

Report for Congress

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Health Insurance for Displaced Workers

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Summary

The events of September 11, 2001, the economic aftermath and the relocation of American-based firms abroad have been separating persons from employment and reducing access to health insurance. In response, the 107th Congress considered a wide array of provisions intended to stimulate the economy and promote job growth, addressing such areas as trade practices, tax policy, labor, state fiscal relief and health care. Part of this debate was about whether, and how, to continue (or restore) health insurance for displaced workers and their families. As economic conditions leading to job loss persist and the number of uninsured increases, discussion concerning policy options for the uninsured will likely continue into the 108th Congress.

The proposals offered in the House and Senate in the 107th Congress reflected concerns among some Members that existing law may not provide a sufficient safety net for the unique economic situation the U.S. is currently facing. This concern is likely due to three contributing factors: health insurance is costly; continuation coverage for those who had employer-based coverage, also known as COBRA coverage has limited reach; and coverage under programs designed to help lower income individuals, such as Medicaid and the State Children's Health Insurance Program (SCHIP), are not available to all displaced workers.

The 107th Congress considered several approaches to expanding this safety net for subsets of the population of displaced workers and their families. Among these approaches were proposals that would have assisted persons with the purchase of health insurance through tax credits for health insurance premiums, block grants to states, subsidies for COBRA continuation coverage, as well as proposals that would have provided states the option of temporarily expanding their Medicaid programs. Although a variety of measures were proposed to assist displaced workers and their families in maintaining or acquiring health insurance, they diverged on who would be offered assistance, and what form of assistance should be provided.

On August 6, 2002, the President signed the Trade Act of 2002 (**P.L. 107-210**), a bill which contains, among other things, provisions aimed at assisting workers who have lost jobs and are receiving Trade Adjustment Assistance (TAA) with the purchase of health insurance. The law provides a refundable and advanceable tax credit of up to 65% of a TAA recipient's health insurance premiums and authorizes grant programs intended to encourage states to establish or expand programs for the uninsured. An expansion of this program may be considered by the 108th Congress as a method for providing assistance to other groups of uninsured individuals.

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Health Insurance for Displaced Workers

Introduction

Largely in response to the events of September 11 and the economic downturn that followed, the House and Senate considered a number of approaches to assist displaced workers with the cost of health insurance. Many of the proposals were in bills that included a wide array of provisions intended to stimulate the economy, addressing such areas as trade practices, tax policy, labor, state fiscal relief and health care. Part of this debate was whether, and how, to continue (or restore) health insurance for persons who lost their jobs as a result of the downturn in the economy, the terrorist activities of last fall, or the relocation of American-based factories abroad. Discussion concerning policy options for the uninsured will likely continue into the 108th Congress, in part due to the U.S. Census Bureau's report that the number of uninsured increased by 1.4 million in 2001, totaling 41.2 million.¹

The 107th Congress considered several bills that would provide health care assistance to certain displaced workers and their families. The conference report (H.Rept. 107-624) for **H.R. 3009** (the Trade Act of 2002) was passed by the House (July 27, 2002) and the Senate (August 1, 2002), and signed by the President (**P.L. 107-210**) on August 6, 2002. The law contains, among other things, authorization of presidential trade promotion authority (TPA) and includes provisions aimed at assisting workers, who have lost their jobs and are receiving Trade Adjustment Assistance² (TAA), with the purchase of health insurance. It provides for a refundable and advanceable tax credit of up to 65% of a TAA recipient's health insurance premiums and will authorize funding for grant programs intended to encourage states to establish or expand programs for the uninsured. Many analysts expect that these provisions and the new programs they establish will provide a model for Congress to evaluate future proposals to provide assistance to other uninsured individuals.

