Congress may be required to strike a difficult balance between its goals of improving access to health care and enhancing job availability and the foreign competitiveness of American firms.

Employer-Provided Health Benefits: Legislative Initiatives

A number of legislative proposals during the 99th Congress emphasized the expansion of health insurance coverage to uninsured Americans—a segment of the population that has been growing. In so doing, Congress changed many of the rules affecting health plans sponsored by employers. Employer-provided health insurance covers more than 66 percent of all nonelderly Americans not living in the families of military or agricultural workers.

Mandated employer-provided health coverage would change the cost of employment and could affect a firm's employment decisions. In the long run there may be increased unemployment as firms capable of substituting machines for workers do so or if firms are not able to absorb the increased cost of labor.

In addition, industries competing with firms in other countries or firms competing with others in regions of the country where health care costs are substantially lower could find their trading positions altered. Small firms could also experience higher administrative costs per employee than larger firms.

The 100th Congress faces a difficult challenge: achieving a balance between improving job opportunities, enhancing American competitiveness in foreign markets, and ensuring that the uninsured and underinsured have access to quality health care.
Introduction

Congressional action during this past session of Congress changed many of the rules affecting employer-provided health plans. For plan years beginning on or after July 1, 1986 (later for negotiated plans), health plan sponsors must allow qualified individuals and their dependents to purchase health insurance from the employer under specific circumstances. In addition, to qualify for tax-exempt status, group health plans must meet new tests to determine whether or not they discriminate in favor of highly compensated employees. The new tax law will require that employers establish data systems to test their group health plans for nondiscrimination. Furthermore, a broader definition of cafeteria plans may now mean that employers offering more than one type of health insurance plan will also have to meet the coverage rules required of cafeteria plans.

Congressional debate during the 99th Congress focused a great deal of attention on the availability of health insurance. From all accounts, the focus on health insurance is likely to continue during the 100th Congress. Employer health plans will be integral to the discussion since they are responsible for providing health insurance coverage to more than 66 percent of all nonelderly Americans not enlisted in the military or employed in agriculture. As major providers of health insurance and health care, employers are affected by public policy concerning health insurance and health care costs.

This Issue Brief (1) examines the legislation that passed and that which was considered by the 99th Congress, including provisions in the Consolidated Omnibus Budget Reconciliation Act of 1985 (P.L. 99-272), the Omnibus Budget Reconciliation Act of 1986 (P.L. 99-509), and the Tax Reform Act (P.L. 99-514); (2) examines the public policy issues that prompted Congress to consider these changes; and (3) suggests what issues employers can expect legislators to consider in the 100th Congress.

Access to Health Care

Having health insurance is almost tantamount to having access to health care. Without health insurance coverage, access to the health care system can be seriously hindered. Individuals will postpone obtaining care until conditions become much more serious; providers might not accept patients who do not have insurance (Davis and Rowland, 1983).

The movement on the part of payers to become more prudent in their health care purchases comes during a time when the number of Americans without health insurance has been rising. Since the 1981-82 recession, the number of nonelderly Americans without health insurance has increased 13 percent. In 1982, 16 percent of the nonelderly population were without health insurance; in 1985 the percentage rose to over 17 percent.

Without health insurance coverage, access to the health care system can be seriously hindered.

One of the consequences of providing care to those without health insurance is that some care might not be paid for by or on behalf of those receiving the care. Uncompensated care, which includes charity care (care for which the provider does not expect to be reimbursed directly) and bad debt (care for which payment is expected but not received), is one manifestation of the problem providers face. Uncompensated care, however, measures only care actually provided: it does not indicate care not sought because an individual did not have the ability to pay.

Providers of health care are facing a period in which it is becoming increasingly difficult to finance uncompensated care as all purchasers of health care become more prudent buyers. Uncompensated care, which is measured as charity care plus bad debt, is financed through public funds, philanthropy, and activities that do not generate medical revenue, such as parking lots and gift shops, and through the shifting of costs to other third-party payers.
The burden of uncompensated care on hospitals alone averaged 7.8 percent of total hospital charges in 1984. This burden, however, is not distributed evenly across hospitals. Moreover, both the absolute amount and the disparity may be growing. Hospital uncompensated care may have more than doubled, reaching $9.5 billion in 1984, from an estimated $4.5 billion in 1978 (1984 dollars; Sloan, Valvona, and Mullner, 1986). About 2 and one-half percent of all private hospitals and nearly 19 percent of all public hospitals provided more than 10 percent of their total charges in the form of charity and bad-debt care.

Classified by teaching status, 19 percent of all American Council of Teaching Hospital members, 11.6 percent of all minor teaching hospitals, and 6.1 percent of all nonteaching hospitals provide more than 10 percent of their total charges in the form of uncompensated care (Sulvetta and Swartz, 1986).

Although the American Council of Teaching Hospitals, a membership group within the Association of American Medical Colleges (AAMC), represents less than 7 percent of all hospitals, they were responsible for collecting 28 percent of net patient revenues and provided nearly 49 percent of all charity care and about 37 percent of all bad-debt care in 1984 (AAMC, unpublished). As a percentage of member hospitals’ net patient revenues, uncompensated care was 9.4 percent in 1980 and 11 percent in 1984 (AAMC, 1982 and unpublished).

Congressional concern about access to health care and the problem of financing uncompensated care has prompted a flurry of legislative initiatives, debate, and some legislative change.

Hospitals with a relatively high volume of uncompensated care tend to have a disproportionate amount of self-paying and Medicaid patients. Self-paying patients, in particular, are more likely to generate uncompensated care. In addition, the proportion of Medicaid patients in a community is usually an indication of the proportion of poor and near poor, who are less likely to have health insurance. In 1984, 73 percent of workers with annual earnings of less than $10,000 had health insurance, compared to 94 percent among those earning $10,000 or more (EBRI Issue Brief, September 1986).

Hospitals with a relatively high volume of uncompensated care also seem less able to finance this care through cost shifting. Among hospitals with more than 10 percent of total charges in the form of uncompensated care, self-paying patients, Medicaid patients, and patients with coverage from state and local governments were relatively more important sources of revenue (49 percent) than among hospitals with less than 2 percent of total charges in the form of uncompensated care (25 percent).

Congressional concern about access to health care and the problem of financing uncompensated care has prompted a flurry of legislative initiatives, debate, and some legislative change. The many proposed solutions considered by the 99th Congress included: (1) provisions to continue access to employer-sponsored group health insurance for terminated workers and dependents of workers who would otherwise lose coverage because of a change in employment or marital status; (2) the encouragement of statewide risk pools, which would sell insurance to uninsured people not eligible for public program coverage, regardless of health status; and (3) programs to finance uncompensated care.

Continuation of Health Insurance

In recent years it has become increasingly common to incorporate wide-ranging legislation into omnibus budget bills. The continuation provisions enacted in the Consolidated Omnibus Reconciliation Act of 1985 (COBRA, P.L. 99-272), however, represent a significant departure in federal law affecting health insurance plans. Prior to the passage of COBRA, many states had requirements for insurance continuation and/or conversion coverage. None were as comprehensive, however, as the COBRA continuation provisions. Furthermore, state-mandated continuation or conversion requirements might not have applied to self-
insured employer health plans, since they are preempted from state regulation. It is not yet clear how each state will reconcile its provisions with the new federal requirements.

For health plans that are not part of a collectively bargained agreement, the continuation provisions take effect for plan years beginning on or after July 1, 1986. Collectively bargained plans will have to meet the continuation provisions for plan years beginning after the last plan-related collective bargaining agreement terminates, or January 1, 1987, whichever is later. The continuation provisions required amending the Internal Revenue Code, the Employee Retirement and Income Security Act of 1974 (ERISA), and the Public Health Act so that any employer with a health plan employing 20 or more people must make group coverage available to certain former employees and their dependents:

- for 18 months if the worker becomes unemployed or if there is a reduction in the number of hours worked;
- for 36 months to dependents of deceased workers, to the former spouse of a worker who is divorced, and to dependent children who reach the age of majority for purposes of insurance under the terms of the policy, or if the active employee becomes eligible for Medicare;
- for 18 months to active workers and their dependents who would lose health insurance benefits because the plan sponsor files to reorganize under Chapter 11 of the federal bankruptcy code; or
- in the case of reorganizations under Chapter 11 of the bankruptcy code, retirees and their spouses and dependents who would otherwise lose coverage through the employer-provided plan would have the option to elect to continue coverage until death of the retiree, reemployment, remarriage resulting in coverage under the spouse’s plan, or failure to pay the premium. The surviving spouse and dependents could elect to remain in the plan for up to three years after the death of the retiree.

