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# Issue Brief

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**MANDATED EMPLOYER PROVIDED HEALTH INSURANCE**

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**CRS**

by

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## MANDATED EMPLOYER PROVIDED HEALTH INSURANCE

SUMMARY

Between 25 and 37 million Americans under the age of 65 lack health insurance. Recent estimates have drawn special attention to the working uninsured: over two-thirds of the uninsured are employed or the dependents of employed individuals.

The growth in the number of uninsured has occurred at a time when changes in reimbursement policy by 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, 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, in some cases, also 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 currently, 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. In addition, 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 are now 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 100th Congress, there is interest in requiring that all employers provide basic health insurance coverage. While some bills would expand access to health insurance by mandating that employers provide basic health insurance, others seek to define the specific nature of the benefits to be offered. In addition, Health and Human Services Secretary, Otis Bowen, has recommended that the Federal Government encourage employers to provide insurance for catastrophic medical expenses.

## 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 25 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 15% for the under age 65 population between 1982 and 1985. Recent U.S. Census Bureau estimates have drawn special attention to the working uninsured: over two-thirds of the uninsured are employed or the dependents of employed individuals. 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 growth in the uninsured population has occurred at a time 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 the 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 100th 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. These proposals have stimulated substantial congressional debate.

## BACKGROUND AND ANALYSIS

### The Uninsured Population

The number of uninsured Americans is substantial: Estimates for 1985 and 1986 range from 25 million (based on the 1986 National Access Survey done for the Robert Wood Johnson Foundation) to 37 million (based on the 1986 Current Population Survey [CPS] of the U.S. Census Bureau). The number has also been increasing. In "The Uninsured and Uncompensated Care," Sulvetta and Swartz report that in the late 1970s, between 13 and 14.5% of the under-65 population were uninsured. This number increased to 17% by 1984. Estimates vary, and some studies report that the number of medically uninsured actually peaked during the economic recession of the early 1980s, and is now on a downward trend. (The wide variations in estimates of the uninsured are explained by the different questions and methods of sampling used in the surveys. Researchers are attempting to resolve this measurement problem.)

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 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.

According to a study by researchers at the National Center for Health Services Research (using data from the 1977 National Medical Expenditure Survey and the 1980 National Medical Care Utilization and Expenditure Survey), 55% of the uninsured are employed part of the time. This is consistent with an analysis done by the Employee Benefit Research Institute (EBRI) using March 1986 data from the CPS, which found that when spouses and dependents are added, over two-thirds of the uninsured live in families where the head of the household is employed. In addition, the number of workers without coverage grew by more than 22% between 1982 and 1985.

### **The 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 1987 analysis of CPS data on the working uninsured reveal that in 1985, 17 million workers (or about 15% of the non-agricultural, civilian work force) reported no coverage from an employer plan. Of that number, 10.2 million were the head of a family (meaning the family member with the greatest earnings or an individual without a family). Another 6.8 million were other family workers and not the head of the household. The majority of uncovered workers were low wage earners. In 1985, 75% of all uninsured workers earned less than \$10,000; 93% earned less than \$20,000. More than 35% of all uninsured workers earned, on average, less than the Federal minimum wage in 1985; 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 roughly 50% more likely to have no health insurance coverage than the average American worker under age 65. These include workers in 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.

#### **The 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, there is interest in requiring that employers provide basic or catastrophic health insurance coverage.

### **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.

### **The 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 EBRI (based on March 1986 CPS data), 16.7 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 \$30 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 (a) face higher per worker premiums since the risk for insurers is spread over fewer persons; (b) do not benefit to the same extent as larger firms from the tax advantages associated with offering health insurance; (c) experience higher fixed costs in choosing and administering a health plan; (d) 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 (e) 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 than 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 4500 firms, which in turn provide insurance to more than 100,000 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 600 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 an 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, employer health plans must treat women affected by these conditions similarly to other employees, based on their ability or inability to work.

Proposals to mandate employers to provide coverage date back to the Nixon Administration. 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.

Under COBRA, 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.)

Failure to provide continued health coverage could result in the loss of tax deductibility for employer contributions to their employees' health insurance, and penalties under ERISA. In addition to the new requirements imposed on private sector employers, Title X of COBRA also imposes similar requirements on group health plans maintained by any state or political subdivision that receives funds under the Public Health Service Act.

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; some imposed new parameters on the nature of the continued health insurance benefit. In 1986, Congress also considered additional expansions of COBRA. For example, under S. 2402 (Kennedy), S. 2403 (Durenberger) and H.R. 4742- (Stark), COBRA would have been amended to require employers to provide continued health coverage to laid-off workers for 4 months at the employer's expense. While these measures did not pass, Congress did provide in the Omnibus Budget Reconciliation Act 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. (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 (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 "by year-end 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 discusses a number of options to encourage employers to provide catastrophic coverage, it recommends that States require that such coverage be offered in all employment-related plans. It specifies that employers should not be required to finance such coverage, and also recommends 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. However, some of these options have been incorporated in legislation introduced in the 100th Congress, such as H.R. 2300 (Gradison), which denies the tax deduction for employer-provided health insurance to employers who fail 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 more than 100 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 (such as recommended in the Bowen report). 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 (S.1265, H.R. 2508), 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 leave the nature of the benefit package unspecified. There are also more 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 (H.R. 1449, S. 968).

#### **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 (S. 1265, H.R. 2508), 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.

