the disabled elderly population living in the community might include up to 14.4 million persons by that time.

Third, while no one Federal program has been designed to support the comprehensive long-term care needs of the elderly, public expenditures for long-term care service, principally nursing home care, already strain Federal and State budgets. In addition, paying for nursing home care is beyond the resources of most elderly persons. Nearly all private spending for nursing home care was paid directly by the consumer out-of-pocket. With nursing home care costing in the range of $20,000 to $25,000 per year, out-of-pocket spending for this care may represent a catastrophic expenditure for many.

This Info Pack provides an overview of these issues. In addition, it provides information on how Federal programs currently finance long-term care and how some private sector options might assist in providing alternative financing for some older persons.

Members of Congress who want further information on this topic may contact CRS at 707-5700. Additional CRS Reports may be identified by looking in the current *Guide to CRS Products* (for congressional use only) under "Medical Economics" and in the latest *Update* under "Health."

Additional information on this subject, primarily in periodicals and newspapers, may be found at a local library through the use of indexes such as the *Readers' Guide to Periodical Literature*, Public Affairs Information Service *Bulletin* (PAIS), *General Science Index*, and various newspaper indexes.

We hope this information will be helpful.

Congressional Reference
Division

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Washington Post, March 3, 1990, pp. A1, A4

Hill Group Backs Broad Health Plan

$66 Billion Tax Cost Is Left Unresolved

By Kenneth J. Cooper
Washington Post Staff Writer

A bipartisan congressional commission yesterday endorsed a comprehensive plan for providing health coverage for 31 million uninsured Americans and long-term care for the elderly and disabled. The expansive plan, which would require $66 billion in new federal funding, came under immediate attack for failing to specify how the government would raise the money.

The commission was established to devise solutions to two major problems of the nation's health care system: providing coverage to uninsured people, who often delay treatment until they must seek free care in hospital emergency rooms, and providing long-term care to the elderly with chronic diseases and the disabled of all ages, groups of people often bankrupted by the cost of nursing home care.

The panel's work, which began a year ago, was intended to produce a report that would frame the issues for Congress, which avoided action on them when it voted to expand Medicare in 1988.

Several members said the 15-member commission, by failing to agree on financing methods, had not fulfilled its mandate and would have little practical impact on congressional deliberations. The part of the plan covering the uninsured was approved on an 8-to-7 vote, while the long-term care section was accepted 11 to 4.

"It won't work. There's no financing, no way to pay for it. It's dead," declared Rep. Fortney H.

See HEALTH CARE, A4, Col. 1

HEALTH CARE, From A1

"Pete" Stark (D-Calif.), chairman of the House Ways and Means subcommittee on health. He voted against both parts of the plan.

"It does not get down to the bottom line," said Rep. Willis D. Gradison Jr. (R-Ohio). "On that point, we have made no useful recommendation whatsoever."

But Sen. Jay D. "Jay" Rockefeller IV (D-W.Va.), the commission chairman, called the proposal a "blueprint" and suggested it was the role of the tax-writing committees of Congress to decide on financing. He said the panel had made a breakthrough by estimating the cost of the health care expansions. "This commission has laid out a plan, and it can work," Rockefeller said.

Sen. Edward M. Kennedy (D-Mass.), another member, denied it was the commission's role to recommend a financing mechanism. "We're not the [Senate] Finance Committee or the [House] Ways and Means Committee," Kennedy said.

Rep. Dan Rostenkowski (D-Ill.), the Ways and Means chairman, criticized the panel for producing what he called incomplete recommendations, saying "when the question of financing arose, it ducked. That sort of evasion is unacceptable in today's budget climate."

Congress established the U.S. Bipartisan Commission on Comprehensive Health Care in the 1988 legislation that created "catastrophic" health coverage under Medicare, benefits that were repealed last year. The panel is commonly called "the Pepper Commission" after the late Rep. Claude Pepper of Florida, its first chairman and a tireless advocate for the elderly. At Pepper's insistence, the panel was established as a way to ensure Congress would return to the issues of long-term care and the uninsured.

A fact sheet distributed on commission letterhead yesterday said the law creating the panel directed it to make "specific recommendations" on financing and "consider" the amount of federal funds neccessary and "the sources of those funds."

In general terms, the panel agreed that "the final tax package ought to be progressive," taxpayers of all ages should contribute and revenues would need to grow 8 percent to 9 percent a year. In addition to federal costs of $42.8 billion for long-term care and $23.4 billion for covering the uninsured, businesses would absorb an estimated $20 billion in costs.

Under the long-term care proposal, state and federal governments would finance a nursing home program that would provide social insurance for a three-month stay and would not require residents to be impoverished before becoming eligible, as has traditionally happened under Medicaid. An individual could keep $30,000 in assets and a couple, $60,000. Private insurance would fill gaps in the nursing home program. In-home care would be provided to severely disabled persons through the social insurance.

To cover uninsured persons, most of whom are employed, large businesses would be required to offer specific health benefits to their workers or pay into a public health plan. The same mandate would apply to businesses with fewer than 100 employees if 80 percent of the uninsured in their ranks were not voluntarily covered. Small businesses would receive tax credits and subsidies.

The public health plan would replace Medicaid, the state-federal program for the poor. The unem-

ployed could buy coverage in the plan or would be subsidized.

A range of reactions to the commission's proposals came from business, health and elderly groups as well as public officials.

Health and Human Services Secretary Louis W. Sullivan, whom President Bush has asked to study the same issues, said disagreement among panel members "reflects the simple fact that there is no consensus in our country today on how to achieve the kind of health care system we want."

The U.S. Chamber of Commerce reiterated its traditional opposition to government mandates on health benefits. The Health Insurance Association of America complained that costly health coverage would go to "middle and upper income Americans who are able to pay for that coverage themselves."

Reviews from groups representing the elderly were mixed. Families United for Senior Action embraced the proposal. The National Council of Senior Citizens criticized the lack of a financing plan. And the American Association of Retired Persons, battered by some members for backing the catastrophic coverage law, said it would withhold judgment until its board meets later this month.

COMMISSION RECOMMENDATIONS

UNIVERSAL HEALTH CARE COVERAGE

- Businesses with more than 100 employees would provide private health insurance (for a specific benefit package) or contribute to a public plan for all employees and non-working dependents.
- Businesses with 100 or fewer employees would be encouraged to provide health insurance for employees and non-working dependents. Tax credits for some small employers would be available.
- The public plan would cover employees and dependents that contribute and non-working individuals who buy in or are subsidized. The plan would replace Medicaid for the specified services and would pay providers according to Medicare rules.
- The minimum benefit package would include primary and preventive care, physician and hospital care and other services. Services are subject to cost-sharing, with subsidies for low-income people and limits on out-of-pocket spending.

LONG-TERM CARE

- The commission plan would establish a Nursing Home Program for nursing home care that would provide financial protection and ensure that no one faces impoverishment.
- Nursing home patients would be entitled to social insurance for the first three months of nursing home care. Such "front-end" insurance would allow people who have short stays to return home with resources intact.
- Severely disabled persons would be eligible for social insurance for home and community-based care.
- The federal government would finance the home and community-based care program and the "front end" nursing home care. The federal and state governments would share in financing the Nursing Home Program.
- Private long-term care insurance would fill gaps not covered by the plan, subject to government oversight.

SOURCE: U.S. Bipartisan Commission on Comprehensive Health Care

THE WASHINGTON POST

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Consummate Consumer

The Long-Term-Care Tangle

Too Often Medical Misfortune & Financial Ruin Go Hand-in-Hand

By Nancy L. Ross
Washington Post Staff Writer

When 86-year-old Mabel Crim's 88-year-old husband became incapacitated by a series of strokes, she put him in a nursing home near her Florida apartment. Little did she realize that paying for his care meant she was obliged by the state to exhaust all but $1,200 of their savings and live on $100 a month before her husband could get public assistance.

"My parents—hard-working good citizens—hadn't ever dreamed they would end up . . . destitute," recalls their daughter, Iona Gilbert of Arlington, who had to support her mother.

Washington painter and musician James McLaurin, 38, had his group health insurance policy canceled after he was fired from his job. Broke, evicted from his apartment and diagnosed with AIDS, he was too weak to work. After two years on Medicaid, during which he got free treatment at a veterans hospital, he became eligible for Medicare, but Medicare doesn't pay enough to afford him the better care he seeks at a private hospital. He has made a public appeal for funds for the Whitman-Walker Clinic in whose house he lives. "If you have AIDS, you are going to go broke; that's just a fact," says McLaurin.

Michael Sheekey, 5, has a rare chronic degenerative disease called Hurler's syndrome. His sister died of it two years ago. Because health insurance did not cover home care and his parents, Marilyn and Arthur Sheekey of Springfield, are not wealthy, Laura was forced to spend her short life in a hospital. The Sheekeys say they hope they will not have to face the same travail with Michael.

Daniel DiManna, 62, of Gaithersburg has had Alzheimer's disease for eight years. He and his wife, Virginia, also 62 and disabled, spent a third of their assets on medical bills. When Social Security disability ran out last year, Medicare would not pay for custodial care for him, estimated at around $30,000 a year. Eventually he was accepted at a Pennsylvania veterans hospital where the annual fee is about $2,000.

Too often a medical misfortune becomes a financial misfortune as well. The changes in Medicare that went into effect at the beginning of the year help ease the costs of catastrophic illness but do little or nothing for the kind of extended care needed by the people in the aforementioned cases.

The outcome might have been different if they had been covered by private long-term-care (LTC) insurance. This quite new form of coverage is being promoted as a means of protecting policyholders and their families against the financial hardships of prolonged nursing-home stays or medical care at home.