The health insurance coverage offered must be identical to that which is provided to other plan participants for whom no qualifying event has occurred; the employer may charge the beneficiary up to 102 percent of the per-employee premium.

Furthermore, once the continuation period expires, the employer must then make available to the former employee or dependent a conversion policy. Self-insured plans may have to contract with a commercial carrier or Blue Cross/Blue Shield to offer conversion policies.

During the 99th Congress, legislation introduced in the Senate by Edward M. Kennedy (D-MA), Dave Durenberger (R-MN), John Heinz (R-PA), and Donald W. Riegle Jr. (D-MI), and in the House by Fortney H. (Pete) Stark (D-CA) and Bill Gradison (R-OH), hereafter called the Kennedy-Stark bill, would have expanded the COBRA continuation provisions. The Kennedy-Stark bill would have required all employers with 20 or more employees that offer a group health plan to continue paying health insurance premiums for four months on behalf of terminated workers and their dependents. In conjunction with COBRA, this would provide terminated employees access to a group plan for 22 months: four months provided at the employer’s expense and 18 months purchaseable from the employer. The Kennedy-Stark bill would have also required employers with health insurance plans to provide a 60-day open enrollment period for employees and their spouses who lose health insurance because of the spouse’s unemployment. Each married employee eligible to be covered under the plan who previously had elected not to join could then enroll in the plan.

Impact of Mandated Continuation Provisions on Access to Health Insurance—Requiring employers to provide plan access to former employees or their dependents will be important to people who face a change in employment or marital status. However, for the majority of people without health insurance these provisions will have a relatively small impact. This is because (1) relatively few of the uninsured are unemployed; (2) individuals must be willing and able to afford to purchase the coverage, which could be more comprehensive and, therefore, probably more expensive than individual insurance coverage; and (3) although somewhat limited in the scope of coverage, at least 40 states already have continuation and/or conversion provisions for group health plans.

Most of the uninsured are employed; many of the unemployed who lack health insurance did not have
The relative magnitudes of these numbers are analogous to earlier studies of the effect of unemployment on health insurance coverage. Studies using 1977 data suggest that about 8 percent of unemployed workers lost their health insurance as a result of becoming unemployed (Monheit, Hagan, Berk, and Wilensky, 1984). If 13 percent of those unemployed during 1984 had lost their health insurance and all of these individuals had purchased coverage from their prior employers, the continuation provisions could have assisted 2.5 million workers and their dependents, or 7 percent of the uninsured. This estimate, however, is probably generous because (1) many states have subsequently initiated
continuation and conversion provisions (although self-insured plans would be excluded); and (2) the unemploy-
ment rate in 1984 (7.5 percent) was closer to the rate in 1977 (7.1 percent) than to the rate in 1982 (9.7 percent),
when unemployment was exacerbated by the recession.

As of May 1985, 23 states had continuation provisions for those who become unemployed (Hewitt Associates, 1985) and at least 40 states had provisions to continue coverage and/or convert coverage into an individual policy upon specified changes in employment or marital status (Blue Cross and Blue Shield Association, unpublished). The provisions in COBRA, however, enable access for a substantially longer period of time than most of the state continuation provisions, include a broader array of qualifying events, and apply to all employers with 20 or more employees, regardless of how their insurance plans are funded.

The COBRA continuation provisions do, however, address a short-run problem: the immediate impact of losing health insurance coverage from an employer. But data on the uninsured by weeks of unemployment indicate that among full-year workers unemployed at some point during the year, the longer the duration of unemployment, the less likely there was employer-provided health insurance to lose. Among full-year workers who were unemployed in 1984 for less than one month, 29 percent did not have employer-provided health insurance; among those unemployed for 13 weeks or more, 47 percent had no employer-provided health insurance (table 1).

COBRA's impact on employers' administrative costs is impossible to gauge. If administrative costs exceed 2 percent of the premium, an employer's cost of continuing health insurance will increase. If qualified

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**Table 1**

Employer-Based Health Insurance Coverage and Reported Noncoverage among Wage and Salary Workers Age 18-64, by Weeks of Unemployment, 1984

<table>
<thead>
<tr>
<th>Employer-Based Coverage</th>
<th>Weeks Unemployed</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Any</td>
</tr>
<tr>
<td><strong>Number of Workers (thousands)</strong></td>
<td><strong>Total</strong></td>
</tr>
<tr>
<td>All workers</td>
<td>102,789</td>
</tr>
<tr>
<td>full-year</td>
<td>89,816</td>
</tr>
<tr>
<td>part-year</td>
<td>12,973</td>
</tr>
</tbody>
</table>

| **Number of Workers (thousands)** | **Total** | **Fully Employed** |  |
| All workers | 102,789 | 13.9% | 11.4% | 28.2% | 23.3% | 24.0% | 32.6% |
| full-year | 89,816 | 12.4 | 9.8 | 27.4 | 19.4 | 22.2 | 32.2 |
| part-year | 12,973 | 24.7 | 22.9 | 32.5 | 29.8 | 32.2 | 41.4 |


aData exclude agricultural, self-employed and noncivinl workers.
bFull-year workers are defined as those who worked or looked for work for 35 weeks or more during 1984.
cPart-year workers are defined as those who worked or looked for work for fewer than 35 weeks during 1984.
beneficiaries purchase coverage under the continuation provisions simply on the basis of anticipated medical need, the actuarial value of the insurance plan probably will increase due to adverse selection. If this happens, the cost of the plan for all workers will increase.

Mandated coverage provided by the employer, like that proposed in the Kennedy-Stark bill, would change the cost of employment and could affect a firm's employment decisions. Initially there might be pressure to reduce costs, including lowering (in real terms) wages and salaries, reducing nonwage compensation, or both. In the longer run there may be increased unemployment as firms capable of substituting machines for workers do so or if firms are not able to absorb the increased cost of labor. In industries where labor costs can be shifted to consumers, another consequence might be upward pressure on prices. Industries competing with firms in other countries or firms competing with others in different regions of the country where health care costs are substantially lower could find their trading positions altered. Relatively smaller firms could also experience higher administrative costs per employee than larger firms since administrative costs would be spread among fewer employees.

**♦♦♦♦**

Requiring employers to provide plan access to former employees or their dependents will be important to people who face a change in employment or marital status. However, for the majority of people without health insurance these provisions will have a relatively small impact.

**♦♦♦♦**

Insurance Risk Pools

In general, risk pools sell insurance to individuals who have been denied insurance because of a preexisting medical condition (table 2, appendix). The plans usually require that participants pay premiums and cost-sharing provisions, such as deductibles and copayments. There are, however, limits on annual out-of-pocket expenses for covered services and limits on lifetime expenses (Bovbjerg and Koller, 1986). Since the group eligible for participation in the risk pool have medical problems prior to joining, the health care expenditures of the plan will be greater than those of most other insured groups. Consequently it is not expected that the premiums will completely finance the plan. Although the plan could be underwritten through a variety of sources, including taxpayers, hospitals, or third-party payers, the versions that emerged during the 99th Congress identified employers as the financing source.

**♦♦♦♦**

Unless the premium is heavily subsidized and the out-of-pocket limits are relatively low, it is expected that relatively few individuals would be willing or able to purchase risk-pool insurance.

**♦♦♦♦**

Information about the total cost of risk pools relative to premiums is limited. However, available data indicate that experiences have varied. In Minnesota, the state pool for uninsurable individuals paid 43 percent of its expenses from premiums in 1983. Insurance companies and health maintenance organizations (HMOs) underwrote 57 percent, equal to $3.3 million. In 1985, the shortfall reportedly cost $5.5 million in excess of premium revenues. North Dakota's relative share of costs not covered by premiums was similar. In 1983, 56 percent of the pool, or $0.21 million, was underwritten by insurers (Bovbjerg and Koller, 1986).

