# PROVIDING HEALTH COVERAGE FOR THE UNEMPLOYED

Staff Memorandum

May 1983

Prepared by the Staff of the Human Resources
and Community Development Division

Congressional Budget Office

---

This study was prepared by the staff of the Human Resources and Community Development Division of the Congressional Budget Office under the supervision of Nancy M. Gordon, Assistant Director for Human Resources and Community Development (226-2669) and Paul B. Ginsburg, Deputy Assistant Director for Income Security and Health (226-2653). Questions regarding the analysis may be addressed to Tom Buchberger (226-2665).

---

## SUMMARY

As of February 1983, 10.2 million jobless Americans and their dependents lacked any form of health insurance coverage as a direct result of unemployment. Another 20 million had no coverage for other reasons. Lack of coverage is known to impede access to health care and it may lead to diminished health, though confirming data are unavailable. For these reasons, high and persistant unemployment rates have made lack of coverage caused by joblessness an important Congressional concern.

THE ALTERNATIVES AVAILABLE

Both the private and public sectors offer an array of health insurance possibilities for jobless workers, but few are readily available. Ranging from modified extensions of employer-provided policies to privately purchased policies, the private-sector alternatives are characterized by relatively high premium costs that can consume an important share of the incomes of unemployed workers. Public-sector choices are either very circumscribed as to whom they can assist (Medicaid, for example) or severely limited in what costs they will cover--specifically, those of very expensive "catastrophic" illnesses.

OPTIONS FOR CONGRESSIONAL CONSIDERATION

In recognition of these twin problems--high rates of unemployment-related noncoverage and the inaccessibility of alternative insurance--several legislative proposals have been advanced that would involve the federal

government in providing coverage for unemployed persons. These plans, and additional ones analyzed by the Congressional Budget Office, would either use a public program or involve the private sector--that is, employing firms laying off personnel and insurance companies that administer employer-provided insurance. Most of the public options analyzed here would establish entitlements, for which all applicants meeting certain eligibility criteria would qualify. Others would take the form of appropriated grants, either to states or to fiscally distressed hospitals. (These options are outlined in the Summary Table.) The commitment of federal money would vary from virtually none for some of the private-sector options to $6.4 billion in 1984 for the most generous entitlement.

These options can be assessed on several dimensions:

- From a federal standpoint or from the point of view of employers, **how controllable would direct costs be**? And might indirect costs also occur?
- **How quickly could a plan be implemented?**
- **How could assistance be directed toward those recipients who need it most,** namely those segments of the jobless population with the scarcest resources to purchase insurance on their own?

In general, entitlement options would direct aid toward persons believed to need it the most according to the chosen eligibility criteria. To whatever extent entitlements would build on programs already in place--Medicaid and Medicare--they could make assistance available with little delay. Further, if these options included uniform national eligibility standards, they would distribute aid with minimal state-to-state variations.

SUMMARY OF OPTIONS TO PROVIDE HEALTH INSURANCE FOR UNEMPLOYED WORKERS AND THEIR FAMILIES

| Options (and Legislative Proposals) | Target Population | Financing Source | Plan Administration | Rate of Phase-in | 1984 Federal Cost Effects |
|---|---|---|---|---|---|
| | | ENTITLEMENT OPTIONS | | | |
| Individual Purchase of Group Policy | Unemployed and lost coverage a/ | Unemployed worker | Employer and insurer | Fast | None |
| Mandatory Employer-Paid Coverage | Unemployed and lost coverage a/ | Employee and employer b/ | Employer and insurer | Moderate | Possible tax revenue decline |
| Trust Fund to Finance Premiums | Unemployed and lost coverage a/ | Employer b/ | State and insurer | Slow | Possible tax revenue decline |
| State Administered Insurance Pools (S. 307) | Unemployed and lost coverage a/ | Employee, employer, b/ and insurer | State and insurer | Slow | Possible tax revenue decline |
| Catastrophic Insurance | Recipients and exhaustees of unemployment insurance | Federal government | Federal government | Moderate | $3.5 billion |
| Limited Primary-Care Coverage (H.R. 2552) | Recipients and exhaustees of unemployment insurance | Federal and state government c/ | State government | Moderate | $2.6 billion |
| Expanded Medicaid | Unemployed and noncovered d/ | Federal and state government | Federal and state government | Moderate | $6.4 billion e/ |
| Expanded Medicare | Unemployed and noncovered d/ | Employee and federal government | Federal government | Fast | $4.8 billion |
| | | GRANT OPTIONS | | | |
| Increased Categorical Grants to States | Recipients of health-care programs for the low income | Federal government | State government | Fast | Congressionally appropriated |
| Grants to States for Health Coverage (S. 951) | Recipients or exhaustees of unemployment insurance who lost health coverage a/ | Federal and state government c/ | State government | Fast | Congressional appropriation of $900 million f/ |
| Grants to Financially Distressed Hospitals | Hospitals with large uninsured patient load | Federal government | Federal government | Moderate | Congressionally appropriated |