Bills considered earlier in the 107th Congress that failed to pass both houses, include **H.R. 622**, passed by the House on February 14, 2002, and **H.R. 3529**, passed by the House on January 20, 2002. Both bills would have provided a refundable, and, for certain individuals who had recently lost jobs and health care coverage, an advanceable tax credit equal to 60% of the amount paid during the taxable year for

¹ U.S. Census Bureau, September 30, 2002: Numbers of Americans With and Without Health Insurance Rise. [<http://www.census.gov/Press-Release/www/2002/cb02-127.html>]

² Trade Adjustment Assistance (TAA) for workers offers extended unemployment benefits and job training to workers left jobless when imported goods have contributed importantly to their job loss. For more information see CRS Report RS21078: Trade Adjustment Assistance for Workers: Legislation in the 107th Congress, by Paul J. Graney.

health insurance premiums. Under these proposals, individuals and their dependents would be eligible for a period not to exceed 12 months. Both bills would have provided a \$4 billion increase to the National Emergency Grants program for subsidies for the purchase of insurance, among other purposes, and just under \$4.6 billion to states through direct payments from the Secretary of Treasury for health care items and services. National Emergency Grants are currently administered by the Department of Labor and are available to states or localities affected by major economic dislocations. Unlike **H.R. 3529**, **H.R. 622** also included a provision that would have provided a total of \$100 million in grants to states to either create high risk pools or fund existing ones.³

H.R. 3090 was passed by the House on October 24, 2001. This bill would have provided health care assistance for the unemployed by increasing Social Service Block Grant funding by an additional \$3 billion for FY2002. If enacted, states could have used these funds for several purposes, including paying for health insurance for certain unemployed individuals who are not eligible for other federal health insurance programs.

In the Senate, a variety of approaches were considered. On November 9, 2001 the Senate Finance Committee considered the House-passed **H.R. 3090**. The committee passed it with an amendment in the nature of a substitute. The Finance committee's version of **H.R. 3090**, The Economic Recovery and Assistance for American Workers Act of 2001, would have provided direct payments from the Department of Treasury to health plans to cover 75% of premiums on behalf of unemployed workers purchasing health insurance through their former employers under the continuation health benefits provisions of the Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA). The bill would also have allowed states to use Medicaid funds to subsidize the cost of the remaining 25% of COBRA continuation health benefits for certain low-income individuals unable to afford their share of the premium. States electing this option would have received federal matching dollars at the State Children's Health Insurance Program (SCHIP) enhanced match (described below). In addition, the bill would have provided states the option of extending Medicaid coverage temporarily to those displaced workers who do not qualify for COBRA continuation coverage.

³ In general, high risk pools provide state subsidized health coverage to individuals who have been denied coverage through the private insurance market or charged premiums that they cannot afford due to their health status. Under high-risk programs, states typically cap premium rates at 125 to 200 percent of standard market rates. Most states use money from taxes levied on health insurers in the state and/or by allocating general revenue or special funds to subsidize the cost of care for these high-risk individuals (Achman, Lori and Chollet, Deborah. *Insuring the Uninsurable: An Overview of State High-Risk Health Insurance Pools*. Mathematica Policy Research, Inc., August 2001). As of January 21, 2001, 29 states have set up high-risk pools (or similar comprehensive state programs) designed to provide insurance and risk-spreading for people who are medically uninsurable. (Comprehensive Health Insurance for High-Risk Individuals: A State-By-State Analysis Includes Operating Statistics, Model Bill, Current Premiums, Funding Mechanisms, State Contacts. Self-Employed Country, Inc., National Association of State Comprehensive Health Insurance Plans, Fourteenth Edition, 2000.)

On November 14, 2001, however, the Senate Finance Committee's version of **H.R. 3090** failed to overcome two budget points of order. Finally, a proposal considered, but not introduced, would have provided refundable tax credit to help displaced workers pay up to 50% of the premiums for COBRA continuation health coverage. The proposal also included a \$5 billion increase for National Emergency Grants to provide subsidies for the purchase of insurance, among other purposes.

This report discusses enacted legislation as well as other proposed bills to show the scope of options considered by the 107th Congress. Many of these approaches will likely be considered again by the 108th Congress as it deals with issues raised by the legislation, including affordability, populations impacted, gaps in coverage and state participation.