"Most people can contemplate the inevitability of their own death, but very few can envision being incapacitated," says William Arnone of Buck Consultants, a New Jersey benefits consulting firm. Americans routinely buy insurance that amounts to a bet with a company on when they will die, but they are loath to bet on how that will happen.

The lifetime odds that a person will wind up in a nursing home for a prolonged, financially ruinous stay are small, far less than those of contracting cancer. Yet, by the time a person gets older and starts to think about the possibility of infirmity, the risk has greatly increased: Almost a third of males over 65 will spend some time in a nursing home, as will 54 percent of women.

In the future, the number of patients is expected to grow rapidly, due not only to the graying of America, but also because of the AIDS epidemic. Moreover, there are 1 million children with severe chronic illnesses, some of whom require nursing care in a facility or at home. The Health Insurance Association of America (HIAA) estimates that by 1990 about 7.7 million Americans will need some form of long-term care. The collective annual bill for nursing homes now exceeds $35 billion.

The average stay for elderly patients in a nursing home is 2.5 years. The average annual cost of skilled care runs $25,000; custodial care costs $11,000 or more. In the Washington area, nursing-home-care costs average $42,000.

Most individual LTC insurance offers a fixed amount per day—typically $50-80—over a set period of, say, two to four years. It may also pay for some home care. Premiums depend on the benefit level selected and the age of the new policyholder. A 70-year-old woman might pay $900 a year for a $50 daily benefit for two years; $80 a day for four years would cost 3½ times that. Options like no limit on length of stay or benefits adjusted for inflation boost rates even more.

Selling LTC policies to young adults would reduce the cost for all. But there are both financial and psychological hurdles. These people willingly buy life insurance that pays off a set amount years later. What at the time of purchase seems like a reasonable amount to help the family if the breadwinner dies young, often erodes to a token sum for the heirs if the policyholder dies old. Yet that kind of policy will not pay for a nursing home stay down the road.

While many employers have been slow to offer workers LTC insurance at low group rates, a score of major corporations have begun the trend, according to the Chicago-based consulting firm Hewitt & Associates.

(continued)

Workers usually are required to contribute. Participants often are in their forties. Still, only 7 or 8 percent of active workers elect LTC coverage, compared with twice as many retirees, Hewitt notes.

The purpose of LTC insurance is to guard one's assets, with Medicaid providing for one's medical needs, if necessary. The United Seniors Health Cooperative (USHC), a nonprofit Washington group concerned with the quality and cost of health care, makes this recommendation: "If you have a substantial estate, over $50,000 excluding home and cars, then insurance may make sense for you. If you have less than $50,000 in savings, even with an insurance policy paying, you quickly will spend your savings for nursing-home care, making you eligible for Medicaid."

For example, a person with an annual income of $40,000 and $100,000 in assets who takes out a policy in 1989, will through private funds and insurance be able to finance 4.5 years in a nursing home in the year 2000. On the other hand, a person with income of $15,000 and $25,000 in assets would need public assistance after the first year. The average length of custodial care, the most common type of nursing home care, is 2.2 years.

Another financing method is self-insurance, which requires the discipline to set aside an amount equivalent to a premium in a safe investment. The money remains the property of the owner, not the insurance company, in case it is not needed for nursing-home care. A person who saves $1,000 a year, starting at age 40, would be able to pay for 16 months of nursing-home care by age 65, according to consumer advocate Esther Peterson.

The number of companies selling individual LTC coverage has quadrupled to about 100 in the past four years. There now are an estimated half-million LTC policies in force, of which about 18,000 are employer-sponsored.

In 1987 the General Accounting Office reviewed 33 policies offered by 25 insurers and concluded, "The potential for abuse related to both unclear policy language, especially with regard to coverage limitations, and abusive marketing practices exists . . . just as it does in the Medigap market."

Consumers Union, the nonprofit testing organization that publishes Consumer Reports, found the 53 policies it studied "a crazy quilt . . . that confuses even the insurance agents who sell the policies." Its executive director, Rhoda H. Karpatkin, declared, "Even if people could afford the premiums, these policies don't usually cover existing health problems until six months have passed, and they're often unclear about whether they cover Alzheimer's disease."

An example of the differing costs is offered by Joe A. Mintz of Dallas, a former insurance agent turned consumer advocate. He recently analyzed individual LTC policies issued by five insurers by applying the contract terms to a hypothetical case: Five men, 65, felled by a mysterious disease, all received the same treatment. During their four months' illness, each had two separate stays in a nursing home, convalescent care at home and spent time at an adult day-care center. The total bill for each, excluding physician's fees, medication, private duty nurses and amenities such as television, was about $30,000.

The amount paid by the carriers ranged from a low of $10,750 for one man to a high of $25,250 for another. And, although the five paid different annual premiums, ranging from $735 to $1,180, the disparity in claims paid ranged from 9.1 times the premium to 32.8 times the premium. In fact, the man who paid the highest premium actually received the smallest benefit due to the restrictions and exclusions in his policy. (If his stay in the nursing home had been lengthy, however, he would have received the most benefits of the five.)

The comparison illustrates the importance of checking restrictions and limitations—the proverbial fine print in the contract that can often mean the difference between collecting benefits and receiving nothing at all—in selecting LTC insurance coverage.

A 1988 study by USHC found that the chances a policyholder will collect no benefits after entering a nursing home were 61 percent. Only 18 percent of the policies issued offered an even chance of ever paying benefits. To improve the odds, USHC makes the following recommendations:

- Do not buy a policy that requires a prior hospitalization.
- Do not buy a policy without a written statement that it covers Alzheimer's disease.
- Do not buy a policy unless it has a guaranteed renewability clause.
- Do not buy a policy unless it offers a guard against inflation for a reasonable additional premium.

Other general cautions include not buying multiple policies, reading the terms before purchase and dealing only with insurance companies that carry an industry rating of A or better.

Consumers Union found that 72 percent of the policies it analyzed required prior hospitalization, yet about 60 percent of insured patients enter a nursing home without prior hospitalization, so they collect nothing.

There have been some recent improvements in coverage:

- Starting this year, Medicare will pay more for skilled nursing home care and some home health care. Moreover, HIAA observes, "Newer products are providing more comprehensive noninstitutional benefits, including adult day care."
- In late 1988 the National Association of Insurance Commissioners (NAIC), a body of state executives that develops model legislation on insurance, passed an amentment that closed the loophole that carriers exploited to avoid paying for Alzheimer's: NAIC now recommends that no prior hospitalization be required before a policyholder is eligible for benefits. It also voids the need for getting skilled care first in order to collect for custodial care.

Half of the states—including Maryland, Virginia and D.C.—have passed the original LTC model legislation; they now will have to pass or adopt the amendment before many more persons can benefit. It is not retroactive for policies in effect. Upgrading coverage probably will increase the premium significantly, maybe even doubling it.

Of the factors determining the future of LTC insurance, none is more important than the role of the federal government. Despite recent growth, LTC insurance is on hold at many companies as they await word from Congress on whether they will assume primary responsibility or will fill in the gaps as they do with Medicare.

The issue of who should pay for long-term care is hotly debated. In 1987 a presidential task force on LTC insurance recommended that it be

handled primarily through the private market, with a safety net for very low-income people.

Alice M. Rivlin, former director of the Congressional Budget Office, and Joshua M. Wiener, both of the prestigious Brookings Institution, last year called for a combined approach. They recommend treating LTC like any other medical expense; i.e., people contribute to a government program and draw benefits "without the stigma of a means test."

The American Association of Retired Persons suggests a program of long-term care for people of all ages, based on expanded Medicare and supplemented by private insurance. In the 100th Congress about half a dozen bills were introduced to augment the government's role.

The recent change in Medicare means that at-home spouses like Mabel Crim could have kept more of her assets and income. Elimination of the prior hospitalization requirement by private insurers could aid Alzheimer's patients like Daniel DiManna. But James McLaurin, who has AIDS, and Michael Sheekey with Hurler's syndrome, probably would benefit only from passage of legislation increasing the federal government's role.

Resources

Among publications and other resources:

- "Long-Term Care: A Dollar and Sense Guide," by Susan Polniaszek, United Seniors Health Cooperative, 1334 G St. NW, Suite 500, Washington, D.C. 20005. $6.95.
- "Long-Term-Care Insurance: Tips and Traps, 50 Major Questions," by Joe A. Mintz, P.O. Box 12066, Dallas, Tex. 75225. $2.
- "Who Can Afford a Nursing Home," Consumers Union Reprints, P.O. Box CS 2010-A, Mt. Vernon, N.Y. 10551. $3.
- "The Consumer's Guide to Long-Term Care Insurance," Health Insurance Association of America, 1025 Connecticut Ave. NW, Washington, D.C. 20036. Free.
- Insurance company ratings, A.M. Best Co., Ambest Road, Oldwick, N.J. 08858. $10 for 2 to 25 companies.

Ways, Means

- **Medicare:** Federal program for those over 65 and some disabled persons. It covers up to 150 days a year of skilled care in a nursing home, defined as daily nursing and rehabilitative care in an approved facility where a registered nurse is always on duty and supervised by a physician. The patient pays $20.50 per day for the first eight days, nothing more until day 151. It covers 38 consecutive days of care, six days a week, one or more visits per day for skilled nursing care at home. It covers hospice care for the terminally ill.

Medicare does not cover intermediate care, defined as occasional nursing and rehabilitation based on a physician's orders in a licensed facility where a registered nurse is on daytime duty. It does not cover custodial care, or assistance with daily activities like eating, bathing by nonmedical personnel but based on a physician's orders. This is the most frequent type of nursing home care.

- **Medicaid:** Federal and state program for financially needy persons. The spouse of a nursing home patient can keep about $786 of income a month and $12,000 in assets. It covers intermediate, custodial and home care, which includes skilled nursing, adult day care, and respite care to give family members a break.
- **Medigap:** Private insurance supplementing Medicare. It does not cover long-term care.
- **Long-term care insurance:** It may or may not cover custodial nursing home care, depending on policy terms.