SOURCE: Congressional Budget Office.

a. Eligible population would be restricted to persons previously covered by employer-provided plans.

b. Costs assessed against employers might be shifted over time to employees through lower wage increases or to customers through higher prices.

c. At state option, participants could be required to pay small amounts.

d. Eligibility not contingent on previous coverage under employer-provided plans.

e. Assumes full federal funding for these benefits.

f. Outlay estimate included in language of S. 951.

On the other hand, entitlements would have the drawback of giving rise to costs of uncertain magnitude at the outset that could be difficult to control in the longer term

Costs of grant programs, in contrast, would be far easier to control through the annual Congressional appropriation process, although exercising such control would mean providing less assistance to the unemployed. This approach would also enable states to vary the program's design to meet local needs most effectively. If new program mechanisms were used, however, provision of health coverage would be delayed.

Instead of emphasizing federal fiscal responsibility for providing health coverage for the unemployed, the Congress could mandate several forms of private-sector responsibility. Reliance on the private sector would avoid much of the impact on already-large federal deficits and could be simpler to administer. A problem with this approach, however, is that those industries and firms that account for large numbers of laid-off workers might be in a poor financial position to shoulder the added burden of coverage for the unemployed. This new expense could worsen such firms' condition--in extreme cases, forcing them out of business. While pooling of such risks across firms is a possibility, such a reinsurance mechanism is not available at present.

## PART I. UNEMPLOYMENT, THE COVERAGE AVAILABLE, AND THE GAPS

In February 1983, perhaps 30 million Americans, or 13 percent of the U.S. population, were covered by neither private nor public health insurance. Of that total, 10.2 million persons had lost coverage because of unemployment; for many U.S. workers and their families, loss of a job brings loss of employer-provided health benefits. 1/ The noncovered population is dominated by people who lack coverage for other reasons, however--people who do not qualify for public assistance, and thus Medicaid; those who do have jobs but work for employers that offer no health insurance benefits; and those who cannot afford the often high costs of private policies. Nonetheless, the fraction now without coverage as a result of joblessness is high enough to be of major concern. Lack of coverage is known to reduce the rate at which people use health-care services, although whether or not this brings about a definite deterioration of health cannot be corroborated with data.

With the current jobless rate at persistently high levels--in April, the civilian unemployment rate stood at 10.2 percent--considerable Congressional attention has focused on the companion problem of lacking health coverage. A number of bills to remedy this situation are now under consideration. Some would rely on the private sector for financing and

---

1. This estimate of the extent of health insurance loss attributable to unemployment represents a revision of a Congressional Budget Office estimate presented to the House Committee on Energy and Commerce, Subcommittee on Health and the Environment, January 24, 1983. The current estimate is based on the civilian population excluding those living in institutions.

administration, others on the states and the federal government, but all would start with federal initiative. Reference to many of these proposals is included in the discussion of options in Part III.

The purpose of this paper is to clarify the link between employment and health coverage, describe the existing array of types of coverage, and analyze a number of options.