Health Insurance Coverage for Unemployed Workers and Their Families

Current Experience and Law

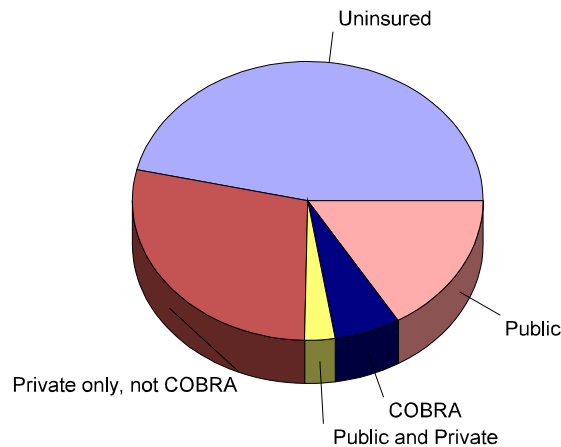
Figure 1 summarizes the insurance status, including COBRA participation, of non-elderly unemployed adults in 1999, the latest year for which such data are available. About one-third (31%) of unemployed non-elderly adults retained private health insurance coverage through their spouses' employers, by purchasing policies in the individual market for insurance, or through some combination of private and public coverage in 1999 (28% private, not COBRA, plus 3% public and private). The current law safety net for workers losing their jobs covered an additional 22% of unemployed non-elderly adults. The safety net consists of COBRA continuation coverage (6%) and public programs (16%), such as Medicaid, the State Children's Health Insurance Program (SCHIP) or other public programs. Among the unemployed, however, the largest group (46%) did not have health insurance coverage. Below is a description of the major options in current law that can be used to cover unemployed displaced workers.

Title X of COBRA. Title X of the Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA, P.L. 99-272) requires employers who have 20 or more employees and who offer health insurance to continue to offer coverage for their employees and their families under certain circumstances (termination or reduction in hours of employment, death, divorce or legal separation, enrollment in Medicare, or the end of a child's dependency under a parent's health plan). Individuals have a maximum 104-day window in which to purchase COBRA coverage.⁴ The coverage generally lasts 18 months, but may be extended for a longer period depending on the nature of the event triggering coverage. Employers are not

⁴ Employers must notify the health plan administrator of the "COBRA qualifying event" within 30 days. The plan administrator must notify the eligible individual within 14 days of receiving the employer's notice. The employee must choose whether or not to elect COBRA coverage within the election period of 60 days, bringing the total number of days to a maximum of 104.

required to pay for this coverage; instead, they may charge the beneficiary up to 102% of the premium (100% of the premium plus a 2% administrative fee). Individuals who purchase COBRA continuation coverage are not eligible for as many tax advantages as those who purchase health insurance through their employers (described below). Purchasers of COBRA continuation coverage may deduct the amount they pay on premiums, only if their total uncompensated medical expenses exceed 7.5% of adjusted gross income.

Figure 1. Insurance Status of Non-Elderly Unemployed Adults, 1999



Source: CRS Analysis of Survey and Income and Program Participation data.

HIPAA Group to Individual Portability Protections. The health insurance reforms of the Health Insurance Portability and Accountability Act (HIPAA) of 1996 (HIPAA, P.L. 104-191) ensure that qualified individuals who are moving from one job to another or from employment to unemployment are not denied health insurance in the group or individual market because they have a preexisting medical condition (portability). HIPAA limits the amount of time a plan can postpone providing coverage to participants and beneficiaries in group health plans due to preexisting conditions and guarantees that qualified individuals and employers who choose to purchase coverage are able to find a plan (guaranteed offer). States have the choice of either enforcing the HIPAA individual market guarantees, referred to as the “federal fallback,” or they may establish an “acceptable alternative state mechanism.” Examples of potential alternative state mechanisms include health insurance coverage pools or programs, mandatory group conversion policies,⁵ guaranteed issue of one or more plans of individual health insurance

⁵ Some states require health insurance issuers to allow a person to “convert” to an individual policy once he or she has lost group coverage. The individual maintains the policy generally (continued...)

coverage, open enrollment by one or more health insurance issuers, or a combination of such mechanisms. Many states have elected to provide group-to-individual portability through high-risk pools, while others utilize a combination of high-risk pools, existing state insurance reform laws, and/or other mechanisms.

Tax Advantages. Current law provides important tax advantages for employer-sponsored health insurance. Employer contributions towards this insurance are excluded from workers' gross income in determining their income tax liability; in addition, the contributions are not considered in determining either the employers' or the workers' share of employment taxes (i.e. social security, Medicare and unemployment taxes). Workers may pay their share of the premiums on a pre-tax basis if their employer has a premium conversion plan. Alternatively, workers can deduct their share of the premiums as an itemized deduction to the extent the premiums and other unreimbursed medical expenses exceed 7 ½ % of adjusted gross income. Self-employed tax payers may deduct 70% of the cost of their health insurance premiums as a deduction in determining adjusted gross income; this "above-the-line" deduction is not limited to itemizers. The self-employed deduction increases to 100% starting in 2003.