The risk-pool losses in Connecticut and Florida have been different from those in Minnesota and North Dakota. In Connecticut, which has a risk pool open to all without insurance, 7 percent of the pool's total expenses in 1983 were not covered by premiums. This shortfall, which is also underwritten by health insurers, HMOs, and self-insured plans, amounted to
Table 3
Laws from the 99th Congress Affecting Health Care Benefits

<table>
<thead>
<tr>
<th>Bill Name, Lead Sponsor, and Status</th>
<th>Health Benefits Provisions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consolidated Omnibus Reconciliation Act of 1985 (COBRA) (became P.L. 99-272 on 4/7/86)</td>
<td>Requires that employer-provided health insurance coverage be continued for certain employees who had been laid off and certain dependents; requires employers to continue group health insurance for workers age 70 and older.</td>
</tr>
<tr>
<td>Tax Reform Act (became P.L. 99-514 on 10/22/86)</td>
<td>Establishes new uniform nondiscrimination requirements; makes technical corrections to COBRA; allows partial deduction for health insurance for self-employed persons.</td>
</tr>
<tr>
<td>Omnibus Budget Reconciliation Act of 1986 (became P.L. 99-509 on 10/21/86)</td>
<td>Makes Medicare secondary payer for disabled employees of employers with more than 100 employees; allows the bankruptcy of a plan sponsor to allow a retiree to elect continuation coverage for life and a spouse and dependents for 36 months.</td>
</tr>
<tr>
<td>Age Discrimination in Employment Amendments of 1986, H.R. 4154 (Pepper, D-FL) (became P.L. 99-592 on 11/1/86)</td>
<td>Requires employers to continue group health insurance for workers age 70 and older.</td>
</tr>
<tr>
<td>Omnibus Health Package (became P.L. 99-660 on 11/14/86)</td>
<td>In general, the changes made could affect the health care market and consequently the cost of health insurance. Allows export of pharmaceuticals not yet approved by the Food and Drug Administration; establishes a no-fault vaccine injury compensation program; reauthorizes federal qualification programs for health maintenance organizations (HMOs); establishes federal grants to states for chronic mental illness services; establishes a program to encourage the training of health care professionals in geriatric medicine; provides funding for research on Alzheimer’s disease; establishes a commission to prevent infant mortality; creates a national clearinghouse on physician malpractice and clarifies anti-trust law regarding physician peer review activities; repeals federal health planning law.</td>
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</table>

$0.2 million in 1983 and $1.5 million in 1985. Florida, on the other hand, has not yet incurred an annual loss. Since 1983 the Florida risk pool for uninsurables has collected $2.3 million in premiums and paid out $1.6 million in claims (Bovbjerg and Koller, 1986).

There were several legislative initiatives during the 99th Congress that would enable states to tax self-insured health plans, which are preempted by ERISA, to help underwrite state insurance risk pools. The Kennedy-Stark bill proposed that mandatory state risk pools be underwritten by all employers that have 20 or more employees and currently offer health insurance. A different version, incorporated into the House-passed version of the Omnibus Budget Reconciliation Act of 1986 (OBRA), would have required all employers with 20 or more employees to underwrite such funds, regardless of whether they offer insurance coverage to their workers. Unlike that in the Kennedy-Stark bill, the risk-pool provision proposed in OBRA would have been voluntary for each state. The provision was removed from the bill several days before the conference agreement was passed, but a similar provision may be proposed in the 100th Congress.

The Kennedy-Stark proposal would have allowed anyone not eligible for Medicare to purchase risk-pool
insurance. Annual out-of-pocket expenditures would have been limited to $1,500 for individual coverage and $3,000 for family coverage, with maximum lifetime benefits of at least $500,000 per individual. The proposal would have limited deductibles to $1,000 per covered individual, and coverage for preexisting health conditions could not have been denied for more than six months. Premiums were to be limited to 150 percent of the average premium charged in a state for comparable group policies.

Impact of Risk Pools on Access to Health Insurance

Unless the premium is heavily subsidized and the out-of-pocket limits are relatively low, it is expected that relatively few individuals would be willing or able to purchase risk-pool insurance. Certainly those without chronic health conditions would not be inclined to choose the risk pool over individual policies. Data identifying individuals with chronic medical conditions by income levels do not exist, so it is difficult to know whether those with chronic medical conditions could afford the coverage.

Coverage through a risk pool is likely to be more expensive than through individual policies, since some

<table>
<thead>
<tr>
<th>Impact of Risk Pools on Access to Health Insurance</th>
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<tbody>
<tr>
<td>Table 4: Health Benefits Provisions That Were Approved by Congress</td>
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<tr>
<td>Plan</td>
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<td>-----------------------------------------------</td>
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<tr>
<td>Health Insurance Continuation Act, 2/1/82</td>
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<tr>
<td>Medicare Prescription Drug Benefits Improvement Act of 2003</td>
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<tr>
<td>Health Care Improvement Amendments of 2007, H.R. 7142 (Sherr, D-CA)</td>
</tr>
<tr>
<td>Prohibition of Discrimination in Medical and Life Insurance Benefits Built on Group Companies, S. 269 (Metscherberg, D-IS)</td>
</tr>
<tr>
<td>Continuation Health Coverage Technical Amendments of 1986, H.R. 5591 (Kerry, D-MA)</td>
</tr>
</tbody>
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January 1987
proposals have called for policies comparable to that of a large group plan. In 1977, the average premium for group health plans was almost 275 percent of the average premium for individual health insurance, reflecting more comprehensive benefits despite the price advantage of group coverage.\textsuperscript{1} Allowing the pool to charge 50 percent more than the average minimum rate for individual standard risks in the state for comparable coverage (as in the Kennedy-Stark proposal) would increase the cost even more. People who purchase from the pool are likely to be those who (1) cannot obtain insurance because of a preexisting medical condition; and (2) can afford the insurance. Thus, a very small subset of the uninsured population is likely to be affected by the establishment of risk pools.

### Uncompensated Health Care Pools

Individuals without health insurance or the apparent means to purchase health care often have problems obtaining both ambulatory and inpatient care. Measures of uncompensated care (usually hospital-provided uncompensated care) do not include care that is either not sought or is sought but not obtained because the individual did not have either insurance coverage or other necessary resources (such as a credit card or cash deposit) to purchase care. The Kennedy-Stark bill would have required that states establish a plan providing assistance for the uninsured and underinsured who seek hospital care. Each state would have discretion in how it would implement the plan and who would finance the payments. It is conceivable that legislators in some states might look to employers for financing; however, most states that have uncompensated health care pools do not directly tax employers.

The most popular financing source for state charity care programs is a tax on hospital providers. Currently Florida, New York, South Carolina, West Virginia, and Wisconsin impose assessments on hospitals. Iowa taxes the premiums of insured health plans.

\textsuperscript{1} In 1977, the average annual premium for nongroup plans was $352 and for group plans, $959 (Cafferata, 1983).

California exempts hospitals from certificate-of-need requirements if they provide indigent care during a five-year period. In six states (Connecticut, Maine, Maryland, Massachusetts, New Jersey, and New York), hospital rate-setting commissions establish hospital-specific add-on rates shared by all payers of health care to cover uncompensated care.

### Federally Mandated Benefits

The continuation provisions in COBRA may represent a turning point in federalism with respect to health insurance benefits. Previously the regulation of health insurance sold by Blue Cross/Blue Shield and commercial carriers was solely under the jurisdiction of individual states. All states mandate that health insurance plans provide certain types of benefits, with most states having as many as eight mandated benefits. Alcohol and drug rehabilitation benefits, dependent coverage for newborns, and coverage for psychologists' services are among the most common state-mandated benefits.

#### In general, self-insured plans tend to enhance coverage for primary care but are less likely to offer coverage that some states require of insured plans.

Self-insured health and welfare plans, however, have not been required to comply with these state mandates. Self-insured plans are regulated by Section 514 of ERISA, which preempts state insurance laws. States' rights to regulate the benefits that employers provide in insured plans in light of their inability to regulate self-insured plans was upheld in the Supreme Court ruling in Metropolitan Life Insurance Co. v. Massachusetts and Travelers Insurance Co. v. Massachusetts (nos. 84-325 and 84-356, respectively).
A firm's decision to self-insure is predicated on many considerations, but some contend that employers do so to avoid having to provide state-mandated benefits. In exchange for accepting the risk of underwriting the health insurance plan, firms that self-insure are also able to avoid paying state taxes on insurance premiums. EBRI tabulations of the Labor Department's Employee Benefits Survey indicate that 42 percent of all workers in medium and large establishments participated in a self-insured health plan in 1985 (EBRI Issue Brief, November 1986).2

The continuation provisions in COBRA may represent a turning point in federalism with respect to health insurance benefits.