## EMPLOYMENT STATUS AND HEALTH COVERAGE

Nine of every ten nonagricultural workers are employed by firms that offer health insurance plans as a fringe benefit. 2/ Thus, about 85 percent of the 170 million persons with private-sector health coverage--some 144 million people--obtain their coverage through employment-related health plans. But the fact of employment is no guarantee that workers and their families have coverage. More than 9 million persons who worked all or part of 1977 were without coverage during all of that year. 3/ Employed workers may lack coverage mainly for two reasons. Either they work in firms that do not offer coverage, or they work part time; part-time employees commonly do not qualify for employer-provided health insurance. Another rather small segment of the noncovered group is those persons who have

---

2. Only at most 75 percent of all employees are covered by employment-based health plans, however. Some employees of firms that offer plans are not eligible--for example, because they work part-time--and others choose not to participate.

3. The most recent year for which data are available is 1977; these data come from U.S. Department of Health and Human Services, National Center for Health Services Research, National Medical Care Expenditure Survey (1977).

secured new jobs too recently to qualify for this employment benefit; many employers do not make health benefits available to new personnel before the end of some waiting period.

Characteristics of the Uncovered Population

As much as 11 percent or 12 percent of the population may have been without private or public health insurance in 1977, when the year's unemployment rate was 7.1 percent--about 3 percentage points lower than unemployment today. Results from the 1977 National Medical Care Expenditure Survey (NMCES) describe the fundamental gaps in coverage (see Table 1). 4/

People without coverage in 1977 fall into two groups: those without coverage for the full year (16 million) and those lacking coverage for only part of the year (17 million). This distinction is important, partly because the use of medical services appears to be significantly lower for persons without coverage for the entire year than for those covered for all or only a part of the year.

By and large, persons lacking coverage throughout 1977 were poorer and younger than persons with coverage. About 6.5 million--or two-fifths--of those not covered throughout all of 1977 were members of families

---

4. Using data for 1977 could result in some undercount of the number of persons who have lacked coverage since that date, because of growth in the size of the population and reduction in the proportion of the population holding jobs since 1977. On the other hand, this undercount might have been offset by expansion of employment-based health insurance since 1977.

TABLE 1. HEALTH COVERAGE STATUS BY INCOME, AGE, AND EMPLOYMENT EXPERIENCE IN 1977 (In millions of persons and percents)

| | Uncovered All Year | | Covered Part Year | | Covered Full Year | |
|---|---|---|---|---|---|---|
| | Number | Percent | Number | Percent | Number | Percent |
| Total | 16.3 | 100 | 17.1 | 100 | 179.2 | 100 |
| | | | BY FAMILY INCOME | | | |
| $5,000 and below | 6.5 | 40 | 7.4 | 43 | 41.3 | 23 |
| $5,001 - $10,000 | 3.3 | 20 | 3.5 | 20 | 29.6 | 17 |
| $10,001 - $15,000 | 2.2 | 14 | 2.3 | 13 | 31.7 | 18 |
| Above $15,000 | 4.3 | 26 | 4.0 | 24 | 76.5 | 43 |
| | | | BY AGE GROUP | | | |
| Under 6 | 1.3 | 8 | 2.1 | 13 | 14.8 | 8 |
| 6-18 | 4.0 | 25 | 4.1 | 24 | 42.4 | 24 |
| 19-24 | 3.2 | 20 | 3.5 | 20 | 15.5 | 9 |
| 25-44 | 4.5 | 28 | 5.0 | 29 | 46.3 | 26 |
| 45-64 | 3.3 | 20 | 2.2 | 13 | 37.8 | 21 |
| 65 and over | 0.1 | 1 | 0.1 | 1 | 22.3 | 12 |
| | | | BY EMPLOYMENT STATUS | | | |
| Never worked | 3.2 | 20 | 3.5 | 20 | 44.8 | 25 |
| Worked full year | 6.4 | 39 | 6.2 | 36 | 71.0 | 39 |
| Worked part year | 2.5 | 15 | 2.2 | 13 | 16.2 | 9 |
| Other employed (duration uncertain) | 0.5 | 3 | 0.5 | 3 | 3.2 | 2 |
| Other a/ | 3.6 | 1 | 4.8 | 1 | 44.1 | 3 |

SOURCE: Congressional Budget Office calculations based on U.S. Department of Health and Human Services, National Center for Health Services Research, National Medical Care Expenditure Survey (1977).

a. Includes adults whose labor force status is not known and children under age 14.

with annual incomes below $5,000. 5/ A disproportionately large number of them--3.2 million persons, or one-fifth of the noncovered--were between the ages of 19 and 24.