Medicaid and SCHIP. Medicaid, Title XIX of the Social Security Act, and the State Children's Health Insurance Program (SCHIP), Title XXI of the Social Security Act, contribute to the health care safety net for uninsured children and for other specified groups of people with low income. Most healthy adults, however, do not qualify for Medicaid or SCHIP because enrollment is offered only to specific groups of parents and disabled individuals. Medicaid and SCHIP are more likely to be sources of coverage for the children of displaced workers.

Medicaid is a federal-state entitlement program providing medical assistance for low-income individuals who are aged, blind, disabled, members of families with dependent children, or who have one of a few specified conditions for which Medicaid coverage is conferred. Those conditions include pregnancy, tuberculosis, and breast or cervical cancer. SCHIP, also a federal-state program, builds upon Medicaid coverage for low- and modest-income children. States can choose to use SCHIP funding to cover certain children in families with income generally at or below 200% of the federal poverty level, but above the Medicaid income cutoff. The federal government shares in a state's Medicaid costs by means of a statutory formula designed to provide a higher federal matching rate, Federal Medical Assistance Percentage (FMAP), to states with lower per capita income. Matching payments are larger under SCHIP than they are under Medicaid and are called Enhanced Federal Medical Assistance Percentage (Enhanced FMAP). The Medicaid FMAP for FY2003 ranged from 50% to 77% while the SCHIP Enhanced FMAP ranged from 65% to 83.3%. Children whose health coverage is funded by SCHIP dollars can receive their health benefits through their state's Medicaid program, or states can

⁵ (...continued)

with the same issuer, but it becomes an individual policy. The benefits offered by the conversion policy may not be the same as those under the group policy and the premiums are often more expensive.

establish separate health care programs. Coverage for adults under SCHIP is restricted to specific circumstances, either through subsidized employer-sponsored family coverage or special demonstration waivers.

Gaps in Current Law Coverage

Provisions in the House and Senate bills reflected concerns among some Members of the 107th Congress that existing law may not provide a sufficient safety net for some displaced workers and their families. Concerns in the past have been partly due to the following contributing factors: health insurance is costly; COBRA has limited reach; and Medicaid and SCHIP are not available to all displaced workers. As economic conditions leading to job loss persist and the number of uninsured increases, concerns about the reach of the existing safety net may reemerge in the 108th Congress.

The Cost of Health Insurance

For many, the cost of health insurance is burdensome. A recent survey of employers found that in 2002 employer-based health insurance policies cost on average \$3,060 for single coverage. For family coverage, the average annual premium was estimated to be \$7,954⁶ For a family of four, earning twice the poverty level (\$36,200 in 2002), this is about 22% of their annual income although employers often contribute to the cost. Often premiums are even higher for those purchasing comparable benefits in the individual market.

For several consecutive years, health insurance costs have risen rapidly, exceeding inflation, and large increases are projected to continue. For example, employer-based health insurance premiums are estimated to have risen by 12.7% between spring of 2001 and spring of 2002.⁷

COBRA's Limitations

About 4.7 million individuals were estimated to be enrolled in employer-based plans continued under COBRA's provisions at any one time in 1999. This represented only 6% of all unemployed workers. This low rate of COBRA coverage reflects COBRA's limited reach. Only certain employers are required to offer continuation health benefits – those firms that have 20 or more employees *and* that offer a group health plan. Firms are only required under COBRA to offer continued coverage to individuals who were enrolled in the plan at the time their job was lost or their hours were reduced. A study released by the Kaiser Family Foundation estimated that in 1999 only 57% of workers and their adult dependents would have been eligible under COBRA's provisions if they had become unemployed.⁸

⁶ The Kaiser/HRET Survey of Employer-Sponsored Health Benefits Estimates, 2001.

⁷ Weber, Joseph. America, This is Really Gonna Hurt. *Business Week*, September 17, 2001.

⁸ *COBRA Coverage for Low-Income Unemployed Workers*. The Kaiser Commission on (continued...)