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CRS Issue Brief

Long-Term Care for the Elderly

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by
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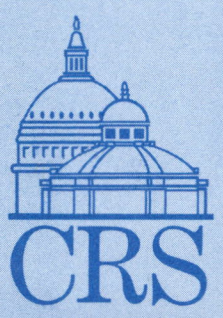

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Long-Term Care for the Elderly

SUMMARY

Policymakers over the years have struggled with issues related to the potentially catastrophic expenses of nursing home care as well as the need and demand for expanded home and community-based care by impaired elderly and their families. Recent congressional legislation on catastrophic health insurance for the elderly focused new attention on the uncovered liability many elderly face for long-term care services.

Expenditures for long-term care services, principally nursing home care, strain the private resources as well as the budgets of public programs. Nearly all private spending for nursing home care is paid directly by the consumer out-of-pocket, since only very limited third party insurance is available to cover this care. With average annual nursing home care costs about $25,000, out-of-pocket spending for long-term care services of an extended duration can represent an expenditure beyond the financial reach of most elderly persons. Medicaid, the Federal-State program for the poor, pays for long-term stays in nursing homes, but only for persons who meet strict income and assets rules.

While significant public resources are devoted to institutional care, comparatively limited funding supports home and community-based services, which are preferred by the elderly and their families over institutional care. Legislation enacted over the years has taken an incremental approach to expansion of such services.

Developing a strategy for changes in public sector programs to address these two broad problems, namely, assisting the elderly to pay for the catastrophic costs of nursing home care as well as expanding support for nonmedical home and community-based services, is difficult for a number of reasons. These include the complex interrelationships of Federal and State programs currently supporting long-term care, but especially, uncertainty about future costs of expanded benefits and eligibility. In addition, observers differ in their views about what the respective public and private sector responsibilities should be in financing long-term care.

Bills introduced in the 101st Congress, and others introduced in the 100th Congress, reflect a wide range of approaches for reforming the way long-term care services are financed, as well as divergent views on what the public and private sector roles should be in any reform. Some bills have taken an incremental approach to public sector financing. Others propose a social insurance program providing universal and comprehensive long-term care coverage for those in need of care regardless of their financial circumstances. Still others define for the private sector a role in financing the costs of long-term care. The U.S. Bipartisan Commission on Comprehensive Health Care, often referred to as the Pepper Commission, recently reported its recommendations for revising the way long-term care should be financed in this country.

ISSUE DEFINITION

The financing and delivery of long-term care for the elderly is an important policy issue for the Congress for a number of reasons. Paying for long-term care services, especially nursing home care, can represent a catastrophic expenditure that impoverishes many elderly persons and their families. In addition, significant Federal resources are devoted to nursing home care through the Medicaid program, while only limited funding supports home and community-based services that the elderly and their families generally prefer over institutional care. These problems are expected to become more acute as a rapidly aging population faces the need for long-term care. The Medicare Catastrophic Coverage Act of 1988, P.L. 100-360, did not address the uncovered liability many elderly face for long-term care costs. This gap in coverage was criticized by many observers during the recent debates on repeal or amendment of that legislation.

The 101st Congress has seen a broad range of long-term care bills introduced for consideration. Some bills focus on large scale revision of the way long-term care is financed through public programs, primarily through an expansion of Medicare coverage of institutional and/or home and community-based services. Out of concern for the costs of any expansion of publicly financed long-term care benefits, Congress has also become interested in private sector approaches to the financing of long-term care. Among private sector approaches, private insurance has received the most attention and a variety of proposals have been introduced to define a broader role for private insurance in financing long-term care for the elderly. In addition to bills introduced, the Pepper Commission has developed a long-term care proposal to be considered by Congress.

BACKGROUND AND ANALYSIS

"Long-term care" refers to a wide array of medical, social, personal, supportive, and specialized housing services needed by individuals who have lost some capacity for self-care because of a chronic illness or condition. Although chronic conditions occur in individuals of all ages, their incidence, especially as they result in disability, increases with age. These illnesses and conditions include heart disease, strokes, arthritis, vision and hearing impairments, and dementia.

Long-term care services range from skilled medical and therapeutic services for the treatment and management of these conditions to assistance with basic activities and routines of daily living, such as bathing, dressing, eating, and housekeeping. These services are provided by skilled personnel, such as registered nurses, therapists, and social workers as well as other personnel, such as homemakers and home health aides. Family members and friends also play a key role in providing long-term care services. Services can be provided in institutions (generally nursing homes), in the community, or in the home.

Congress has considered issues related to the financing of long-term care services for the elderly for many years. Recent congressional legislation on catastrophic

health insurance for the elderly (P.L. 100-360) focused new attention on the potentially high out-of-pocket payments many Medicare beneficiaries face for services not covered by Medicare, especially nursing home care, and their lack of coverage for home and community-based long-term care services.

The average annual cost of nursing home care is about $25,000, representing a catastrophic expenditure beyond the financial reach of most elderly persons. Only one public program, Medicaid, the Federal-State health program for the poor, covers long-term stays in nursing homes. It does so, however, only for those persons who meet strict income and assets rules. For many elderly persons facing the catastrophic expenses of nursing home care, these rules require that they first apply most of their assets and income toward the cost of their nursing home care before they can become eligible for Medicaid coverage.

Medicaid rules also affect the income and assets of spouses of nursing home residents needing assistance with the cost of their care. Under Medicaid rules, the amount of income protected for the basic living expenses of the spouse remaining in the community has been limited in most States to levels below the Federal poverty level. As a result, these Medicaid rules have had the effect of impoverishing spouses of Medicaid-eligible nursing home residents. P.L. 100-360 liberalized these rules to protect higher levels of income and assets for the spouse remaining in the community.

By far the great majority of Federal and State spending for long-term care is for nursing home care under the Medicaid program. Public programs provide only limited support for nonmedical home and community-based long-term care services. Over the years, Congress has struggled with ways to expand public financing for home and community-based care, especially in view of the fact that the elderly and their families prefer this care to nursing home care. Congress has proceeded very cautiously in expanding public financing for home and community-based care out of concern with its costs.

Long-term care financing issues are expected to become more pressing in years to come, given demographic trends of the elderly population and projections of utilization of long-term care services. Currently 1.3 million elderly persons are residents of nursing homes. For every elderly person in a nursing home, there are at least twice as many persons living in the community requiring various kinds of care and assistance. Estimates show that if rates of nursing home use remain the same, about 3.8 million elderly will reside in nursing homes by 2030. The disabled elderly population living in the community might include up to 10.1 million persons by 2020 and 14.4 million persons by 2040.

Public and Private Spending for Long-Term Care

Comprehensive data on total national spending for long-term care, from public and private sources, through Federal and State programs, and for institutional and non-institutional care, are difficult to obtain. The most recent attempt to quantify this spending was made by the Congressional Budget Office (CBO) for FY1985, shown in **TABLE 1**. CBO preliminary estimates show that in FY1985 total public and private spending for both nursing home and certain home health care services amounted to about $45 billion. This total is for all age groups using long-term care. Of this total, about $36 billion, or about 80% of total long-term care expenditures, was spent for nursing home care. Public programs paid $19 billion, or 53% of the Nation's total spending for nursing home care. Federal and State Medicaid payments for nursing home care accounted for $17 billion of this $19 billion total.

TABLE 1. Summary of Spending for Long-Term Care, FY1985 by Source of Payment and Type of Service
(in billions of dollars)

	Public programs (Federal and State/local)	Private sources (out-of-pocket, insurance, and other)	Total all services
Nursing home care	$19.0	$16.7	$35.8
Home health care	4.5	4.6	9.1
Total	23.5	21.3	44.9

Source: Preliminary Congressional Budget Office estimates, based on data supplied by the Actuarial Research Corp. Totals may not add due to rounding. Home health services exclude certain nonmedical services.

Private spending for nursing home care amounted to about $17 billion in FY1985. Nearly all (97%) private spending for nursing home care is paid directly by consumers out-of-pocket. Private insurance coverage for long-term nursing home care is very limited, with private insurance payments amounting to less than 1% of total spending for nursing home care in FY1985.

CBO estimates that total spending for home health care amounted to about $9 billion in FY1985. This amount represents about 20% of total spending for all long-term care services. These estimates for home health care should be approached with caution since certain public program and private spending data for home health care are especially difficult to aggregate. In addition, CBO's total for home health care does not include spending for certain nonmedical home and community-based care services. CBO estimates that the $9 billion total for home health care spending was about evenly split between public and private sources of payment. Out-of-pocket

expenditures accounted for about 80% of private spending, private insurance again being very limited for this care. Most home and community-based care is provided by family and friends. One recent survey found that more than 70% of the functionally impaired elderly living in the community relied exclusively on unpaid sources, generally family and friends, for the assistance they need.

Major Federal Programs Supporting Long-Term Care

Five programs represent the major source of Federal financial support available for nursing home and community-based long-term care -- Medicaid, Medicare, the Social Services Block Grant (SSBG), the Older Americans Act, and the Supplemental Security Income (SSI) program. No one of these programs supports the full range of long-term care services. Certain programs provide health services while excluding social services. Others provide strictly social services. Some have income eligibility requirements, others do not. Some observers contend that these varying characteristics reflect the fragmented and uncoordinated nature of Federal support for long-term care.

Medicaid is the Nation's major program of financial support for long-term care, principally because of its coverage of nursing home care. Medicaid payments for nursing home care (excluding nursing homes for the mentally retarded) amounted to 30% of total Medicaid spending in FY1986, and two-thirds of Medicaid payments made on behalf of the elderly that year. Comparatively little funding is devoted to home and community-based care. Coverage of both nursing home and home and community-based services is restricted to those persons who have limited income and assets. In general, Medicaid rules limit eligibility to those persons who qualify for cash welfare assistance or who incur large health care expenses that deplete their income and assets.