With respect to income and age, the 17 million persons who lacked coverage for a portion of 1977 resembled the population that lacked coverage for the entire year more than they resembled the population with year-round coverage. Family incomes for those covered part of the year tended to be low, with 43 percent of the partially covered having incomes below $5,000. About 20 percent of those covered part of the year were between the ages of 19 and 24--the same proportion as those without coverage for the entire year, but twice the proportion of those with year-round coverage. Children below the age of six made up a larger proportion of those with part-year coverage than of either of the other two groups.

## COVERAGE FOR LOSERS OF EMPLOYMENT-RELATED HEALTH INSURANCE--PRIVATE AND PUBLIC POSSIBILITIES

Various other sources of health insurance are available to persons who lose coverage when they lose jobs. The alternatives--to which jobless persons have differing degrees of access--include a mix of private and public insurance:

- Extended coverage under former employers' plans,
- Coverage under an employed spouse's plan,

---

5. The federally set poverty level in 1977 was an annual income of about $6,200 for a family of four, for example. This corresponds to about $10,000 in 1983.

- o "Conversion policies" offered to laid-off workers,
- o Personally purchased individual coverage,
- o State-sponsored general and catastrophic coverage and "reinsurance pools," and
- o Medicaid, sponsored jointly by states and the federal government.

Private-Sector Possibilities

The first four of these possibilities are versions of private health insurance, with public involvement limited to state statutes that mandate the availability of certain levels of coverage.

Extended Coverage Under Employer-Provided Plans. Most employment-based plans offer some extended coverage to laid-off persons, but this continued coverage tends to be of limited duration. Fewer than half of all private-sector workers with some extended coverage are eligible to receive that coverage for longer than five weeks after layoff. For many laid-off workers, this period runs out long before new jobs are found, and this problem is especially acute in a period of high unemployment, when the duration of joblessness may be especially long. In February 1983, when the average period of unemployment was 19 weeks, probably no more than 20 percent of the unemployed who had been covered by an employer-provided plan while working still retained their former coverage. 6/

---

6. Congressional Budget Office approximations of extended coverage provisions based on U.S. Department of Labor, Health Population Study Center, Battelle Human Affairs Research Center, "Study to Develop Methods of Encouraging the Growth and Maintenance of Employee Benefit Plans Among Firms with No Such Plans," prepared

Coverage Under a Spouse's Plan. Some job losers may have coverage under policies held by their spouses, but access to this protection is limited. Even though the number of families in which both head and spouse are in the labor force has increased, to 24 million in February 1983, unemployed persons with an employed spouse made up only about 25 percent of all those unemployed. Further, no more than one-quarter of all two-earner families have "duplicate coverage"--that is, two family policies that would provide uninterrupted coverage should one earner with coverage become unemployed. (Such families may carry two family policies because of complementary sets of benefits.) In contrast, in many two-earner families, one earner may work for a firm that offers no health benefits, or have a part-time job and thus be ineligible for employer-provided coverage.

In some instances, a spouse who is still employed has elected not to participate in his or her employer's group plan or has chosen a "self-only" policy that does not cover other family members. Opportunities to join the plan or to broaden coverage exist, but they are not universal, and when they are available, they often come with certain limitations such as waiting periods or exclusions of known medical conditions. Many insurers permit changes in participation--new enrollments, broadened coverage, and the like--only at certain "open seasons," short periods that occur only once or twice a year. Thus, for example, if one spouse is laid off in December and

---

6. (continued) for the Labor Management Services Administration, Assistant Secretary for Policy Evaluation and Research (March 28, 1980). Duration of unemployment data from U.S. Department of Labor, Bureau of Labor Statistics, Employment and Earnings (March 1983).

his still-working wife's November open season has just closed, that couple's family may have to wait for 11 months before an opportunity for broadened coverage arises.