Low-wage workers are less likely to have access to COBRA's protections than other workers. This is largely for two reasons. First low-income workers are less likely to work for employers that offer coverage. An Urban Institute study estimates that about 32% of low-income (individuals with incomes under 200% FPL) workers and their adult dependents qualify for COBRA compared to 67% of high-income (individuals with incomes over 300% FPL) workers.⁹ Second, when offered coverage, low-wage workers are less able to afford their required premium contributions. As described above, the beneficiary is responsible for up to 102% of the premium. The Kaiser study estimated that among those who are newly unemployed, fewer than 20% purchase it, and those with lower incomes are less likely to purchase it than their wealthier counterparts.¹⁰

Medicaid/SCHIP Limitations

Under current law, Medicaid and SCHIP eligibility for non-disabled adults is allowed only under very limited circumstances. Through demonstration waivers, states can extend eligibility to non-traditional groups, such as childless adults. But those waivers are held to a budget neutrality requirement that prohibits new program spending. This means that states cannot expand coverage for some groups without reducing spending in some other part of the program. In most states, this is a barrier to large scale eligibility expansions, even in states that are prepared to devote additional state funds to expansion groups. SCHIP has another option for extending coverage to non-disabled adults who are parents of SCHIP eligible children. The "family variance" allows states to use SCHIP funds for a premium (presumably for employer-based coverage) for an entire family as long as the payment is not more than the agency would have paid for the SCHIP-eligible children in the household alone to be enrolled in traditional SCHIP coverage.

Policy Considerations

Although a variety of measures were proposed to assist displaced workers and their families in maintaining health insurance coverage or in acquiring new coverage, they diverged on who would be offered assistance, and what form of assistance should be provided.

⁸ (...continued)

Medicaid and the Uninsured. Washington, D.C. October 2001. (Hereafter cited as COBRA Coverage. The Kaiser Commission, 2001.)

⁹ Zuckerman, Stephen, Jennifer Haley, and Matthew Fragale. *Could Subsidizing COBRA Health Insurance Coverage Help Most Low-Income Unemployed?* Urban Institute, Washington, DC, 2001.

¹⁰ COBRA Coverage. The Kaiser Commission, 2001.

Legislation in the 107th Congress

While all of the proposals target displaced workers, each defined the group of workers eligible for assistance differently. **Table 1** describes the major legislation and populations they targeted.

Table 1. Health Provisions in Major Economic Stimulus Legislation in the 107th Congress

Proposal and status	Form of assistance	Method	Target group
P.L. 107-210, signed by the President on August 6, 2002	Tax credit	Up to 65% of health insurance premiums will be available as a refundable and advanceable tax credit payable to providers of qualified health insurance.	Persons who are receiving Trade Adjustment Assistance (TAA), who would be eligible to receive TAA but for the requirement to exhaust unemployment compensation, who are eligible for alternative TAA, or who are receiving a pension under the Pension Benefit Guaranty Corporation.
	Grants to states	Authorizes grants to states of \$510 million for 2002-2007.	Available to states for fiscal years 2002-2007 for enrollment assistance and for fiscal years 2002-2004 for health insurance and other support services.
	Grants to states	Establishes a \$100 million grant program for Qualified High Risk Pools.	Available to states for fiscal years 2003-2004 for establishing new qualified high risk pools and operation of existing pools. States with established high risk pools can receive a grant of up to 50% of the losses incurred by the state in connection with the operation of its pool.

Proposal and status	Form of assistance	Method	Target group
H.R. 622 as amended and passed by the House on February 14, 2002	Tax credit	Up to 60% of health insurance premiums would be available either as a refundable tax credit or advanceable through direct payments from Treasury to health insurance plans.	Displaced workers who are receiving Unemployment Compensation (UC) or are certified by a state as eligible for UC benefits but are beyond their benefit year or have exhausted their maximum benefit levels. Qualifying plans would include individually-purchased plans as well as employer-based plans (such as COBRA continuation health benefits) for displaced workers responsible for more than 50% of the premiums. The credit would be available for no more than 12 months.
	Grants to states	Increases National Emergency Grants by \$3.9 billion.	Distributed to states or localities affected by major economic dislocations for employment, training, and health insurance assistance.
	Grants to states	Establishes Temporary State Health Care Assistance grants of just below \$4.6 billion.	Available for states through the end of 2002 to pay for health care items and services (not including Medicaid).
	Grants to states	Establishes \$100 million in grants for Qualified High Risk Pools.	Same as P.L. 107-210.
H.R. 3529 as passed by the House on January 20, 2001	Tax credit	Up to 60% of health insurance premiums would be available either as a refundable tax credit or advanceable through direct payments from Treasury to health insurance plans.	Same as H.R. 622.
	Grants to states	Increases National Emergency Grants by \$4 billion.	Same as H.R. 622.
	Grants to states	Establishes Temporary State Health Care Assistance grants of just below \$4.6 billion.	Same as H.R. 622.