Self-insured health plans may provide a different mix of benefits than those found in insured plans. In general, self-insured plans tend to enhance coverage for primary care but are less likely to offer coverage that some states require of insured plans. Conversely, in 1985 insured plans were more likely than self-insured plans to cover treatment for alcoholism (69 percent versus 64 percent) and drug abuse (62 percent versus 57 percent) (EBRI Issue Brief, November 1986).

Many bills introduced during the 99th Congress would have mandated health benefits (tables 3, 4, and 5). In addition to provisions for continuation of coverage and participation in risk pools, there were provisions to

- amend ERISA to make self-insured plans subject to state laws;
- require all employers to provide health insurance;
- require insured and self-insured employer health plans to provide pediatric preventive care;
- require insured and self-insured employer health plans to cover in-home care for medical-technology-dependent children; and
- require employers to provide employees leave without pay for the care of newborn, adopted, or seriously ill children.

None of these proposals have become law, but are likely to be reintroduced during the 100th Congress.

One possibility already under discussion would require employers to provide a minimum health insurance benefit analogous to the minimum wage laws. One political deal might be to propose raising the minimum wage and then trading away the proposed increase in the minimum wage for a minimum health benefit. This would decrease the number of workers without health insurance coverage but may not alter the number of dependents without health insurance. Such action could, however, increase unemployment, reduce other forms of compensation, or both.

Designing legislation that defines a minimum health plan would require addressing some difficult equity issues. For example, how would an employer treat employees who work less than full time? How would variations in health care costs across regions, industries, and firm sizes be considered? Depending on how part-time workers are included, relatively large firms currently offering health insurance probably would not be affected. But smaller firms—especially those that do not offer health insurance—could experience significant increases in labor costs.

A firm's decision to self-insure is predicated on many considerations, but some contend that employers do so to avoid having to provide state-mandated benefits.

A similar approach under consideration would enable the working poor who do not have employer-provided...
Table 5
Bills in the 99th Congress Affecting Health Care Benefits That Did Not Pass Committee

<table>
<thead>
<tr>
<th>Bill Name, Lead Sponsor, and Status</th>
<th>Health Benefits Provisions</th>
</tr>
</thead>
<tbody>
<tr>
<td>H.R. 11 (Latta, R-OH); referred to House Ways and Means 1/3/85; H.R. 810 (Lloyd, D-TN); introduced 1/30/85</td>
<td>Allows one-half of the health insurance premium paid by a self-employed person to be deducted as a business expense.</td>
</tr>
<tr>
<td>H.R. 1296 (Carr, D-MI); referred to House Ways and Means 2/27/85</td>
<td>Allows full deductibility for self-employed persons' health insurance premiums.</td>
</tr>
<tr>
<td>Preferred Provider Health Care Act of 1985, H.R. 733 (Wyden, D-OR); referred to House Energy and Commerce 1/24/85</td>
<td>Preempts state insurance laws from hindering the negotiation of preferred provider organization (PPO) contracts by group health insurance plans.</td>
</tr>
<tr>
<td>H.R. 2696 (Sabo D-MN); introduced 6/6/85</td>
<td>Requires all employers to offer a health insurance plan; specifies minimum benefits to be included in those plans.</td>
</tr>
<tr>
<td>Economic Equity Act, S. 1169 (Durenberger, R-MN); referred to Senate Finance 5/20/85</td>
<td>Would amend ERISA and the Internal Revenue Code to include five-year continuation of employer health plans for widowed, separated, divorced, or Medicare-ineligible spouses and covered workers' dependents; beneficiaries may pay premium cost.</td>
</tr>
<tr>
<td>H.R. 1375 (Stark, D-CA); referred to House Education and Labor 2/28/85</td>
<td>Amends ERISA to make self-insured plans subject to state laws requiring freedom of choice of provider.</td>
</tr>
<tr>
<td>Child Health Incentives Reform Plan, H.R. 3469 (Jenkins, D-CA); referred to House Ways and Means 10/1/85; S. 376 (Chafee, R-RI); hearings held 9/16/85</td>
<td>Denies tax deduction for group health plans that do not cover pediatric preventive care.</td>
</tr>
<tr>
<td>Health Insurance Availability Act, S. 1372 (Heinz, R-PA); H.R. 1770 (Kennelly, D-CT); referred to House Ways and Means 3/27/85 and to Senate Finance 6/27/85</td>
<td>Would require insured and self-insured employer plans to contribute to state assigned-risk pools that provide health insurance to people who are uninsurable.</td>
</tr>
<tr>
<td>Health Equity and Fairness Act, S. 1211 (Durenberger, R-MN); referred to Senate Finance 5/23/85</td>
<td>Limits amount of employer's contribution to a health benefit plan that may be excluded from income; requires coverage for catastrophic expenses and minimum levels of acute care; provides deduction for certain costs incurred by noncovered individuals for health benefit plans.</td>
</tr>
<tr>
<td>Alternatives to Hospitalization for Medical Technology Dependent Children Act, S. 1793 (Kennedy, D-MA) and Hatch (R-UT); introduced 7/28/86</td>
<td>Mandates employer health plans to cover home care services for technology-dependent children.</td>
</tr>
<tr>
<td>Medicare Voucher Act of 1986, S. 1985 (Durenberger, R-MN); referred to Senate Finance 12/18/85</td>
<td>Enables employers to offer managed-care programs to retirees.</td>
</tr>
</tbody>
</table>
Table 5 continued

Access to Health Care Act of 1986, 
S. 2402 (Kennedy, D-MA); hearings recessed by 
Senate Intergovernmental Relations subcommittee 
6/26/86

Amends the Public Health Service Act to broaden health insurance 
coverage and requires states to have a plan to compensate hospitals 
for providing indigent care; requires employers to provide health in-
surance at no charge to laid-off workers and participate in state pools 
to provide insurance for those not covered.

(Durenberger, R-MN); Senate Governmental 
Affairs subcommittee hearing held 6/26/86

Amends the Internal Revenue Code; requires employers to provide 
health insurance at no charge to laid-off workers and participate in 
state pools to provide insurance for those not covered; broadens 
health insurance coverage and requires states to have a plan to 
compensate hospitals for providing indigent care.

Uninsured Workers' Health Insurance Act, 
S. 2484 (Durenberger, R-MN); 
referred to Senate Finance 8/21/86

Allows workers not eligible for health insurance to take a tax credit 
on premiums for coverage; allows self-employed unincorporated 
individuals to deduct cost of health insurance coverage.

Health Equity and Incentives Reform Act, 
S. 2485 (Durenberger, R-MN); 
referred to Senate Finance 8/21/86

Would include in gross income and impose Social Security taxes 
on certain employer contributions to accident or health plans, and 
allow a tax credit for individuals purchasing health insurance.

Health Plan Promotion Act of 1986, 
S. 2486 (Durenberger, R-MN); 
referred to Senate Finance 8/21/86

Includes all employer contributions to health insurance as 
taxable income; allows employers to assign contributions to 
individual employees using actuarial methods; grants U.S. residents 
tax credit of up to 40 percent of the limit on subsidized premiums.

Retirement Health Plan Act of 1986, 
H.R. 5575 (Rowland, R-CT); referred to House 
Ways and Means and House Education and 
Labor 9/23/86

Amends ERISA and the tax code to require prefunding of tax-
exempt retirement health plan trusts and vested rights to health 
benefits. Also establishes a Retirement Benefit Guaranty Corpora-
tion to insure retirement health benefits.

health insurance to "buy-in" to the Medicaid program. 
The current discussion includes charging individuals 
premiums based on their income and taxing employers 
that do not offer at least minimum health insurance 
coverage to finance the additional costs to the 
Medicaid program.

♦ Health Care for Retirees

For most retirees, Medicare is the primary source of 
acute-care insurance coverage. However, Medicare 
eligibility does not begin until age 65. Retirees who 
are not eligible for Medicare—usually because they 
are under age 65—have limited options for obtaining 
health insurance if their employers do not continue 
coverage. The continuation provisions of COBRA will 
allow all retirees to continue purchasing their former 
employer's health plan for 18 months and then 
purchase a conversion policy.