Required Conversion Policies. In at least 12 states, insurance companies that sell employment-related group coverage must offer a terminated worker the opportunity to continue coverage at the person's own expense, under a so-called "conversion policy." A conversion policy is usually issued with no waiting period or exclusion of existing medical conditions, but benefits are often less extensive than those provided under the group plan. From the worker's standpoint, an advantage of the mandatory conversion approach is that the insurer must accept all who apply, regardless of health status. A disadvantage, however, is cost. On average, about 80 percent of a premium's cost while the worker is employed is paid for by the employing firm. For the employed worker, the employer-paid premium may be a valuable but not specifically recognized (in dollar terms) part of compensation, whereas a terminated worker generally has to pay the entire premium.

Beyond that, however, premiums for conversion policies are usually calculated on a basis different from employment group plan premiums, and the former are commonly higher. Premiums for conversion plans tend also to be costly, however, because of a phenomenon that actuaries refer to as "adverse selection." Persons who are or who expect to be low users of

medical care are more likely to forego coverage, whereas high users are likely to accept the coverage offered. This results in high costs for insurers and, thus, in high premium rates. Despite the high premiums, some jobless workers may elect conversion plans because, for reasons of existing medical conditions, they cannot qualify for any other coverage.

Individual Insurance Plans. Private individual health insurance policies--characterized by relatively high premiums and, sometimes, by exclusions of existing medical conditions--are also available. Persons who do meet the underwriting standards and can afford the premiums usually receive more extensive coverage than can be obtained at a similar price through conversion policies. But private individual coverage can cost a significant portion of a jobless worker's income. For example, in Pennsylvania, a state with high unemployment, premiums for private family policies offered by Blue Cross/Blue Shield range from $90 to $200 a month, or between about 15 percent and 30 percent of the average unemployment benefit in that state.

## Public-Sector Possibilities

Most of the coverage involving the public sector is restricted to state-level sponsorship. Only one form of coverage now available to any of the noncovered unemployed involves the federal government.

Catastrophic Coverage. Four states operate so-called "catastrophic" health insurance programs that provide reimbursement for expenses that exceed a certain dollar threshold. 7/ These programs, financed out of state revenues, protect state residents against the costs of illnesses that translate into extraordinarily high expenses. States operating these programs account for only 1 percent of the nation's jobless workforce, however.

Reinsurance Pools. About six states require insurers to participate in so-called "reinsurance pool" arrangements to provide coverage to persons unable to obtain policies privately. In general, the administrative costs of these pools are paid by insurers in proportion to their shares of the health insurance markets in their states; other expenses are paid, in the form of premiums, by subscribers.

Coverage under these pool arrangements is even less affordable than individual policies, however. In general, persons covered in such pools have health conditions that prevented them from obtaining ordinary individual coverage, so claims paid by pools are high; that, in turn, drives up premium costs. In Connecticut, for example, the premium for coverage in a pool arrangement is 125 percent to 150 percent of that charged by private insurers for similar coverage.

---

7. The four states are Alaska, Maine, Minnesota, and Rhode Island.

Medicaid. Though some low-income persons may obtain coverage through Medicaid, the joint federal/state program that finances health care for low-income persons, few in the currently unemployed population satisfy Medicaid's eligibility criteria. Specifically, groups eligible for assistance under this program are primarily single-parent families receiving cash assistance through the Aid to Families with Dependent Children (AFDC) program and the aged, blind, and disabled receiving aid from the Supplemental Security Income (SSI) program. In about 30 states, those unemployed persons who would otherwise be eligible for AFDC or SSI, except that their incomes and/or their assets are too high, can also qualify for Medicaid, if they have substantial medical expenses.