Proposal and status	Form of assistance	Method	Target group
H.R. 3090 as passed by the House on October 24, 2001	Grants to states	Increases Social Services Block Grant by \$3 billion.	Unemployed individuals (and their families) who were employed at some point during 2001, are seeking and available to work and who are not eligible for any other federal health benefit program.
H.R. 3090 as reported by the Senate Finance Committee on November 9, 2001	Premium assistance for COBRA continuation health benefits	The Secretary of Treasury would make payments for up to 75% of the premium directly to group health plans, employers, and or state unemployment insurance offices.	Workers who lose their jobs at any time from September 11, 2001 through December 31, 2002, and who are eligible for and have elected COBRA continuation health benefits. The subsidies could last up to 12 months and would be paid by the Department of the Treasury directly to group health plans, employers, and/or state unemployment insurance offices.
	Medicaid payment of COBRA continuation health benefits	Provides states the option of extending Medicaid to low-income recipients of COBRA premium assistance to cover remaining 25% of premium at an enhanced matching rate.	Low-income individuals whose family income does not exceed 200% of the federal poverty level and who are receiving the proposed 75% subsidy.
	Temporary Medicaid expansion	Provides states the option of extending Medicaid to displaced workers who do not have access to COBRA continuation health benefits and to certain noncitizens. States would be required to terminate enrollment for this new group of beneficiaries once they become insured through another program or under employer-sponsored plans. States electing this option would receive federal matching dollars at the SCHIP enhanced match.	Displaced workers who do not qualify for COBRA continuation coverage; are separated from employment at any time from September 11, 2001 through December 31, 2002; are uninsured; and whose income, asset and resource limitations do not exceed standards established by the state.
Senate Proposal Not Acted Upon	Tax credit for payment of COBRA continuation health benefits	Refundable credit that could be claimed in advance of filing one's tax return, covering up to 50% of COBRA premiums, not to exceed \$140 per month for single coverage and \$340 per month for family coverage.	Individuals who purchase COBRA coverage and file tax returns.

Proposal and status	Form of assistance	Method	Target group
	Grants to states	Increases National Emergency Grants by \$5 billion.	Distributed to states or localities affected by major economic dislocations, to be used for employment, training, and health insurance assistance.

During the 107th Congress, Members chose to consider the health insurance needs of a very small group of uninsured individuals, namely those impacted by U.S. trade policies and those receiving pensions through the Pension Benefit Guaranty Corporation. The number of individuals without insurance, however, is a much larger group. The different target groups in these bills reflect diverse opinions among Members of Congress about which group of uninsured individuals represents the highest priority for assistance. At the end of 2001, the leading bills under consideration focused on those individuals impacted by the terrorist incidents of September 11, 2001. As time passed, the target population changed to individuals impacted by the economic recession. Still later, the leading bills' target group narrowed to extend benefits only to those recipients of Trade Adjustment Assistance. Little information is available to assist with prioritizing among groups of uninsured and determining the best form of assistance for the highest priority groups. It is unknown exactly how many individuals lost health insurance as a result of the terrorist incidents on September 11, 2001, the economic decline, and trade practices that impact U.S. workers. At a national level, there has been an increase in the number of persons experiencing unemployment. The unemployment rate rose to 5.7% in August 2002, among the highest levels since December 1996. Less is known, however, about how many of those recently unemployed individuals are uninsured. Further uncertainty exists about job losses that may yet occur as a result of the general economic downturn, U.S. policies reducing trade barriers, or even recent bankruptcies of several large corporations.

Proposed Forms of Assistance

Each of the options under consideration in the 107th Congress is described below and some of their varying aspects are raised. Each would have provided assistance for either the purchase of health insurance or the provision of health care, but the approaches, as well as who would have been eligible, differ. The 108th Congress may consider these options again as it considers methods of reducing the number of uninsured individuals.