Medicare, the Federal health insurance program for the elderly and disabled, is focused primarily on acute health care and was never envisioned to provide protection for long-term care. Coverage of nursing home care, for instance, is limited to short-term stays in certain kinds of nursing homes, referred to as skilled nursing facilities, and only for those persons who demonstrate a need for daily skilled nursing care. Many persons who require long-term nursing home care do not need daily skilled nursing care, and, therefore, do not qualify for Medicare's benefit. As a result of this restriction, Medicare paid for less than 2% of the Nation's expenditures for nursing home care in 1988.

For similar reasons, Medicare pays for only limited amounts of community-based long-term care services, primarily through the program's home health benefit. To qualify for home health services, the person must be in need of skilled nursing care on an intermittent basis, or physical or speech therapy. Most chronically impaired persons do not need skilled care to remain in their homes, but rather nonmedical

supportive care and assistance with basic self-care functions and daily routines that do not require skilled personnel.

Three other Federal programs -- SSBG, the Older Americans Act, and the SSI program -- provide support for community-based long-term care services for impaired elderly persons. The SSBG provides block grants to the States for a variety of home-based services for the elderly as well as the disabled and children. The Older Americans Act also funds a broad range of in-home services for the elderly. Under the SSI program, the federally-administered income assistance program for aged, blind, and disabled persons, many States provide supplemental payments to the basic SSI payment to support selected community-based long-term care services for certain eligible persons, including the frail elderly. However, since funding available for these three programs is limited, their ability to address the financing problems in long-term care is also very limited.

Major Themes of Reform

While issues related to the financing of long-term care have received a great deal of attention recently, this concern is not new. Creation of Federal task forces on long-term care issues, as well as Federal investment in research and demonstration efforts to identify cost-effective "alternatives to institutional care," date back to the late 1960s and early 1970s when it was becoming evident that payments for institutional care were consuming a growing proportion of public expenditures. The awareness that public programs provided only limited support for community-based care, as well as concern about the fragmentation and lack of coordination in Federal support for long-term care, also led to the development of a number of legislative proposals beginning in the mid-1970s. Over the years, bills have variously proposed (1) establishing in Medicare new comprehensive long-term care benefits; (2) consolidating certain existing benefits of the Medicare, Medicaid, and SSBG programs into a new program of Federal support for long-term care with uniform benefits and eligibility; and (3) providing block grants to the States for expanded home and community-based care.

While a number of proposals to provide for large scale reform have been considered by Congress over the years, enacted long-term care legislation has taken an incremental approach, principally through limited expansion of existing program support for home and community-based services. Congress has proceeded cautiously in expanding community-based care for a number of reasons. Federal long-term care demonstrations have generally shown that expanded community-based services represent new costs that are not offset by reductions in nursing home spending. In addition, policymakers are concerned about the unpredictability of the demand for community-based care.

Incremental changes enacted into law have included 1981 legislation authorizing the Secretary of the Department of Health and Human Services (DHHS) to approve

waivers of certain Medicaid requirements to allow States to broaden coverage for a range of community-based long-term care services under their Medicaid plans (known as the "2176 home and community-based waiver" program). In 1982, Congress also established a new Medicare hospice benefit that provides broad home care coverage to terminally ill Medicare beneficiaries. Another incremental change enacted by Congress in 1987 gave States limited new authority to provide in-home services for the frail elderly under the Older Americans Act. While the Medicare Catastrophic Coverage Act of 1988 did not comprehensively address long-term care, it contained a limited respite care benefit for certain chronically dependent beneficiaries, and a liberalization of certain income and asset requirements for spouses of Medicaid nursing home residents.

Issues in 101st Congress Legislation

Legislation introduced in the 101st Congress includes a variety of approaches to financing long-term care services. Many bills share with past proposals goals of providing additional financing for home and community-based care. For example, H.R. 2263 (Pepper) would establish in Medicare new home care benefits for chronically ill aged, disabled and children; H.R. 3933 (Wyden)/S. 1942 (Rockefeller) would allow States to cover a broad range of nonmedical home and community-based services for disabled elderly as an optional service under their Medicaid programs; H.R. 3203 (Stark) would amend SSI to provide targeted income supplements to low income aged and disabled persons in need of home and community-based care. Other bills, H.R. 3140 (Waxman) and S. 2163 (Kennedy), would finance comprehensive home and community-based services and establish new nursing home benefits. Other bills provide various tax incentives for private financing of long-term care services.

While there seems to be a consensus on the problems that exist, Congress has not yet agreed on a strategy for addressing them. Policymakers differ in their views about what the respective public and private sector responsibilities should be in financing long-term care services. Some believe that the Federal Government should assume the major role in financing additional long-term care services. Others believe that the costs of any public sector expansion may be prohibitive and that the private sector, through insurance and other risk-pooling mechanisms, should take the lead. Still others believe that a combination of public and private sector strategies is needed.

Public and/or Private Sector Strategies

Whereas in the past the focus of debate on long-term care reform had been almost exclusively on public program support, today there is interest in defining for the private sector a role in financing the costs of long-term care. This interest has occurred as a result of concern with large Federal budget deficits as well as increasing expenditures under the Medicare and Medicaid programs. Also, some analysts point out that the economic status of future generations of the elderly may

improve so as to allow them to protect themselves against some of their long-term care costs, if only a risk-sharing mechanism were available to make these costs affordable.

The wide range of proposals of the 100th and 101st Congresses reflects the divergent views as to what public and private sector responsibilities should be for financing long-term care. Approaches range from those that would establish totally public benefits, without a role for the private sector, or private insurance, in particular, to those that would rely almost exclusively on the private sector -- whether this be individuals or insurance -- to provide the additional financing needed by the elderly for long-term care.

S. 2163 (Kennedy), for example, would establish in a new title of the Public Health Service Act, a long-term care program covering nursing home and home care for certain chronically disabled persons of all ages regardless of financial circumstances. Benefits would be primarily publicly financed, without deductibles or significant copayments. This bill aimed to assure that additional sources of private financing are unnecessary. H.R. 2263, introduced in the 101st Congress, takes a similar approach to public sector financing of long-term care, but focuses coverage strictly on home and community-based care.

At the other end of the spectrum are bills that leave to the private sector the responsibility for providing the additional financing needed for long-term care. Some of these bills would provide tax incentives to individuals for the care they provide others. Other bills would provide tax incentives for saving for long-term care needs. Still others would provide tax incentives to individuals and employers for the purchase of private insurance to encourage the growth of this market. These bills include, among others, H.R. 388, H.R. 421, H.R. 1010, S. 139, S. 140, and S. 141, all of the 101st Congress. The cost of this approach is limited to the revenues that would be lost for providing tax deductions for various purposes.

In between are bills that would establish comprehensive long-term care benefits at the Federal level, but to a greater or lesser extent, would include with these new benefits certain beneficiary cost-sharing responsibilities that could be financed through the purchase of private insurance. H.R. 3140 (Waxman), introduced in the 101st Congress, and H.R. 5393 (Stark), introduced in 1988, would each establish in Medicare comprehensive nursing home and home care benefits that would be accompanied by limited copayments and deductibles. For those below 200% of the Federal poverty level, Medicaid would share in the cost of these copayments and deductibles. Others who could afford to do so could purchase private long-term care insurance. In this case, private insurance would function as a supplement to Medicare benefits in the way that "medigap" policies have paid for costs of acute care benefits not covered by Medicare.

Another bill introduced in 1988, S. 2305 (Mitchell), would create a larger role for private insurance than the medigap model, specifically with regard to coverage of a chronic nursing home benefit. Under this proposal, persons would be required to

incur the first 2 years of nursing home costs before a new Medicare nursing home benefit would begin to pay. Since studies of nursing home utilization have shown that 75% of persons entering a nursing home stay less than 1 year, and 83% stay less than 2 years, most persons would either have to rely on out-of-pocket payments for their care or purchase insurance to cover the costs. This benefit has been designed to encourage private insurers to develop policies and persons to be able to afford long-term care insurance.

Pepper Commission Long-Term Care Recommendations. The Pepper Commission's recommendations for long-term care reform would also use a public/private insurance model for financing expanded long-term care benefits. The Commission's proposal includes three components: (1) a federally financed social insurance program covering home and community-based care for severely disabled individuals of all ages; (2) a federally financed social insurance program covering the first 3 months of a nursing home stay; and (3) a means-tested Federal and State financed nursing home program covering stays beyond 3 months that would protect certain levels of income and assets of persons needing care. For both the home and community-based care program and the first 3 months of a nursing home stay, individuals would be responsible for 20% of the costs of care, with the Federal government subsidizing this required cost sharing for persons with incomes below 200% of the Federal poverty level. For the nursing home program that would cover stays longer than 3 months, individuals would be required to apply to the cost of their care non-housing assets above $30,000 for single persons and $60,000 for married persons, before the program would begin to pay for care. Individuals would also be required to contribute to the cost of their care income that remains after certain set-asides for housing and personal needs were made. Private long-term care insurance could fill in the gaps not covered by this plan. The Pepper Commission has estimate the costs of these benefits to be $42.8 billion (in 1990 dollars).

Private Long-Term Care Insurance. Private long-term care insurance is a relatively new, but rapidly growing, market. In 1987, a DHHS Task Force on Long-Term Care Insurance found 73 companies writing long-term care insurance policies covering 423,000 persons. As of December 1989, the Health Insurance Association of America found that more than 1.5 million policies had been sold, with 118 insurers selling this coverage.