Promises of post-retirement medical benefits are fairly 
common among medium and large establishments. In 
1985, 72 percent of employees working in medium and 
large establishments were promised employer-
provided health insurance coverage upon early 
retirement; 66 percent had coverage continued after age 
65 (EBRI Issue Brief, November 1986). Current data do 
not enable us to know how many retirees actually 
receive private health insurance through an employer-
provided plan. However, an estimated 23 percent of 
all retirees received supplemental private health 
insurance from their former employer in 1977 
(Cafferata, 1984).
Promises to retirees for post-retirement medical benefits are under a great deal of scrutiny. Recent court cases have made it difficult, and in some cases impossible, for employers to alter the health benefits promised to current retirees. The Financial Accounting Standards Board (FASB) has made clear its intent to issue accounting standards for including any potential unfunded liabilities for post-retirement medical benefits in a firm's financial statement. Concurrently, the Deficit Reduction Act of 1984 (DEFRA) has limited prefunding of post-retirement medical benefits on a tax-preferred basis.

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Designing legislation that defines a minimum health plan would require addressing some difficult equity issues.

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Most firms promising post-retirement medical benefits have not prefunded those benefits. As firms mature and the number of retirees relative to active employees increases, the cost of post-retirement medical benefits begins to accelerate. Rising health care costs over the past 10 years have only exacerbated the unfunded liabilities some firms potentially face. The Department of Labor has estimated that the total accrued unfunded liability, based on current retirees and active workers age 40 and older, was over $98 billion in 1983 (U.S. Department of Labor, May 1986). This estimate is slightly more than the total payments employers made for health care benefits in 1984. Some argue that this estimate is very conservative and that the accrued unfunded liability is between $500 billion and $1 trillion. Benefit consultants have reported that, for some firms, the unfunded liability may be greater than total assets.

Post-retirement medical benefits received considerable attention when the LTV Corporation filed for Chapter 11 reorganization July 17, 1986, in the U.S. Bankruptcy Court for the Southern District of New York. At the time of its filing, LTV stopped paying premiums for health and life insurance policies for employees who had already retired. On July 28, 1986, LTV provided access to an insurance plan for retirees whose plans had been cancelled; retirees were responsible for paying the entire premium. After considerable pressure from active workers and Congress, LTV obtained on July 30, 1986, a federal bankruptcy court order authorizing the company to resume paying retiree health and life insurance premiums through January 17, 1987.

In response to the situation raised by LTV, the 99th Congress passed two provisions. The first was the addition, through OBRA, of a new qualifying event under the continuation provisions of COBRA. This action made a firm's entering into Chapter 11 bankruptcy proceedings on or after July 1, 1986, a qualifying event covering any retired employee. Under the continuation provisions in COBRA, retirees can continue to purchase their post-retirement medical benefits until they die or obtain coverage from another source. The retiree's spouse would be able to continue purchasing the coverage for an additional 36 months. The second provision, House Joint Resolution 738, established that any company paying post-retirement medical benefits as of October 2, 1986, that had not had its reorganization plans confirmed by a bankruptcy court, and any companies filing for Chapter 11 reorganization after that date, would have to continue paying benefits until May 15, 1987.

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Recent court cases have made it difficult, and in some cases impossible, for employers to alter the health benefits promised to current retirees.

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It is certain that congressional attention will focus on this issue during the 100th Congress. Although the expiration of H.J. Res. 738 may draw congressional attention as early as May, the Treasury Department report due to Congress in the fall of 1987 is likely to

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3 For more information see Chollet and Friedland, 1987.
trigger further debate. Treasury's report may include recommendations on tax incentives for prefunding post-retirement medical benefits. Budget constraints may inhibit Congress from establishing a tax-preferred vehicle for prefunding post-retirement medical benefits, but further attention, from both inside and outside the legislative arena, will focus on the issue if FASB issues its promised statement on accounting standards for post-retirement medical benefits, and as the courts continue to decide suits brought by retirees in cases where post-retirement benefits have been changed or eliminated.

**Catastrophic Health Care Expenses**

Related to the issues of post-retirement medical benefits and access to health care are out-of-pocket health care costs that exceed net wealth or drastically reduce living standards. Catastrophic expenses arise because the illness is not sufficiently covered by insurance or the individual does not have (or is not able to purchase) insurance. Catastrophic expenses for illness recently received attention when the Department of Health and Human Services (HHS) issued a report to President Reagan in November 1986. HHS Secretary Otis Bowen presented a list of recommendations that would either restructure existing public programs or encourage the private sector to provide new products. The secretary's report addressed acute-care catastrophic protection for the elderly, the development of protection alternatives against the catastrophic costs of long-term care, and catastrophic protection for the nonelderly population.

The issue of catastrophic protection—for both acute care and long-term care, especially for the elderly—is likely to persist as an emergent issue. Currently the elderly represent nearly 11 percent of the U.S. population; but by the year 2030 the elderly population is projected to double, representing 20 percent of the population. As more Americans live longer, the number of individuals with chronic health conditions could rise. An increased demand for care for chronic health conditions without drastic increases in the availability of appropriate resources will increase the cost of providing care. As more families become familiar with the gaps in Medicare coverage and the scarcity of private insurance options that fill those gaps, the likelihood increases that health care for the elderly will persist as a public policy concern.

**Tax Treatment of Employer-Provided Group Health Benefits**

Employer-provided health insurance is the most important source of health coverage for workers and their families. In 1985 over 80 percent of all full-time, full-year workers and their dependents had employer-provided coverage and 66 percent of the nonelderly population, or 131.8 million Americans, were covered by an employer-provided plan (table 6). Virtually all covered workers received employer contributions toward their health insurance. In 1985, employer contributions for group health plans exceeded $105 billion, or 4.9 percent of wages and salaries. Employer contributions to tax-qualified health insurance plans are exempt from corporate, Social Security, and personal income taxation.

The Tax Reform Act requires that all employer-provided group health plans meet nondiscrimination rules. Prior to this legislation, only self-insured plans were obliged to comply with these provisions. The new rules require that employers subject their plans to various tests to determine whether the plans favor highly compensated employees. In plans that fail the nondiscrimination tests, highly compensated employees must include the value of the discriminatory portion of the plan in their taxable income.

The new tax law requires that tax-qualified health plans must satisfy both a benefits and an eligibility test or, in lieu of that, a single alternative 80 percent test. Meeting the benefits test is relatively straightforward, but the eligibility requirements consist of satisfying three distinct tests: (1) a 50 percent test; (2) a 90 percent/50 percent test; and (3) a "nondiscriminatory provisions" test.

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4 For more information on the issue of long-term care see Friedland, 1987.
5 In addition to the elderly, agricultural and military workers and their dependents have been excluded from estimates.
<table>
<thead>
<tr>
<th></th>
<th>Insured Population (millions)</th>
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<th>Other private &amp; public</th>
<th>No Health Insurance Coverage</th>
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<tr>
<td></td>
<td>Total</td>
<td>Total</td>
<td>Employer-provided</td>
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<td>All persons</td>
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<tr>
<td>full-time workers(d)</td>
<td>143.5</td>
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<tr>
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<td></td>
<td></td>
</tr>
<tr>
<td>part-time workers(e)</td>
<td>8.7</td>
<td>5.9</td>
<td>3.1</td>
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<tr>
<td>Sometimes-unemployed</td>
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<tr>
<td>workers(f)</td>
<td>19.6</td>
<td>13.6</td>
<td>9.9</td>
<td>3.7</td>
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<tr>
<td>Part-year workers(g)</td>
<td>10.3</td>
<td>7.1</td>
<td>3.1</td>
<td>4.0</td>
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<tr>
<td>Nonworkers(h)</td>
<td>17.7</td>
<td>13.1</td>
<td>*</td>
<td>13.0</td>
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<table>
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<tr>
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<th>Insured Population (percents)</th>
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<th>No Health Insurance Coverage</th>
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<td></td>
<td>Total</td>
<td>Total</td>
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</tr>
<tr>
<td>All persons</td>
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<td>65.93%</td>
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<tr>
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<td>full-time workers(d)</td>
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<tr>
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<tr>
<td>part-time workers(e)</td>
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<td>Nonworkers(h)</td>
<td>100.00</td>
<td>73.70</td>
<td>*</td>
<td>73.54</td>
</tr>
</tbody>
</table>


a. Less than 50,000 people.
b. Excludes persons employed in the military and agriculture.
c. Family head is defined as the family member with the highest 1985 reported earnings. In nonworker families, the family head is the family member with the highest reported personal income.
d. Public coverage includes Medicaid, Medicare, or Civilian Health and Medical Program of the Uniformed Services (CHAMPUS).
e. Primary family worker worked or sought work for 35 or more weeks during the year and worked 35 hours or more in a typical week.
f. Primary family worker was steadily employed and worked less than 35 hours in a typical week.
g. Primary family worker worked or sought work for 35 or more weeks during the year and reported at least one week of unemployment.
h. Primary family worker worked or sought work during the year, but for less than 35 weeks.