Tax Credits for Health Insurance Premiums. A number of bills, including the recently passed Trade Act of 2002, contained health provisions that would have provided tax credits for displaced workers. Although they differ in their details, their approaches share some common advantages and disadvantages.

Subsidies through the traditional tax system may not provide individuals with the money in time to pay health insurance premiums. Individuals file taxes annually and make claims based on the prior calendar year. Under this system, individuals

need to pay for health insurance premiums first and wait to receive the credit until the next consecutive tax calendar year. **P.L. 107-210**, the House-passed **H.R. 622** and **H.R. 3529** avoided this barrier by providing advanceable credits to eligible individuals through direct payments from the Secretary of Treasury to health insurance plans. Although advanceable payments could correct the timing problem for those who are qualified to receive them, their effectiveness will be determined by the speed in which the administrative processes are implemented to distribute them and by the eligible individual's ability to afford the remainder of the premium. Under some of these proposals, only individuals who file federal tax returns would be eligible for the tax credit. This might exclude some very low wage earners who do not file tax returns.

Block Grants. Block grants were proposed in a number of bills and included in **P.L. 107-210**. Grants to states to fund high risk pools can assist states in designing programs that provide health insurance coverage to persons who are high-risk and often otherwise uninsurable in the state. Under **P.L. 107-210** and **H.R. 622**, funds can be used to either create high risk pools or fund existing ones. Under **P.L. 107-210**, funds will be directed toward pools in which the state restricts premiums charged to no more than 150% of the premium for applicable standard risk rates and that offers a choice of two or more coverage options. However, states will still be able to determine how much to charge enrollees in out-of-pocket costs, what benefits to include under the plans, the length of waiting periods for obtaining care for preexisting conditions, within federal standards, and whom among the otherwise uninsurable population they wanted to cover. **H.R. 3090, as passed by the House**, would have provided an additional \$3 billion to the Social Services Block Grant (SSBG) program to allow states to assist the recently unemployed with the cost of health insurance.

Block grants offer predictability for both state and federal budgets, reducing the chance that costs will escalate uncontrollably. For states, on the other hand, the advantage predictability brings may be reduced if the funds are insufficient to cover the target population. If \$3 billion is divided by the average cost of a private employer-based insurance plan (about \$7,000 for a family policy in the group market in 2001, and \$2,600 for an individual policy), then an estimate of how many average premiums could be paid with \$3 billion can be calculated.¹¹ This calculation would suggest that just over 400,000 families or 1 million individuals could be covered with full subsidies for one full year.¹² If partial subsidies were provided, the number of people that could be reached would increase.

Two advantages of SSBG grants are simplicity and flexibility. Under **H.R. 3090**, funds would have been distributed to states through an established program based on an established formula. The bill did not include specific requirements about who would be eligible for assistance under the grant program nor how such assistance would have been provided. Using SSBG grants, states would have the ability to design and administer the subsidy program that best fits their needs.

¹¹ The Kaiser/HRET Survey of Employer-Sponsored Health Benefits Estimates, 2001.

¹² Such a program is likely to cover a mix of family and individual policies.

On the other hand, under the block grant approach, states would be faced with difficult issues, such as how to reach the target population, how to administer funds quickly and efficiently, and what to do if the funds ran out without having covered all or most of the target population. Distributing funds for displaced workers and families through federal SSBG payments to states may create other inefficiencies as well. Social service programs are not likely to have staff experienced in purchasing health insurance on behalf of low-income people or administrations in place to do so. **H.R. 3090** would have prohibited states from using the funds to expand Medicaid or SCHIP, programs with experienced staff and existing administrations. Second, it is not clear that the current law formula used for distributing SSBG funds would be best for distributing health insurance assistance to people impacted by the recent recession. SSBG funds are distributed to states using a formula based on the population of the state, which may not correlate to the states with the greatest need created by the events of September 11, 2001 or another economic downturn.

National Emergency Grants, like SSBG, can be used to quickly and efficiently move money to states.¹³ An advantage of using the National Emergency Grant program is that funds can be targeted to areas that have been affected by major economic dislocations rather than through an allocation formula to all states. This could allow the Secretary the flexibility to target assistance. Health insurance advocates, on the other hand, opposed this approach because proposals would have allowed the authorization to pay for other employment and training assistance as well as for health insurance. It is thus possible that only some of the funds would have been used to pay for health coverage for dislocated workers.