While private insurance is considered a promising option for providing the elderly additional protection for long-term care, observers have expressed concern with the quality of coverage offered under existing policies. Most plans are sold on an individual basis and provide indemnity benefits that pay only a fixed amount for each day of covered service, thereby limiting the insurers' liability. Generally these payment amounts are not indexed for increases due to inflation. In addition, policies often exclude from coverage certain preexisting conditions and have often required that covered care be medically necessary or follow a hospitalization. These provisions may be particularly restrictive for persons needing certain home care and personal care assistance.

In addition, long-term care insurance policies are considered to be unaffordable for large numbers of elderly persons. Many agree that a key to the future development and growth of the long-term care insurance market is increasing the affordability of premiums. One of the ways suggested to accomplish this is to expand the pool of persons to whom policies are sold. Some argue that employer-based group coverage, not available until recently, offers significant potential for expanding the long-term care insurance pool and reducing premium cost. Premiums should be lower in employer-based group coverage because younger age groups with lower levels of risk of needing long-term care would be included, allowing reserves to be built up. In addition, group coverage has lower administrative expenses. As of the end of 1989, 54 employers offered long-term care coverage to their employees, and these group policies covered about 51,000 persons. About half of the enrollees were active employees, and other half were retirees and their spouses and immediate relatives of the employee.

But just how broad-based employer interest is in a new employee benefit, let alone a long-term care benefit, is unclear at the present. Many employers currently face large unfunded liabilities for retiree pension and health benefits. Also, many employers have recently experienced fairly substantial increases in premiums for their current health benefits plans. In addition, employers offering coverage for long-term care have required their employees to assume the full premium cost of these plans. In contrast, the majority of medium and large size employers pay the full premium cost of regular health care benefits for their employees.

One other suggestion has been offered for increasing the affordability of long-term care insurance. This would involve limiting the exposure of the insurance company to the costs of long-term care services by creating new Federal benefits that would assume some portion of these costs. By defining in advance the specific liability for costs that private insurance companies would face, and limiting these costs, this approach assumes that private insurance companies will be able to offer policies that more people can afford and, at the same time, share substantially in the costs of care. This approach, often referred to as "stop/loss," is currently focused on nursing home care. Persons who need nursing home care would be responsible for the first 2 or 3 years of the costs of care and would presumably buy an insurance policy to provide that protection. After that exposure, a government program would pick up the cost, without requiring persons to deplete their income and assets on their care as is currently required under Medicaid.

There is interest at both the Federal and State levels in this idea. As noted, S. 2305, introduced in the 100th Congress, includes a 2-year exclusionary period for nursing home care before a new Medicare nursing home benefit would begin to cover the costs of care. Various States have begun to explore options for encouraging persons to purchase long-term care insurance by extending to those persons buying policies the protection of Medicaid without requiring depletion of income and assets. What impact this approach will have on the premium costs and marketability of private insurance for long-term care is unclear at the present time. It should be noted that the private insurance industry has expressed reservations about S. 2305's

approach for covering nursing home care and has suggested that premium costs may not be significantly reduced when a government program begins to pick up the costs for long-stay nursing home patients. The insurance industry suggests that initial age of purchase has more of an impact on premium cost than duration of coverage. According to the industry, when persons at younger ages purchase policies, the size of the pool sharing the risk expands greatly and reserves can be accumulated over longer periods to cover costs when benefits must be paid.

Issues Related to Services, Eligibility, Management, and Financing

Long-term care bills that propose new publicly funded long-term care benefits generally require resolution of a number of other issues including the following: what services should be covered; what eligibility criteria should be used for determining participation and how care for participants should be managed; what share of the costs of the program should be born by beneficiaries; what respective roles the Federal and State governments should play in the organization and management of the program; what provider reimbursement strategies should be used; and what financing mechanisms should be used.

Covered Services. Services that are generally considered critical services for chronically impaired elderly persons to remain in their homes are nonmedical support services, such as homemaker/home health aide services, adult day care, and services that relieve family caregivers from their responsibilities (generally referred to as respite care). Bills proposing new publicly funded long-term care benefits would provide broader coverage for some or all of these services. It should be noted that the insurance industry has approached coverage of these services with caution. Insurance companies have argued that many personal care and homemaker services tend to be uninsurable because of difficulty in confining eligibility to a limited number of persons. In addition, given the nature of many chronic conditions, insurance companies might face an open-ended liability for coverage of these services.

Some bills would also provide broader coverage of nursing home care. One approach would provide coverage after a person had first spent a certain length of time in a nursing home -- 2 months in the case of H.R. 3140 and 2 years in the case of S. 2305. Private insurance could play a role in covering these costs. Another approach contained in S. 2163 would cover the first 6 months of nursing home care under a public program; longer stays would be covered under a voluntary program financed by premiums and Federal revenues.

Eligibility. Bills proposing publicly financed benefits generally define eligibility for long-term care benefits according to a person's inability to perform one or more basic self-care functions called activities of daily living (ADLs). ADLs include such functions as bathing, dressing, eating, toileting, and/or mobility from one place to another. Using ADLs allows long-term care benefits to be targeted to a limited number of persons, and also enables the new benefit to be provided without regard to certain medical criteria commonly used to establish eligibility for health benefits. Eligibility criteria for health benefits, such as prior hospitalization or need for skilled nursing care, often have little to do with the social service needs of a chronically

impaired population and can limit access to services needed by a long-term care population.

Some proposals would also establish eligibility for expanded benefits on the basis of the existence of cognitive impairments. Many persons suffering from dementia or Alzheimer's disease, for example, may not have limitations in ADLs, but require supervision to carry out these functions.

While surveys have found up to 6 million elderly persons living in the community with varying ADL limitations, the number of such persons who would try to establish eligibility for new publicly financed benefits cannot be determined with any certainty. There is a paucity of data on utilization of long-term care services in an insured environment. Studies have shown that the great majority of elderly currently rely on family and friends to provide assistance with their needs. While studies have shown that families do not withdraw their support when expanded home and community-based care are provided under government demonstration projects, information does not exist to show what demand for services will be when a program permanently establishes new publicly financed long-term care benefits.

Role of the States. Currently State governments have substantial responsibility for long-term care. Not only do States administer home and community-based services authorized under the Medicaid, SSBG, and Older Americans Act programs, they also have responsibility for implementation and oversight of Federal standards governing nursing homes and home health care agencies receiving reimbursement under the Medicaid and Medicare programs. Over the past 10 to 15 years some States have made major strides in dealing with the complexities involved in coordinating the various Federal home and community-based long-term care programs and to overcome what they believe is a bias in Federal funding for institutional care.

State initiatives have included development of methods to control access to institutions through preadmission screening mechanisms; development of case management systems to authorize and control use of community-based services (sometimes through designation of local agencies to act as single entry points for long-term care services); and/or consolidation of State administration of the various long-term care services programs. In addition, some States have spent substantial State dollars to support home and community-based long-term care services to be responsive to the strong preference of the elderly for such care.

Some observers point out that a State role in the administration of an expanded publicly funded long-term care program may compromise a uniform benefit, with different and inconsistent determinations made about similar cases of need for long-term care services. Given the complexities involved in implementing and coordinating nonmedical long-term care benefits, however, other analysts and State officials argue that local governments must be involved in the administration of new Federal long-term care benefits and that States not only have the experience but are also in a good position to work with the multiplicity of local providers of care.

Enacted legislation that has incrementally expanded nonmedical home and community-based services, such as the Medicaid 2176 waiver program and the Older Americans Act, has built upon existing State roles. H.R. 3140 would require the Secretary to designate for each State a public or nonprofit agency to be responsible for assessment and eligibility determination for long-term care benefits. S. 2163 would require the Secretary to contract with a State or, if the State declines, a private nonprofit organization, to administer long-term care services. Other bills, such as S. 2305 and H.R. 5393, did not create specific roles for State government.

Role of Case Management. Case management generally refers to ways of matching services to an individual's needs. In the long-term care services context, case management generally includes the following components: screening and assessment to determine an individual's eligibility and need for a given service or program; development of a plan of care specifying the types and amounts of care to be provided; authorization and arrangement for delivery of services; and monitoring and reassessment of the need for services on a periodic basis.

Some State and local agencies have incorporated case management as a basic part of long-term care system development. The availability of Medicaid funds under the 2176 home and community-based waiver program has spurred the development of case management services; but, other sources of funds have been used by States to develop case management systems, including SSBG, Older Americans Act, and State funds.

Case management is carried out in a wide variety of ways. Organizational arrangements may range from systems in which case management functions are centralized in one agency to those in which some case management functions are conducted by different agencies. Case management may be provided by many community organizations, including home health agencies, area agencies on aging, and other social service or health agencies. In some cases where statewide long-term care systems have been developed, one agency at the community level has been designated to perform case management functions, thereby establishing a single point of access to long-term care services.

While there seems to be a certain degree of consensus as to the promise case management offers as a means to control utilization of long-term care services as well as to coordinate services, there does not yet appear to be an agreed upon strategy as to the most effective way to incorporate case management functions into expanded long-term care benefits. However, because there is a recognition that responsibility for client assessment and eligibility should be vested in a designated entity, most bills proposing new Federal long-term care benefits designate specific agencies to carry out some or all of the case-management functions.

Cost Sharing. Traditionally cost sharing through deductibles and copayments has been included in private and public health insurance plans as a way to control utilization of benefits and limit a plan's liability for the costs of services. Cost sharing in long-term care bills has taken two major forms. First, bills often include

deductibles that require beneficiaries to incur certain expenditures out-of-pocket before payments can be made on behalf of an individual. Cost-sharing can also take the form of copayments and coinsurance that require the beneficiary to share in the cost of any services received under the program.