\(d\) No family member worked or sought work during the year.
The benefits test is a single test which is met if the average employer-provided benefit received by nonhighly compensated employees under all of the employer’s plans of the same type is at least 75 percent of the average employer-provided benefit received by highly compensated employees under all of the employer’s plans of the same type.

The eligibility test requires that the employer satisfy three requirements. First, nonhighly compensated employees must constitute at least 50 percent of the group of employees eligible to participate in the plan. This requirement can also be satisfied if the percentage of highly compensated employees who are eligible to participate is not greater than the percentage of nonhighly compensated employees who are eligible. This allowance may be important to smaller firms where more than 50 percent of the workers are defined as highly compensated. Comparable plans may be aggregated to satisfy this test.

The second requirement of the eligibility test is that at least 90 percent of the employer’s nonhighly compensated employees are eligible for a benefit that is at least 50 percent as valuable as the most valuable benefit available under all such plans to any highly compensated employee. For health plans, the employer may elect to test coverage of employees separately from coverage of spouses and dependents. The employer may also elect to take into account only employees who have a spouse or dependent.

An employer may elect to treat a group of comparable health plans as a single health plan if one of those plans would otherwise fail the 50 percent test or the 80 percent alternative single test. Grouping health plans together as a single plan requires that the value of the smallest employer-provided benefit available to any participant in any plan in the group is equal to at least 95 percent of the value of the largest benefit available to any participant in any of the plans.

Finally, the third requirement of the eligibility test provides that a plan may not contain any provision relating to eligibility to participate that suggests discrimination in favor of highly compensated employees.

In lieu of satisfying the eligibility and benefits tests, an employer can meet an alternative 80 percent test, provided the “nondiscriminatory provisions” portion of the eligibility test is satisfied. Under the alternative 80 percent test a plan must benefit at least 80 percent of an employer’s nonhighly compensated employees. Only individuals who receive coverage under a plan will be considered as beneficiaries from the plan; eligibility to receive coverage is not sufficient. A firm might fail to meet this test if, for example, many of the nonhighly compensated employees are covered under their spouse’s plan.

All tests are based on the value of the coverage provided and not on the level of contributions. Benefits will be valued using procedures to be prescribed by the Treasury Department. The average employer-provided benefit is defined in the new tax law as the amount of benefits received by either the highly or the nonhighly compensated divided by the total number of highly or nonhighly compensated employees, respectively, whether or not they are covered under any of the plans.

Cafeteria Plans

Under the new tax law, a broader definition of Section 125 cafeteria plans may mean that employers that offer a choice of health plans, such as a standard insurance plan and an HMO, would have to meet nondiscrimination standards as a cafeteria plan as well.

The new law retains the present-law eligibility test and concentration test for cafeteria plans. Failure to meet either test, however, requires that the “qualified benefits” received by highly compensated employees are taxable and participants lose the special cafeteria plan exemption from the constructive receipt rules. The new law removes the special cafeteria plan benefits test of current law, but requires that each type of benefit under a cafeteria plan be tested under the particular nondiscrimination rules and applicable concentration tests that apply.

Other Provisions

The new tax law redefines employees who may be excluded from coverage, permits the nondiscrimination
tests to be met separately by line of business, and establishes a uniform definition of "highly compensated" employees throughout the tax bill. Highly compensated employees are those who during the preceding year (1) were a 5 percent owner; (2) received more than $75,000 in annual compensation from the employer; or (3) received more than $50,000 in annual compensation from the employer and was a member of the top-paid group or an officer of the employer. In general, the top-paid group includes all employees who are in the top 20 percent of the employer's workforce on the basis of annual compensation.

The new tax law also amends the tax code to allow self-employed individuals to deduct health insurance costs from their taxable income if, in general, health insurance is available to all of their employees. Under the new provision, self-employed individuals (sole proprietors or partners) may deduct 25 percent of the costs of their own and their dependents' coverage. The deduction is limited to net earnings and subject to nondiscrimination rules, and is disallowed altogether if the self-employed worker is eligible to participate in an employer-paid health plan, even as a dependent. This provision might encourage unincorporated firms to provide health insurance for employees since employers' health insurance for themselves and their dependents would receive tax treatment similar to that of employees. The impact of this change, however, will depend on how important the tax treatment of benefits is in the decision to offer health coverage.

◆ Conclusion

The 99th session of Congress established fundamental changes in health and welfare benefit plans. Benefit managers must now respond to an array of new rules established in the Tax Reform Act of 1986, the Consolidated Omnibus Budget Reconciliation Act of 1985, and the Omnibus Budget Reconciliation Act of 1986. Perhaps the most significant changes, in terms of foreshadowing the potential for legislation in the future, are the continuation provisions found in the omnibus budget bills.

The size of the budget deficit, which is currently projected by the Congressional Budget Office to be close to $170 billion, is likely to influence much of the policy agenda. Problems such as access to health care, the cost of public health care programs, the unfunded liability of post-retirement medical benefits, and long-term care will require Congress to find policy solutions that make sense but do not overly burden tax revenues. Federal budget constraints are likely to make policy solutions that are financed by employers and states much more attractive to federal lawmakers.

Congress is expected to make many technical corrections to the new tax code. Faced with a budget deficit above the Gramm-Rudman-Hollings target, Congress might consider broadening the tax base even more (including taxation of employer-provided health benefits—an idea debated during the 99th Congress) or raising tax rates. Congress may consider a variety of mandated benefits, including: (1) requiring employers to provide a minimum level of health insurance; (2) continuing health insurance coverage after employment termination; (3) covering pediatric preventive care; and (4) requiring that new parents or parents of seriously ill children, employees with seriously ill parents, or ill employees are able to take leave without pay without losing benefits or job status. Incentives for all states to establish risk pools for health insurance and funding mechanisms for hospital-provided uncompensated care may also be considered.

In addition, Congress may consider at least two issues concerning post-retirement medical benefits: (1) access to retiree health benefits for firms that file for reorganization under Chapter 11 of the bankruptcy code before the May 15 expiration of the relevant provision (H.J. Res. 38); and (2) the ability of firms to prefund post-retirement medical benefits on a tax-preferred basis. The Treasury Department's DEFRA-mandated report to Congress on vesting, funding, nondiscrimination, and fiduciary rules for corporate retiree health insurance plans may trigger this debate. Treasury's report is scheduled to be released in the fall of 1987.

The new Senate leadership has already indicated a desire to expand access to health insurance among those not insured. Sen. Kennedy, the new chairman of the Senate Labor and Human Resources Committee, is committed to finding ways to ensure that the poor and uninsured have access to health insurance (Kennedy,
1986). Sen. Lloyd Bentsen (D-TX), the new chairman of
the Senate Finance Committee, has said he would like
to ensure that catastrophic illness does not wipe out
family savings. He has suggested the establishment of
a new program to finance catastrophic health expenses
(Clark, 1986).

These are difficult challenges, requiring that a
balance be struck between the desire to enhance
American competitiveness in international markets,
ensuring jobs, and meeting the constraints of the budget
deficit and the national debt, while ensuring that the
uninsured and underinsured have access to health care.