### **LEGISLATION**

#### **H.R. 1449 (Jenkins), S. 968 (Chafee)**

Child Health Incentives Reform Program. Amends the Internal Revenue Code of 1986 to deny an employer a deduction for group health plan expenses unless such plan includes first dollar coverage for pediatric health care. H.R. 1449 introduced Mar. 5, 1987; referred to Committee on Ways and Means. S. 968 introduced Apr. 9, 1987; referred to Committee on Finance.

#### **H.R. 2300 (Gradison)**

Catastrophic Illness Expense Protection Amendments of 1987. Amends the Internal Revenue Code of 1986 to deny a deduction for group health plan expenses unless an employer's plan includes protection against catastrophic physician and hospital expenses as part of that coverage. Limits employee liability for physician and hospital expenses to out-of-pocket costs of \$2000 for individuals and \$3,500 for families. Applies to employers with 20 employees or more. Introduced May 6, 1987; referred to Committee on Ways and Means.

#### **H.R. 4951 (Stark)**

Employee Health Benefit Improvement Act of 1988. Amends the Internal Revenue Code of 1986 to impose a tax on employers that fail to provide health benefit plans to their employees and their dependents. Prescribes coverage and premium requirements for such plans, and establishes a tax credit for employee health care premium payments. Provides for the establishment of a Federal health insurance pool in any State that fails to provide a qualified pool. Requires the State or Federal pool to make health insurance available to all employers and individuals in that State. Introduced June 29, 1988; referred to Committee on Ways and Means.



**S. 1265 (Kennedy), H.R. 2508 (Waxman)**

Minimum Health Benefits for all Workers Act. Amends the Public Health Service Act, the Fair Labor Standards Act, and the Employee Retirement Income Security Act to require that employers enroll their employees in a health benefit plan that covers specified health services, and provides protection against catastrophic illness expenses. Limits the deductible to \$250 per person (\$500 per family) and limits copayments to 20% of the cost of any service (excluding certain services for which copayments are prohibited). Limits the employee's share to 20% of the cost of coverage, and requires the employer to cover the full cost of the premium for low wage workers. Provides that employers can provide benefits that are equivalent on an actuarial basis to those specified. Employers who do not have a plan that meets the minimum benefit standards would be required to join regional insurance pools to be established by the Secretary of Health and Human Services. Failure by an employer to provide insurance would result in the loss of eligibility 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. S. 1265 introduced May 21, 1987; referred to Committee on Labor and Human Resources. On Feb. 17, 1988, the Committee voted to report S. 1265, as amended, to the Senate. H.R. 2508 introduced May 21, 1987; referred to Committees on Energy and Commerce, and Education and Labor.

**CONGRESSIONAL HEARINGS, REPORTS, AND DOCUMENTS**

- U.S. Congress. House. Committee on Education and Labor. Subcommittee on Labor-Management Relations. Access to health insurance. Hearing, 100th Congress, 2d session. June 9, 1988. (unpublished)
- Committee on Energy and Commerce. Subcommittee on Health. Minimum Health Benefits for All Workers Act of 1987 and related bills. Hearing, 100th Congress, 2d session. Apr. 14, 15, 1988. (unpublished)
- Committee on Small Business. The health insurance problem. Hearings, 100th Congress, 1st session. May 6, June 16, 18, 1987. Washington, U.S. Govt. Print. Off., 1987. Serial no. 100-7
- Committee on Ways and Means. Subcommittee on Health. Insurance protection for catastrophic health expenses for individuals under age 65. Hearing, 100th Congress, 1st session. May 12, 1987. (unpublished)
- The Employee Health Benefit Improvement Act of 1988. Hearings, 100th Congress, 2nd session. Aug. 9 and Sept. 22, 1988. (unpublished)
- U.S. Congress. Senate. Committee on Finance. Hearing on the Uninsured. Hearing, 100th Congress, 2nd session. July 25, 1988. (unpublished)

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- Minimum Health Benefits for All Workers Act of 1987. Hearing, 100th Congress, 1st session. June 24, 1987. Washington, U.S. Govt. Print. Off., 1987.  
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- Minimum Health Benefits for All Workers Act. Hearing, 100th Congress, 1st session. Nov. 4, 1987. (unpublished)
- Minimum Health Benefits for All Workers Act; report. May 25, 1988. (100th Congress, 2d session. Senate. Report no. 100-360)
- Committee on Small Business. To examine the cost and availability of health care benefits for small businesses and proposals for federally mandated health benefits. Hearing, 100th Congress, 1st session. Apr. 23, 1987. U.S. Govt. Print. Off., 1987.  
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- U.S. Library of Congress. Congressional Research Service. Private health insurance continuation coverage, by Beth C. Fuchs. [Washington] 1987. (Updated regularly)  
CRS Issue Brief 87182
- Private health insurance continuation coverage: legislative history of Title X of COBRA, by Beth C. Fuchs. [Washington] July 15, 1987.  
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- Health insurance and the uninsured: background data and analysis, prepared for the Subcommittee on Labor - Management Relations and the Subcommittee on Labor Standards of the House Committee on Education and Labor, and the Subcommittee on Health and the Environment of the House Committee on Energy and Commerce, and the Senate Special Committee on Aging. by Beth Fuchs, [Washington] May 1988.  
CRS Report 88-537 EPW
- Employer provided health insurance: comparison of the major provisions of the "Minimum Health Benefits for All Workers Act" (S. 1265/H.R. 2508) as introduced, S. 1265 as reported by the Senate Labor and Human Resources Committee, and the "Employee Health Benefits Improvement Act" (H.R. 4951), by Beth C. Fuchs and Linda Akiyana. [Washington] Sept. 2, 1988.  
CRS Report 88-588 EPW