The deductible and copayment requirements of some bills, e.g., S. 2305 and H.R. 5393, are also intended to define a role for private long-term care insurance in financing a portion of the costs of services. Another approach contained in S. 2163 would require individuals to pay 35% of nursing home costs for stays longer than 6 months. This amount is intended to represent the cost of room and board which the resident would have to pay if living in the community. This bill intends that new Federal long-term care benefits offer comprehensive protection, with additional insurance coverage unnecessary.

Reimbursement. The way long-term care services are reimbursed will have a significant impact on expenditures under any new program. Medicare currently reimburses covered home health and nursing home services on the basis of reasonable costs (defined by the program) that have actually been incurred for care provided to program beneficiaries, up to specified limits. This method has been criticized on a number of grounds, including its lack of incentives for providers to maximize efficiency and minimize costs. Most States use, at least in part, a prospective payment method for reimbursing nursing home care under their Medicaid programs. Prospective payment reimbursement establishes in advance of the time when services are provided, payment rates for care on a per visit, per case, per month, or other basis. Many bills would require that reimbursement for community and/or nursing home care be based on a fee schedule, or other prospectively-determined reimbursement mechanism, established by the Secretary.

Various Federal long-term care demonstrations have attempted to control payments for expanded home and community-based care by establishing caps on amounts that can be spent for services. Generally these have been linked to average Medicaid payments for nursing home care in the State, on the assumption that expanded services will serve as a substitute for institutional care and should cost less. The National Long-Term Care Channeling Demonstration, for example, required that average per client expenditures for expanded community-based care not exceed 60% of the average of the State's Medicaid rates for nursing homes in the demonstration area. Bills generally use some variation of this cap concept. Other bills, e.g., H.R. 3140, would limit payment for services based on an individual's level of impairment.

Financing. Bills proposing new publicly funded long-term care benefits recognize that new revenues would be required to finance these benefits. Cost estimates for these bills range from $7 to $9 billion per year for H.R. 3436 (introduced in the 100th Congress), very similar to this year's H.R. 2263, to $50 to $60 billion per year for H.R. 3140.

Financing issues in long-term care involve not only questions of how revenues will be raised, but also who should be paying the costs of expanded long-term care

benefits. To finance new expenditures, bills variously proposed increases in the Medicare payroll tax, increases in the Social Security payroll tax (generally, by applying these taxes to all income above the wage cap, currently $48,000), increases in Medicare Part B premiums, increases in supplemental premiums (or surtaxes) that finance Medicare catastrophic insurance, new estate taxes (on the grounds that expanded long-term care coverage under a public program protects assets that would be inherited by children or others), and deductibles and copayments for services received. Bills that proposed to provide tax incentives for the purchase of private insurance for long-term care also required new Federal expenditures, specifically tax expenditures that represent revenues lost to the Treasury. These various tax approaches are discussed in CRS Report 89-329, Tax Options for Financing Long-Term Care for the Elderly.

Financing questions also include concern about the adequacy of revenues to cover costs into the future. There is a good deal of uncertainty that accompanies any estimate of costs of new long-term care benefits for the future. Because of the lack of experience with utilization of long-term care in an insured environment, information does not exist to show what demand will be when a formal program of coverage is available for care. Nor does information exist about what the demand for services will be in the future as the population ages.

LEGISLATION

H.R. 3933 (Wyden)/S. 1942 (Rockefeller)

Medicaid Frail Elderly Community Care Amendments of 1990. Amends Medicaid to allow States to cover, for certain functionally disabled elderly persons, a broad range of nonmedical home and community-based care services as an optional service under their Medicaid programs. H.R. 3933 introduced February 1; referred to the Committee on Energy and Commerce. S. 1942 introduced Nov. 20, 1989; referred to the Committee on Finance. Earlier versions of these bills had been considered as part of the reconciliation process of 1989, but not included in the enacted OBRA 89, P.L. 101-239.

H.R. 2263 (Pepper)

Long-Term Home Care Act of 1989. Amends Medicare to provide coverage of long-term home care services to chronically ill elderly, disabled, and children who are functionally dependent in at least two ADLs. Limits payments for services to a certain percentage of institutional care costs, depending on the eligibility category of the individual and degree of impairment. Finances benefits through the elimination of the cap on income subject to the Medicare payroll tax. Introduced May 4, 1989; referred to Committees on Ways and Means and Energy and Commerce.

H.R. 3203 (Stark)

SSI Community Living Amendments of 1989. Authorizes funds to States for targeted income supplements on behalf of low income aged and disabled persons who need regular assistance with ADLs in their place of residence. Authorizes grants to

States to assist them in identifying and investigating unlicensed group living arrangements where SSI recipients live. Ties a State's eligibility for targeted income supplements for individuals to State implementation of procedures to identify and investigate unlicensed or unsafe group living arrangements. Introduced Aug. 4, 1989; referred to the Committee on Ways and Means.

H.R. 3140 (Waxman)

Elder-Care Long-Term Care Assistance Act of 1989. Amends Medicare to provide coverage of nursing facility and home and community-based services to chronically dependent persons. Payment for home and community services would be dependent upon an individual's degree of impairment and coverage would be limited to a specified number of hours per week. Payment for nursing facility care would be shared with beneficiaries who would pay 10% of the cost of care after 2 years of care and lower amounts before that time. Finances benefits through the elimination of the cap on income subject to the social security and Medicare payroll tax. Introduced Aug. 4, 1989; referred to the Committees on Energy and Commerce and Ways and Means.

S. 2163 (Kennedy)

Lifecare Long-Term Care Protection Program. Amends the Public Health Service Act to provide coverage for home and community-based care and nursing home care for functionally impaired persons. Payment for home and community-based care would be based on severity of dependency in ADLs, cognitive impairment, age, and other factors. Nursing home care would be covered in full for the first 6 months of needed care. An optional nursing home program would cover stays longer than 6 months if persons had enrolled by paying premiums beginning at age 45 or age 65. Introduced Feb. 22, 1990; referred to Committee on Labor and Human Resources.

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CRS Report for Congress

Long-Term Care Financing: Selected References

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Library Services Division

January 1989

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LONG-TERM CARE FINANCING: SELECTED REFERENCES

SUMMARY

This bibliography includes references on financing long-term care as a national issue. The articles cited discuss both public and private funding as well as the impact of catastrophic illness on long-term care policy. Materials were drawn from the CRS Public Policy Literature file (PPLT) and include articles from 1981 through 1988.

LONG-TERM CARE FINANCING: SELECTED REFERENCES

Brody, Stanley J.

Strategic planning: the catastrophic approach. Gerontologist, v. 27, Apr. 1987: 131-138. LRS87-2489

"Three major societal responses to the perceptions of catastrophe for the aging family are traced. The first two, the needs for basic subsistence and for access to acute care medicine, were resolved . . . . The third and unresolved catastrophe, the need for continuity of care, is defined, popular perceptions of that need evaluated, and a policy solution suggested."

Chollet, Deborah J. Friedland, Robert B.

Employer financing of long-term care. Washington, Employee Benefit Research Institute, 1987. 36 p. LRS87-14407

"Examines the potential for employer-based financing of long-term care among current and future retirees in the United States. Two assertions underlie our discussion: (1) employer-based plans have been and will continue to be a successful means of retirement saving; and (2) for most people, saving over one's working years is the most efficient way to finance long-term care."

Clinkscale, Robert M. Ray, Sheila S.

Survey of Medicaid home and community-based care waivers: FY1986. Columbia, Md., La Jolla Management Corp., 1987. ca. 75 p. in various pagings (Medicaid program evaluation working paper MPE 1.11) LRS87-14406

Partial contgents.--Status of waiver program implementation.--Waiver programs serving the aged and/or physically disabled.--Waiver programs serving the developmentally disabled and chronically mentally ill.--State perspectives on administration of the waiver programs.

Committee on Aging Society (U.S.).

America's aging: health in an older society. Washington, National Academy Press, 1985. 241 p. LRS85-15409

Partial contents.--Demographic aspects of the older population.--Waxing of the gray, waning of the green.--Active life expectancy: societal implications.--Health, disease, and cardiovascular aging.--Depressive illness in late life.--Aging and age-dependent disease: cognition and dementia.--Informal social support systems for the frail elderly.--Financing long-term care for the elderly: institutions, incentives, issues.

Completing the long term care continuum: an income supplement strategy. Washington, Center for the Study of Social Policy, 1988. 235 p. LRS88-1407

Provides in-depth profiles of State SSI supplement programs. Asks "does an income supplementation strategy possibly offer the kind of individualized, flexible and need-targeted resource that will best contribute to a desirable long term care system? What are its specific problems and limitations, and how can it be integrated with health care, housing and social services?"

Doty, Pamela, Korbin Liu, and Joshua Wiener.
An overview of long-term care. Health care financing review, v. 6, spring 1985: 69-78. LRS85-12908

"Long-term care (LTC) refers to health, social, and residential services provided to chronically disabled persons over an extended period of time. Especially during the last 20 years, State and Federal Governments have played an increasing role in the financing of long-term care. The aging of the population underlines the future importance of this topic. This article provides background data on need, supply, and expenditures; discusses government financing programs; and addresses quality of care concerns and options for LTC reform."

England, Robert S.
The catastrophic health care blunder. American spectator, v. 21, Nov. 1988: 25-28, 30. LRS88-9054

"The story of how Ronald Reagan, Otis Bown, and a rogue Congress came up with what might be the most expensive piece of social legislation since the Great Society--and still failed to provide real catastrophic care for our elderly."

Feder, Judith, and John Holahan.
Financing long-term care. National journal, v. 15, June 4, 1983: 1203-1205. LRS83-5958

"Describes the current state of long-term care financing, explains why improved efficiency is unlikely to solve its problems, and briefly considers options for improved financing from private and public sources."