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(Mimeographed.)
## Appendix: Table 2
### Comparison of 10 State Health Insurance Pools

|-------------------|----------------------------|------------------------|------------------------|------------------------
| **1. Eligibility**| All state residents ineligible for Medicare and Medicaid. | All state residents ineligible for Medicare who have been rejected by 2 health insurers for similar health insurance coverage or who have received notice of benefit reduction, condition exclusion, or premium increase exceeding the rate for pool coverage. | All state residents ineligible for Medicare who have been rejected by 2 health insurers for similar health insurance coverage, or who were only offered health coverage at a rate exceeding the rate for pool coverage. | All state residents ineligible for Medicare who have been rejected by 1 insurer for similar health insurance coverage or who were offered health coverage with a restrictive rider that decreases benefits or a preexisting condition limitation within 6 months prior to enrolling in the pool plan. Individuals who have been treated for certain chronic health conditions within 3 years of pool application are directly eligible for coverage under the pool without satisfying other requirements. |
| **2. Covered Benefits** | Subject to cost-sharing requirements, benefits covered include hospital services, professional diagnostic and treatment services (other than dental), skilled nursing facility services, home health services, oral surgical services, prescription drugs, and rental of durable medical equipment. The maximum lifetime benefit per covered person is $1 million. | Subject to cost-sharing requirements, benefits covered include hospital services, professional diagnostic and treatment services (other than dental), limited mental health services, skilled nursing facility services, home health services, oral surgical services, prescription drugs, and rental of durable medical equipment. The maximum lifetime benefit per covered person is $500,000. | Subject to cost-sharing requirements, benefits covered include hospital services, professional diagnostic and treatment services (other than dental), limited mental health services, skilled nursing facility services, home health services, oral surgical services, prescription drugs, and rental of durable medical equipment. The maximum lifetime benefit per covered person is $250,000. | Subject to cost-sharing requirements, benefits covered include hospital services, professional diagnostic and treatment services (other than dental), skilled nursing facility services, home health services, oral surgical services, prescription drugs, rental or purchase of durable medical equipment, and well-baby care. The maximum lifetime benefit per covered person is $250,000. |
3. **Preexisting Conditions and Waiting Period**

- Coverage is excluded for the first 12 months following enrollment for a medical condition that was diagnosed or treated during the 6-month period prior to coverage.

- Coverage is excluded for the first 12 months following enrollment for a medical condition that was diagnosed or treated during the 6-month period prior to coverage.

- Coverage is excluded for the first 6 months following enrollment for a medical condition that was diagnosed or treated during the 6-month period prior to coverage.

- Coverage is excluded for the first 6 months following enrollment for a medical condition that was diagnosed or treated during the 90-day period prior to coverage.

- The 6-month waiting period can be waived if another health insurance plan is in effect immediately before pool coverage begins and if application to the pool is made within 60 days of becoming eligible. Individuals who request a waiver are subject to a 25 percent increase in their premium on each renewal date during the life of the policy.

- The 6-month waiting period can be waived if preexisting condition exclusions were satisfied under prior health insurance coverage that was involuntarily terminated and if application to the pool is made within 30 days following involuntary termination.

- None.

- None.

- None.

- None.

4. **Cost-Sharing**

- Plan options available under the program offer deductibles of $.400, $1,000, and $1,500. In addition, 20 percent coinsurance is required for all covered expenses. Out-of-pocket expenses for covered services are limited to $2,000 for individual coverage and $4,000 for family coverage.

- Plan options available under the program offer deductibles of $1,000, $1,500, and $2,000. In addition, 20 percent coinsurance is required for all covered expenses. Limitations on out-of-pocket expenses for covered services vary by plan options available under the program. Limits range from $2,500 to $3,500 for individual coverage and from $5,000 to $6,000 for family coverage.

- Plan options available under the program offer deductibles of $500 and $1,000 and any others authorized by the administering board. In addition, 20 percent coinsurance is required for all covered expenses. Out-of-pocket expenses for covered services are limited to $3,000 per covered person.

- Plan options available under the program offer deductibles of $500 and $1,500. In addition, 20 percent coinsurance is required for all covered expenses. Out-of-pocket expenses for covered services are limited to $2,000 to $4,000 for family coverage.
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<tr>
<th>Features</th>
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<th>Indiana</th>
<th>Iowa</th>
<th>Minnesota</th>
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<tr>
<td>5. Pool Members</td>
<td>All health insurance carriers, including health care service plans and health maintenance organizations authorized to issue insurance in the State of Connecticut, are required to be members of the pool. Self-insured employer health plans established in the state after 1976 are also required to participate.</td>
<td>All health insurance carriers, including health care service plans authorized to issue insurance in the State of Florida, are required to participate in the pool. Health maintenance organizations are not required to be members of the pool.</td>
<td>All health insurance carriers, including health care service plans and health maintenance organizations authorized to issue insurance in the State of Indiana, are required to be members of the pool. Self-insured employer health plans are also required to participate.</td>
<td>All health insurance carriers, including health care service plans and health maintenance organizations authorized to issue insurance in the State of Iowa, are required to be members of the pool.</td>
<td>All health insurance carriers, including health care service plans and health maintenance organizations authorized to issue insurance in the State of Minnesota, are required to be members of the pool. The statute originally required self-insured and self-funded employer health plans to participate. A U.S. District Court ruled in 1980 that ERISA exempts self-insurers from state insurance regulation and, therefore, from participation in risk pools.</td>
</tr>
<tr>
<td>6. Financing</td>
<td>a) Premium</td>
<td>The premium rates cannot be less than 125 percent or more than 250 percent of the average group premium rate offered by health insurers in the state for comparable coverage.</td>
<td>The premium rates cannot be less than 150 percent or more than 200 percent of the average premium rates for individual standard risks in the state for comparable coverage.</td>
<td>The premium rates cannot exceed 150 percent of the average premium rates for individual standard risks in the state for comparable coverage.</td>
<td>The premium rates cannot exceed 125 percent of the average premium rates for individual standard risks in the state for comparable coverage.</td>
</tr>
<tr>
<td>b) Pool funding</td>
<td>All pool members are assessed in proportion to their share of the state insurance market.</td>
<td>All pool members are assessed in proportion to their share of the state insurance market. Members can credit their assessments against state premium and income taxes.</td>
<td>All pool members are assessed in proportion to their share of the state insurance market. Members can credit assessments against state premium and income taxes and can increase rates to offset assessment.</td>
<td>All pool members are assessed in proportion to their share of the state insurance market. Members can credit assessments against state premium tax.</td>
<td></td>
</tr>
<tr>
<td>c) Estimated pool loss</td>
<td>$1,533,000 in calendar year 1985.</td>
<td>Data not available.</td>
<td>$3,339,000 in calendar year 1985.</td>
<td>Program is not operational.</td>
<td>$5,507,000 in calendar year 1985.</td>
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</tr>
<tr>
<td>1. Eligibility</td>
<td>All state residents ineligible for Medicare who have been rejected by 2 health insurers or have had restrictive rider or preexisting condition limitations required by 2 insurers within 6 months prior to applying to the pool.</td>
<td>All persons who have been state residents for at least 6 months who are ineligible for Medicare and who within 6 months prior to applying to the pool, were rejected by 1 health insurer or had coverage with a restrictive rider that limits coverage for more than 12 months. Individuals with coverage at a rate higher than the pool rate are also eligible.</td>
<td>All persons who have been state residents for at least 6 months who have been rejected by 1 health insurer or who have had restrictive rider or preexisting condition limitations from 1 health insurer within 6 months prior to applying to the pool.</td>
<td>All state residents ineligible for Medicaid who have been rejected for similar coverage by 1 health insurer.</td>
<td>All state residents who have been rejected from 2 health insurers (only 1 required for persons with AIDS) or who have received notice of benefit reduction or a 50 percent or more premium increase.</td>
</tr>
<tr>
<td>2. Covered Benefits</td>
<td>Subject to cost-sharing requirements, benefits include hospital services, professional diagnostic and treatment services, home health services, oral surgical services, prescription drugs, and rental or purchase of durable medical equipment. The maximum lifetime benefit per covered person is $100,000.</td>
<td>Subject to cost-sharing requirements, benefits include hospital services, professional diagnostic and treatment services (other than dental), limited mental health services, skilled nursing facility services, home health services, prescription drugs, and rental or purchase of durable medical equipment. The maximum lifetime benefit per covered person is $500,000.</td>
<td>Subject to cost-sharing requirements, benefits include hospital services, professional diagnostic and treatment services (other than dental), limited mental health services, skilled nursing facility services, home health services, oral surgical services, prescription drugs, and the rental or purchase of durable medical equipment. The maximum lifetime benefit per covered person is $250,000.</td>
<td>Subject to cost-sharing requirements, benefits include hospital services, professional diagnostic and treatment services (other than dental), limited mental health services, skilled nursing facility services, home health services, oral surgical services, prescription drugs, and rental or purchase of durable medical equipment. The maximum lifetime benefit per covered person is $250,000.</td>
<td>Subject to cost-sharing requirements, benefits include hospital services, professional diagnostic and treatment services (other than dental), limited mental health services, skilled nursing facility services, home health services, oral surgical services, prescription drugs, and rental or purchase of durable medical equipment. The maximum lifetime benefit per covered person is $250,000.</td>
</tr>
<tr>
<td>Features</td>
<td>Montana</td>
<td>Nebraska</td>
<td>North Dakota</td>
<td>Tennessee</td>
<td>Wisconsin</td>
</tr>
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</tr>
<tr>
<td>3. Preexisting Conditions and Waiting Period</td>
<td>Coverage is excluded for the first 12 months following enrollment for a medical condition that was diagnosed or treated during the 5-year period prior to coverage. The waiting period does not apply to persons who have had continuous coverage under a policy during the previous year.</td>
<td>Coverage is excluded for the first 6 months following enrollment for a medical condition that was diagnosed or treated during the 6-month period prior to coverage.</td>
<td>Coverage is excluded for the first 6 months following enrollment for a medical condition that was diagnosed or treated during the 3-month period prior to coverage.</td>
<td>Coverage is excluded for the first 6 months following enrollment for a medical condition that was diagnosed or treated during the 6-month period prior to coverage.</td>
<td>Coverage is excluded for the first 6 months following enrollment for a medical condition that was diagnosed or treated during the 6-month period prior to coverage.</td>
</tr>
<tr>
<td>Waiver of Waiting Period</td>
<td>None.</td>
<td>The 6-month waiting period can be waived if preexisting condition exclusions have been satisfied under prior health insurance coverage. Individuals who request the waiver may be subject to a 10 percent increase in their premiums.</td>
<td>The 6-month period can be waived if a person had health insurance coverage for the 12-month period immediately before pool coverage begins. The waiting period can also be waived for persons who pay a premium, which is 3 times the monthly premium for the 6-month period, in addition to the normal monthly rate.</td>
<td>None.</td>
<td>None.</td>
</tr>
<tr>
<td>4. Cost-Sharing</td>
<td>Deductibles offered cannot exceed $1,000. In addition, 20 percent in coinsurance is required for all covered expenses. Out-of-pocket expenses for covered services are limited to $5,000 per covered person.</td>
<td>Plan options available under the program offer deductibles of $250, $500, and $1,000. In addition, 10 percent in coinsurance is required for all covered expenses. Out-of-pocket expenses for covered services are limited to $5,000 per covered person.</td>
<td>Plan options available under the program offer deductibles of $150, $500, and $1,000. In addition, 20 percent in coinsurance is required for all covered expenses. Out-of-pocket expenses for covered services are limited to $3,000 per person.</td>
<td>Plan options available under the program offer deductibles of $500 and any other amounts authorized by the administering board. In addition, 20 percent in coinsurance is required for all covered expenses. Out-of-pocket expenses for covered services are limited to $2,000 for individual coverage and $4,000 for family coverage.</td>
<td>The deductible is set at $1,000. In addition, 20 percent in coinsurance is required for all covered expenses. Out-of-pocket expenses for covered services are limited to $2,000 for individual coverage and $4,000 for family coverage.</td>
</tr>
</tbody>
</table>
5. **Pool Members**