Subsidies for COBRA Continuation Coverage. Subsidies, like the Senate Finance Committee proposal, that pay all or part of premiums under COBRA's continuation health benefit provisions had several advantages. Individuals who participate in these proposed subsidy programs would have been able to remain in their current provider network and maintain continuous access to medical services. Further, the proposed programs could have also reduced the number of uninsured. Subsidies could have provided incentives to individuals and their families to purchase COBRA continuation health coverage when they might not otherwise have done so.

The proposed legislation also has disadvantages. It would have assisted only those individuals who previously had insurance coverage (as described above). Subsidizing COBRA continuation health coverage may be relatively expensive because employees are guaranteed the same coverage as they had immediately before the qualifying event. Subsidies for more limited benefits packages may be more cost-effective both in terms of federal funding as well as for the enrollee who is required to pay the unsubsidized portion of the premium. In addition, subsidizing employer-based plans would result in larger subsidies for some individuals than for others since some employer plans are more expensive than other employer plans. Finally,

¹³ National Emergency Grants were established by the Workforce Investment Act of 1998 and are administered by the Department of Labor. They are available to states or localities affected by major economic dislocations.

subsidies might result in government payments for people who would have purchased insurance independently.

Although COBRA provides an established mechanism for continuing health insurance, COBRA subsidies would have required the creation of a new administrative system. For example, to implement the 75% subsidy, the Senate Finance Committee proposed to make payments directly from the Department of Treasury to group health plans, employers, and/or state unemployment insurance offices. This activity is not currently conducted by any existing governmental administrative entity. Under the proposal, state Medicaid programs would have had the option to pay the remaining 25% of premiums for individuals in families with income below 200% of FPL. To distribute these payments, state Medicaid offices would have had to determine which individuals receive the 75% subsidy as well as their income levels possibly requiring coordination between state Medicaid offices and the Department of Treasury.

Temporary Medicaid Expansion Legislation. As a means-tested program, Medicaid is able to provide certain low-income individuals with health insurance coverage that they could not otherwise afford through the group or individual markets. Furthermore, Medicaid has an established administration designed to count applicants' income and resources to determine wealth status. Thus, the administrative burden of providing coverage to this new eligibility group would have been reduced. On the other hand, Medicaid is sometimes perceived negatively because of its association with welfare. This perception could deter some eligible individuals and families from enrolling in Medicaid.

An additional consideration is that Medicaid financing is shared by federal and state governments. Although the cost of this temporary eligibility expansion would have been largely paid with federal dollars, the financial burden would have been distributed across states and the federal government. The effectiveness of the proposal, therefore, would have depended on state decisions to elect to cover this new eligibility group, since they would not have been required to do so. Many state budgets are already strained, with declining state revenue trends forcing many states to initiate funding cuts for their Medicaid programs.¹⁴ The increase in unemployment rates will likely result in an increasing number of persons who will be eligible for Medicaid. States will therefore likely face a growth in enrollment, even without electing to cover this proposed new group. It is thus not clear how many states would have participated.

The Senate Finance Committee proposal also included a provision that would have provided states with additional Medicaid funds to assist them in maintaining their current eligibility standards. It would have allowed states whose FMAP declined for 2002 to maintain their 2001 rates plus one percentage point. All other states would have received their 2002 FMAP plus one percentage point. In addition, those states experiencing higher than average unemployment rates over 3 consecutive

¹⁴ State Budgets Under Stress: How are States Planning to Reduce the Growth in the Medicaid Costs. *Kaiser Commission on Medicaid and the Uninsured*, July 30, 2002. [<http://www.kff.org/content/2002/20020730/statbudupdate73002.pdf>]

months (beginning on or after June 2001 and ending with the second month before the beginning of the calendar quarter), would have received an additional 1% percentage point increase in FMAP, raising their matching rate by a total of two percentage points.¹⁵ The increased federal matching payments were intended to offset state budget shortfalls and increase the likelihood that states will maintain current eligibility levels. The Finance Committee proposal, as drafted, however, did not guarantee that states maintain current eligibility standards.

¹⁵ A similar provision was included in S. 812, as passed by the Senate on July 31, 2002. This provision would hold states with declining FY2003 FMAPs harmless, by allowing them to maintain their 2002 FMAPs and, in addition, would provide all states with an increase of 1.35 percentage points.