Feder, Judith, and William J. Scanlon.
Federal financing and fiscal incentives: shuffling Federal programs to pay for long-term care. Washington, Urban Institute, 1983. 45 p. (Working paper 1466-15) LRS83-19791

Firman, James P.
Private long term care insurance: how well is it meeting consumer needs and public policy concerns? Washington, United Seniors Health Cooperative, 1988. 46 p. LRS88-12063

Addresses "three questions about private long-term care insurance policies: 1. What is the probability that a person will collect any benefits from a long-term care insurance policy if he or she is admitted to a nursing home? 2. If a person is in a nursing home for a long period of time and qualifies for coverage, how much of the total bill will the policy pay? How much will the consumer have to pay out of pocket? 3. How comprehensive is the home care coverage?"

The Financial capacity of the elderly to insure for long-term care. Gerontologist, v. 27, no. 4, 1987: 494-502. LRS87-7550

"Considered was the financial capacity of the elderly for purchasing any of four emerging long-term care plans: Social/Health Maintenance Organizations, long-term care insurance, Life Care at Home, and Continuing Care Retirement Communities. Between 50% to 80% of all elderly could afford to purchase one of these plans depending on the amount of discretionary income they would be willing to spend. The market for these options will largely be determined by the willingness of the elderly to spend assets."

Financing care for patients with Alzheimer's disease and related disorders; a briefing by the Subcommittee on Human Services of the Select Committee on Aging, House of Representatives, 99th Congress, 2nd session. Washington, G.P.O., 1986. 35 p. LRS86-12720

At head of title: Committee print.

"Comm. pub. no. 99-596"

"Outgrowth of a one-day workshop held in May, 1986 and sponsored by seven Representatives and ten Senators," which "focused on a paper that was written by Dr. Karen Davis and Ms. Patricia Neuman of Johns Hopkins University."

Financing long-term care. EBRI [Employee Benefits Research Institute] issue brief, no. 48, Nov. 1985: 1-11. LRS85-11660

"Evaluates demographic changes and health care expenditures of the elderly and the risks associated with chronic health conditions. Existing financial mechanisms are explored, as are alternative approaches to long-term care financing. The financing of long-term care is the most fundamental issue discussed."

Haislmaier, Edmund F.
Catastrophic health legislation: Congress's case of Medicare malpractice. Washington, Heritage Foundation, 1988. 15 p. (Issue bulletin no. 139) LRS88-4257

Hay, Joel W., and Richard L. Ernst.
The economic costs of Alzheimer's disease. American journal of public health, v. 77, Sept. 1987: 1169-1175. LRS87-6797

"The estimated present value of total net costs to society for all persons first diagnosed with Alzheimer's Disease in 1983 was $27.9--31.2 billion. Development of a public or private insurance market for the economic burdens of Alzheimer's Disease would fill some of the gaps in the current US system of financing long-term chronic disease care."

Increasing private financing of long-term care: opportunities for collaborative action. Prepared for SRI Conference on Private Financing of Long-Term Care. Menlo Park, Calif., SRI International, 1985. 56 p. LRS85-11601

Identifies "an action agenda for promoting public-private partnerships; and reviews alternative models for private financing of long-term care. Both insurance instruments and non-insurance instruments, often termed cash accumulation approaches, are considered. Design issues such as reimbursement methods and types of services to cover are assessed, as well as implementation problems such as product design, state regulation, and the availability of Medicaid benefits."

Isaacs, Mareasa R. Goldman, Sybil K.
State initiatives in long-term care: report of a survey of 32 states. Washington U.S. Dept. of Health and Human Services, Bureau of Health Maintenance Organizations and Resources Development, Office of Health Planning; reproduced by NTIS, 1984. 62, 18 p.
LRS84-13157

"HRP-0905897, Aug. 1984"

Partial contents.--Key state policy issues in long-term care.--Federal and private sector demonstration projects: new resources for the provision and financing of long-term care services.--State coordination of long-term care.--Changes in the delivery and financing of long-term care services.

Jacobs, Bruce, and William Weissert.
Using home equity to finance long-term care. Journal of health politics, policy and law, v. 12, spring 1987: 77-95. LRS87-2290

"Analyzes the potential of using home equity to finance long-term care of the elderly, including payments for home care and for long-term care insurance . . . . First estimates each homeowner's risk of need for care (and risk of institutionalization) and then calculates the degree to which home equity could be used to cover the costs of home care (or of insurance premiums)."

Kemper, Peter. Applebaum, Robert. Harrigan, Margaret.
Community care demonstrations: what have we learned? Health care financing review, v. 8, summer 1987: 87-100. LRS87-13422

"Policymakers should move beyond asking whether expanding community care will reduce costs to addressing how much community care society is willing to pay for, who should receive it, and how it can be delivered efficiently."

Kosterlitz, Julie.
The graying of America spells trouble for long-term health care for elderly. National journal, v. 17, Apr. 13, 1985: 798-801. LRS85-3065

Sees a worsening crisis in provision for the health needs of nursing home patients, many of whom end up receiving Medicaid. Describes how both State and Federal officials are concerned with who will pay and how to limit costs.

Lave, Judith R.
Cost containment policies in long-term care. Inquiry (Chicago), v. 22, spring 1985: 7-23. LRS85-3250

"The rapidly increasing growth of the elderly population in the United States, especially the increasing proportion of the 'old old' among the elderly, has thrust long-term care--its evolution, organization, and financing--into the national limelight. In this report of the effectiveness of various policies to contain the costs of long-term care, the author focuses on the aggregate public costs of providing this care. Also discusses the impact of public policy on access to needed services by the vulnerable population, the quality of these services, and the quality of life of the recipients of long-term care."

Long-term care financing and delivery systems: exploring some alternatives: conference proceedings. Edited by Patrice Hirsch Feinstein, Marian Gornick, and Jay N. Greenberg. Baltimore, Md., U.S. Health Care Financing Administration, for sale by the Supt. of Docs., G.P.O., 1984. 135 p. (HFCA publication no. 03174) LRS84-13251

Partial contents.--Long-term care insurance.--Life care communities.-- Social/health maintenance organization.--Housing.--Home equity conversion.--State and Federal tax modifications.--Family care.--Volunteerism.

Moon, Marilyn.
Private capacity to finance long term care. Washington, Urban Institute, 1983. 52 p. (Working paper 1466-12) LRS83-19787

Partial contents.--A conceptual approach to assessing resources for financing long-term care.--Empirical results for the elderly.--Empirical results for impaired persons.--Future direction for research.

Neuschler, Edward, and Claire Gill.
Medicaid eligibility for the elderly in need of long term care. Sept. 1987. Washington, Congressional Research Service, 1987. 152 p. 87-986 EPW

The purpose of this report is to begin to explore the process by which elderly persons become eligible for skilled and intermediate nursing home care under Medicaid. Based on a survey of 50 States' Medicaid programs, the report discusses the basic criteria elderly people must meet in order to become eligible for Medicaid and presents limited information on the availability of nursing home beds and on the process by which the need for nursing home care is certified. State and Federal rules governing the income and assets of the non-institutionalized spouse of a Medicaid nursing home resident are also discussed.

Excerpts appear in Senate document no. 100-26. What should the Federal Government do to enhance the quality of life for United States citizens over age 65? National debate topic for high schools, 1988-1989, pursuant to Public Law 88-246. 1988. p. 308-310.

O'Shaughnessy, Carol, and Richard Price.
Financing and delivery of long-term care services for the elderly. Revised May 25, 1988. Washington, Congressional Research Service, 1988. 109 p. 88-379 EPW

This report provides an overview of information on these two major issues in long-term care--(1) the potentially catastrophic expenses elderly persons can incur as the result of chronic illness or disability and (2) the need and demand for additional home and community-based care. It includes information on characteristics of the elderly and their utilization of long-term care services as well as their projected utilization of services in the future. It also reviews public sector programs that support long-term care and private sector approaches that have been suggested in the past few years as feasible alternatives for financing this care.

Paringer, Lynn.
The forgotten costs of informal long-term care. Washington, Urban Institute, 1983. 41 p. (Working paper 1466-28) LRS83-19786

Partial contents.--Characteristics of the functionally disabled.--The care givers.--Allocation of time to informal care giving.--The cost of informal care.

Price, Richard J., and Carol O'Shaughnessy.
Long-term care for the elderly: issue brief. Updated regularly. Washington, Congressional Research Service. IB88098

Financing and providing for long-term care for the elderly is an important issue for the Congress for a number of reasons. Paying for long-term care services, especially nursing home care, can represent a catastrophic expenditure that improvishes many elderly persons and their families. In addition, significant Federal resources are devoted to nursing home care through the Medicaid program, while only limited funding supports home and community-based services that the elderly and their families prefer over institutional care. In the 100th Congress, bills have been introduced proposing large scale reform of the way long-term care is financed through public programs, primarily through an expansion of Medicare coverage of institutional and/or home and community-based services. This new issue brief explores the major considerations related to this timely topic.

Rivlin, Alice M., and Joshua M. Wiener.
Caring for the disabled elderly: who will pay? Washington, Brookings Institution, 1988. 318 p. LRS88-5000

Partial contents.--Private sector strategies for reform.--Private long-term care insurance.--Continuing care retirement communities.--Social/health maintenance organizations.--Home equity conversions.--Public sector strategies.--Block grants.--Family responsibility.--Support for unpaid caregivers.--Liberalized Medicaid.--Recommendations for financing long-term care.

Who should pay for long-term care for the elderly? Brookings review, v. 6, summer 1988: 3-9. LRS88-5155

"The disabled elderly must rely on their own resources or, when these have been exhausted, turn to welfare . . . . Americans should carefully consider alternative ways of financing long-term care."

Rovner, Julie.
Long-term care: the true 'catastrophe'? Congressional Quarterly weekly report, v. 44, May 31, 1986: 1227-1231. LRS86-4494

Examines the question of who pays for long-term care and looks at proposals to deal with these costs. The proposals include expanding Medicare coverage as well as a number of private sector initiatives.