All health insurance carriers, including health care service plans and health maintenance organizations authorized to issue insurance in the State of Montana are required to be members of the pool.

All health insurance carriers, including health care service plans and health maintenance organizations authorized to issue insurance in the State of Nebraska are required to be members of the pool.

All health insurance carriers, including health care service plans and health maintenance organizations authorized to issue insurance in the State of North Dakota are required to be members of the pool. Health maintenance organizations are not required to be members.

All health insurance carriers, including health care service plans and health maintenance organizations authorized to issue insurance in the State of Tennessee are required to be members of the pool.

All health insurance carriers, including health care service plans and health maintenance organizations, authorized to issue insurance in the State of Wisconsin are required to be members of the pool. Self-insured employer health plans are also required to participate. However, a U.S. District Court ruled in 1981 that ERISA exempts self-insurers from state insurance regulation and, therefore, from participation in the pool.

6. **Financing**

   a) **Premium**

   The premium rates cannot be less than 150 percent or more than 400 percent of the average premium rates for individual standard risks in the state for comparable coverage.

   The premium rates cannot be less than 135 percent or more than 165 percent of the average premium rates for individual standard risks in the state for comparable coverage.

   The premium rates cannot exceed 135 percent of the average premium rates for individual standard risks in the state for comparable coverage.

   The premium rates cannot exceed 125 percent of the average premium rates for individual standard risks in the state for comparable coverage.

   b) **Pool Funding**

   All pool members are assessed in proportion to their share of the state insurance market. Members can credit assessment against state premium tax.

   All pool members are assessed in proportion to their share of the state insurance market. Members can credit assessment against state premium tax.

   All pool members are assessed in proportion to their share of the state insurance market. Members can credit assessment against state premium and income taxes.

   All pool members are assessed in proportion to their share of the state insurance market. Members can credit assessment against state premium tax.

   c) **Estimated Pool Losses**

   Program is not operational.

   Program is not operational.

   $5,900,000 in calendar year 1985.

   Program is not operational.

   $1,730,000 in calendar year 1985.
<table>
<thead>
<tr>
<th>Features</th>
<th>Montana</th>
<th>Nebraska</th>
<th>North Dakota</th>
<th>Tennessee</th>
<th>Wisconsin</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of Covered Persons</td>
<td>Program is not operational.</td>
<td>Program is not operational.</td>
<td>1,131 members as of May 1, 1986.</td>
<td>Program is not operational.</td>
<td>1,964 members as of May 1, 1986.</td>
</tr>
</tbody>
</table>


1. Legislation establishing the program was enacted in April 1985. Coverage was scheduled to be available under the program on January 1, 1987.
2. Legislation establishing the program was enacted in April 1985. Coverage is expected to be available under the program on July 1, 1987.
3. Legislation establishing the program was enacted in April 1985. Coverage was scheduled to be available under the program on October 1, 1986.
4. Legislation establishing the program was enacted in April 1986. Coverage is expected to be available under the program on July 1, 1987.
5. Estimates are from the Health Insurance Association of America and state insurance commissioners.
Pension Lump-Sum Distributions and Tax Reform

Tax reform bills would increase the taxes owed by individuals receiving a lump-sum distribution from a pension plan in an attempt to encourage saving for retirement. This study published by the Employee Benefit Research Institute (EBRI) shows that there is generally a less than 5 percent probability that a preretirement lump-sum distribution will be rolled over into retirement savings, and there is only a 30 percent chance that it will be saved in any form.

_Spend It or Save It? Pension Lump-Sum Distributions and Tax Reform_, by Dr. G. Lawrence Atkins, explores the policy question of whether allowing people access to their pension money when they change jobs enhances or diminishes their eventual retirement income. Atkins, the deputy staff director for the Senate Special Committee on Aging, estimates that 71 percent -- 35.5 million -- of the nonfederal pension-covered work force can receive some form of cash payment upon leaving their job, and 30 percent -- 15 million -- can receive a preretirement lump-sum distribution from their primary pension plan.

Under tax reform proposals, amounts not rolled over into an IRA or taken as an annuity would (1) be subject to a penalty tax and (2) no longer qualify for 10-year forward averaging (one-time five-year forward averaging would be available for those over age 59 1/2).

The EBRI study finds that more than 9 million workers have access to a full lump sum, although a lump-sum payment of the pension accrual is not generally available for most workers. Most receiving them are covered under a pension plan sponsored by a single, private-sector employer, but availability varies depending on the type of plan.

Only 10 percent -- 2.6 million -- of the workers covered under single-employer defined benefit plans can receive an unlimited lump-sum payment, and another 20 percent -- 4.9 million -- can receive a lump sum only in the case of a small accrual. By contrast, nearly 81 percent -- 7.2 million -- of the workers covered under a single-employer defined contribution plan have the option of a full cash out available.

_Spend It or Save It? Pension Lump-Sum Distributions and Tax Reform_ is available for $10 prepaid by writing EBRI-ERF Publications, P.O. Box 753, Waldorf, MD 20601.
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EBRI Issue Brief and Employee Benefit Notes (a monthly newsletter featuring the latest news on legislation, corporate trends, statistics, events, and reviews in the field of employee benefits) are written, edited, and published by the staff of the Employee Benefit Research Institute and its Education and Research Fund (ERF). For information on periodical subscriptions and other EBRI publications, contact EBRI-ERF Publications, 2121 K Street, NW, Suite 860, Washington, DC 20037-2121, (202) 659-0670.

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