Though in about half the states, two-parent families with an unemployed parent can also qualify for AFDC--and thus for Medicaid--if their incomes are low enough, those now receiving benefits under this provision make up a relatively small portion of the total number of families with unemployed parents. In large part, these families do not qualify because their assets exceed the limit allowed under AFDC provisions--$1,000 in 1983 in most states 8/--or their incomes from other sources such as spouses' earnings are too high. Single persons and childless couples who are not aged, blind, or disabled, regardless of income, cannot qualify for Medicaid.

---

8. This limit does not apply to a family's home or essential furnishings or to a car unless its equity value exceeds $1,500.

Some low-income persons who are ineligible for Medicaid may receive medical assistance through state general assistance programs and through general hospitals. Little is known about the extent of the population served this way.

## CONCLUDING OBSERVATIONS

The foregoing description suggests that the array of private and public health coverage possibilities for the unemployed is wide. By and large, though, the private-sector options may be expensive to the jobless worker. Inaccessibility to persons with known medical problems--commonly those persons who stand to feel the loss of employment-based coverage most acutely--is another trait that characterizes many of these possibilities. Public programs help few of the unemployed, with state-provided catastrophic expense protection provided in only a few states, and most of the jobless work force ineligible for Medicaid.

## PART II. UNDERLYING ISSUES

A wide array of proposals to provide health insurance for persons who lost coverage because they lost their jobs has been put forth in the Congress, and additional options are also possible. Many of these are examined in Part III. Several difficult issues underlie Congressional consideration of them.

- **An entitlement versus an appropriated program** -- If federal involvement is deemed appropriate, what form of control should the Congress exercise over program costs? Should an entitlement program be created that would require changes in benefits or eligibility to limit costs? Alternatively, should a categorical grant be adopted so that the Congress could limit costs through the appropriation process?

- **Targeting** -- How could assistance be clearly directed toward persons least able to afford medical care or insurance of their own?

- **Funding** -- Who should finance benefits for the unemployed--the unemployed themselves, their previous employers, or the general taxpayer?

### ENTITLEMENT VERSUS APPROPRIATED PROGRAMS

In general, entitlement approaches would delineate at the federal level an eligible population, and they would define the medical benefits that group could receive. Such programs could be implemented through either the private or the public sector. Discretionary grant programs, in contrast, could channel federal funds to public or private agencies to help some of the unemployed obtain medical care, but the agencies (or state governments) would determine what services to provide and who would receive those services, possibly within federally established guidelines.

The costs of entitlement programs are often difficult to project and difficult to control. Projecting outlays under such programs involves estimating the size of the eligible population, the proportion that would participate, and the amount of services each participant would use. Controlling the cost of an entitlement program requires legislation changing eligibility criteria or program benefits--potentially hurting those who have come to depend on the program.

During the current recession, either the public or the private sector would have experienced high costs for a program in which workers were by some definition entitled to participate. One example would be public or private health insurance to cover all laid-off employees. For example, if fully implemented in fiscal year 1984, extension of Medicare coverage to persons who lost their health insurance along with their jobs could cost almost $5 billion, adding to already large federal deficits. 1/ Similarly, an entitlement program funded by the private sector could be costly, especially to industries and firms already in severe fiscal straits. Firms that have laid off many workers are likely to be in a poor position to finance continuing health insurance coverage.

In contrast, the costs of grant programs could be controlled through the annual appropriations process, although exercising this control would imply not serving many families needing assistance, and having grantees

---

1. This estimate represents the annual cost of a fully implemented plan.

making the difficult decisions of who is not to be served. On the other hand, grant programs would generally allow states to design eligibility criteria and benefit packages to suit their special circumstances.

## TARGETING

Eligibility criteria could limit the provision of aid to unemployed persons with the least financial resources and, hence, with the greatest need for assistance in meeting medical expenses. This could be done by delaying eligibility for several weeks following date of layoff or by providing assistance only to those who had exhausted their Unemployment Insurance (UI) benefits.