Scanlon, William J., and Judith Feder.
The long-term care marketplace: an overview. Healthcare financial management, v. 14, Jan. 1984: 18-19, 24-26, 28, 30, 34, 36.
LRS84-18975

"Provides an overview of the long-term care marketplace, identifying the long-term care population, examining how population and policy changes have affected the use and nature of long-term care services up to now, and exploring how future population and socio-economic changes are likely to influence the long-term care market."

Sherwood, Sylvia, John N. Morris, and Hirsch S. Ruchlin.
Alternative paths to long-term care: nursing home, geriatric day hospital, senior center, and domiciliary care options. American journal of public health, v. 76, Jan. 1986: 38-44. LRS86-1725

"Examines certain quality of life outcomes, as well as comparative costs of care, for selected types of persons entering three very distinct types of alternative service programs that address the long-term care needs of vulnerable elderly persons. . . . Except for the issue of institutionalization, quality of life impact analysis showed only a few more post-test differences than would be expected by chance (although the few post-test differences that were observed in each case favored less restrictive settings). This more general similarity of outcome is indeed provocative, suggesting that in many ways the applicants adapted similarly to these quite distinct programs. Cost analyses found that nursing home and geriatric day hospital care, the two most restrictive settings, were also the two most expensive interventions."

Smeeding, Timothy M. Straub, Lavonne.
Health care financing among the elderly: who really pays the bills? Journal of health politics, policy and law, v. 12, spring 1987: 35-52.
LRS87-2288

"Investigates the issue of who pays the health care bills of the elderly by considering the types of subsidized health insurance protection enjoyed by the noninstitutionalized elderly and the way that increased Medicare cost-sharing efforts in the 1980s are affecting those without additional health insurance subsidies . . . . Found that increased cost sharing is likely to fall most heavily on those elderly least likely to afford it: the poor and near-poor elderly who have only Medicare as a health insurance subsidy, particularly those who are older and sicker and who use Medicare services more heavily."

Smith, Mary F.

Medicaid services for persons with mental retardation or related conditions. Dec. 8, 1988. Washington, Congressional Research Service, 1988. 52 p. 88-759 EPW

The major source of Federal financing for services for persons with mental retardation or related conditions is the Medicaid program, authorized under title XIX of the Social Security Act. This report discusses the service needs, service delivery issue, and costs and trends related to services for this population.

Somers, Anne R.

Insurance for long-term care: some definitions, problems, and guidelines for action. New England journal of medicine, v. 317, July 2, 1987: 23-29. LRS87-5344

"The costs of long-term care should and will almost certainly continue to be met through multiple sources (including personal savings, family responsibility, private insurance, and state and local assistance), but federal leadership, standards, revenue collection, and some form of coordinating framework are essential for equitable access; adequate risk pooling, income, and benefits; continuity of care and records; and avoidance of wasteful duplication."

Stone, Robyn. Cafferata, Gail Lee. Sangl, Judith.

Caregivers of the frail elderly: a national profile. Gerontologist, v. 27, Oct. 1987: 616-626. LRS87-12243

Reports on a 1982 survey of caregivers to noninstitutionalized disabled people over age 65.

Tell, Eileen J., Marc A. Cohen, and Stanley S. Wallack.

Life care at home: a new model for financing and delivering long-term care. Inquiry, v. 24, fall 1987: 245-252 p. LRS87-11374

"In this paper we describe the Life Care at Home (LCAH) concept, a new long-term care insurance and service delivery model that combines the financial and health security of a continuing care retirement community (CCRC) with the freedom and independence of living at home."

U.S. Congress. House. Committee on Ways and Means. Subcommittee on Health.

Long-term care. Hearing, 100th Congress, 1st session. Mar. 31, 1987. Washington, G.P.O., 1987. 220 p. LRS87-11125

"Serial 100-19"

Examines the projected need for long-term care services and the problems of the existing financing and delivery systems. Discusses options for financing long-term care including expanded Medicare benefits, home equity conversions, and private long-term care insurance.

U.S. Congress. House. Select Committee on Aging.
Catastrophic health costs: broad problem demanding equally broad solution. Joint hearing before Select Committee on Aging, House of Representatives and the Special Committee on Aging, United States Senate, 100th Congress, 1st session. Jan. 28, 1987. Washington, G.P.O., 1987. 102 p. LRS87-4433

"House Select Committee on Aging pub. nbr. 100-618; Senate Sepcial Committee on Aging pub. nbr. 100-2"

Examines the Dept. of Health and Human Services' report (LRS86-12213) on catastrophic illness coverage for Medicare beneficiaries and individuals under age 65.

U.S. Congress. House. Select Committee on Aging. Subcommittee on Health and Long-term Care.
Paying the price of catastrophic illness: from accidents to Alzheimer's. Hearing, 100th Congress, 1st session. Jan. 28, 1987. Washington, G.P.O., 1987. 176 p. LRS87-3574

"Comm. pub. no. 100-616"

Presents examples of long-term care needs, illustrating the inadequacy of public policies and private health insurance coverage.

U.S. Congress. Senate. Special Committee on Aging.
Developments in aging: 1987; vol. 3--the long-term care challenge; a report . . . pursuant to S. Res. 80, Sec. 19, January 28, 1987 resolution authorizing a study of the problems of the aged and aging. Washington, G.P.O., 1988. 67 p. (Report, Senate, 100th Congress, 2nd session, no. 100-291, v. 3) LRS88-3551

U.S. Congress. Senate. Committee on Finance.
Catastrophic health insurance. Hearing, 100th Congress, 1st session. Part 1 of 3. Jan. 28, 1987. Washington, G.P.O., 1987. 122 p. (Hearing, Senate, 100th Congress, 1st session, S. Hrg. 100-169, pt. 1) LRS87-11121

Discusses the issue of coverage of catastrophic illness expense and reviews proposals made by the Dept. of Health and Human Services (See also LRS86-12213).

U.S. Congress. Senate. Committee on Finance. Subcommittee on Health.
Long-term health care. Hearing, 100th Congress, 1st session. Feb. 24, 1987. Washington, G.P.O., 1987. 405 p. (Hearing, Senate, 100th Congress, 1st session, S. Hrg. 100-35) LRS87-4115

Examines long-term health care issues and options for improving delivery and financing of long-term care for the elderly, including Medicare and Medicaid coverage revisions and expansion of home and community-based alternatives to nursing home care.

U.S. Congress. Senate. Committee on Governmental Affairs. Subcommittee on Government Efficiency, Federalism and the District of Columbia.
Resolving catastrophic health problems in the Medicare program. Hearings, 100th Congress, 1st session. Washington, G.P.O., 1988. 376 p. (Hearings, Senate, 100th Congress, 1st session, S. Hrg. 100-365) LRS88-435

Hearings held August 27, 1987 (Nashville, TN); August 28, 1987 (Memphis, TN); and August 29, 1987 (Chattanooga, TN).

Presents examples of the impact of catastrophic illness on families illustrating the inadequacy of Medicare coverage and the need for programs for the financing of long-term care.

U.S. Congress. Senate. Special Committee on Aging.
Catastrophic health care costs. Hearing, 100th Congress, 1st session. Jan. 26, 1987. Washington, G.P.O., 1987. 199 p. (Hearing, Senate, 100th Congress, 1st session, S. Hrg. 100-69) LRS87-4981

"Serial no. 100-1"

Discussion of catastrophic health care costs and coverage issues, including Medicare, Medicaid, and private health insurance reimbursement limitations.

U.S. Dept. of Health and Human Services.
Catastrophic illness expenses; report to the President. Washington, The Department, 1986. 117 p. LRS86-12213

Partial contents.--The current health care system and the problem of catastrophic expenses.--Coverage and risk patterns: acute care for the elderly.--Long term care for the elderly.--Coverage and risk patterns: the working age population.--Catastrophic illness coverage policy options.--More complete coverage of catastrophic illness expense for Americans: recommended strategy.

Weissert, William G.
Seven reasons why it is so difficult to make community-based long-term care cost-effective. Health services research, v. 20, Oct. 1985: 423-431. LRS85-15871

"A decade of research on home- and community-based long-term care shows that few of the assumptions behind expectations of its potential cost- effectiveness were warranted. Few who use home- and community-based long-term care would otherwise have been long-stayers in nursing homes. Long-stayers tend to be older, sicker, more dependent, and poorer in social resources than those who use community care. Fewer still who use community care actually have their institutional stay averted or shortened by its use, even if they are at risk. But more effective targeting on those most likely to be institutionalized may lead to high screening costs and small, inefficient programs, because few patients in the community fit the profile for high risk of institutionalization."

Where coverage ends: catastrophic illness and long-term health care costs. Washington, Employee Benefit Research Institute, 1988. 274 p. (EBRI-ERF policy forum) LRS88-6789

Concludes that "many millions of Americans face possible financial ruin from uninsured health care expenses that are potentially catastrophic in nature. What is not clear is whose responsibility it is to pay these expenses."

Who can afford a nursing home? Consumer reports, v. 53(s), May 1988: 300-311. LRS88-12062

Discusses the rising costs of nursing home care and the effectiveness of long-term care insurance in helping people cope with these costs. Argues that the federal government should create universal coverage for long-term care no matter where the service is rendered.

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Private long-term care insurance: cost, coverage, and restrictions. Gerontologist, v. 27, no. 4, 1987: 487-493. LRS87-6798

"A descriptive analysis of 31 private long-term care insurance policies was conducted. Policies were examined for premium rates, extent and levels of coverage, restrictions on eligibility to purchase a policy, and indemnity payment levels. Findings suggested that policies are expensive, impose numerous eligibility restrictions, offer limited coverage for certain services, and provide indemnity payments that fail to account for inflation."