Resources vary significantly among individuals and families who are both unemployed and uninsured, but one influential factor is duration of unemployment. Persons who have been jobless for long periods--say three months--are more likely to have depleted their resources, including UI benefits, than are those who have been jobless for relatively brief periods. (Between 60 percent and 70 percent of those who received UI benefits in 1982 became reemployed before they exhausted their UI benefits.) On the other hand, if eligibility were extended to all job losers meeting such a criterion, and their families, a family with one unemployed earner but another still employed would be eligible for federal benefits even though that family might have significant annual income--perhaps, exceeding that of many individuals who are employed but uninsured.

To avoid providing coverage to persons who have chosen to remain jobless and/or who have left the labor force--another targeting issue--the Congress might wish to limit the duration of health coverage for the unemployed. This would also limit program costs. A further way to limit costs would be to restrict eligibility to those unemployed persons who have been covered by an employer's health insurance plan. This would, however, exclude many families with limited resources.

Another way of targeting assistance to the needy would be to make grants directly to hospitals experiencing financial distress as a result of serving large numbers of uninsured persons. Assistance would then be available only to those too needy to pay their hospital bills, but it would not be restricted to those who were uncovered because of job loss. Even so, many hospitals might not be willing to serve the uninsured, especially if financial distress had to be experienced in order to receive funding.

## FUNDING

The costs of providing health insurance coverage to the unemployed could be met either through the private or the public sector. Laid-off workers could pay the cost of health insurance coverage, or their previous employers could be required to finance continued coverage. In the long run, if the cost of continued coverage were imposed directly on employers, it could be passed on to consumers through higher prices or shifted to employees by slowing the growth in wages.

Alternatively, taxes could be used to fund health benefits for the uninsured. Specifically, general federal revenues could be used to finance any new program, or new taxes could be enacted. Through general revenues, all taxpayers--including the self-employed and employees who either lack insurance coverage or pay for it themselves--would be subsidizing coverage for certain unemployed persons. If only those with employer-paid coverage prior to layoff were eligible to participate in the program, the use of general revenues would result in workers without employer-sponsored coverage supporting a program that would not benefit them during lay-off.

Two alternatives to general revenue funding are a percentage tax on employer-paid health insurance and taxing (as income to employees) employer contributions to health insurance above a certain threshold. Either of these taxes would result in persons currently with coverage subsidizing benefits for those participating in the new program. Some of those paying the new tax to fund coverage for the unemployed could, however, become recipients of the program at some future date.

## PART III. OPTIONS

Two broad categories of options are examined in this section: those that would provide coverage to jobless persons and their families on an **entitlement basis,** and those that would support health-care coverage by means of **appropriated grants.** (Table 2 summarizes them.) Many would build on practices that are already in effect in small numbers of states, and many have already been proposed as bills before the Congress. A number of general considerations apply to these options.

The costs of providing coverage are not limited to what would appear on the outlay side of federal or state budgets. Many options would depend heavily or even exclusively on the private sector to cover costs. To the extent that private-sector financing were mandated, the financial burdens would be placed on industries that are already experiencing financial difficulty--as manifested in the high rates of unemployment caused by layoffs. Whereas corporate participation in providing health-insurance coverage for the unemployed would offer clear advantages of efficiency and simplicity, it could translate into lower wages for workers still employed and/or lower profits. In either case, federal revenues would fall, so that the federal government would automatically share with the private sector the burden of such options.

TABLE 2. SUMMARY OF OPTIONS TO PROVIDE HEALTH INSURANCE FOR UNEMPLOYED WORKERS AND THEIR FAMILIES

| Options (and Legislative Proposals) | Target Population | Financing Source | Plan Administration | Rate of Phase-in | 1984 Federal Cost Effects |
|---|---|---|---|---|---|
| | | ENTITLEMENT OPTIONS | | | |
| Individual Purchase of Group Policy | Unemployed and lost coverage a/ | Unemployed worker | Employer and insurer | Fast | None |
| Mandatory Employer-Paid Coverage | Unemployed and lost coverage a/ | Employee and employer b/ | Employer and insurer | Moderate | Possible tax revenue decline |
| Trust Fund to Finance Premiums | Unemployed and lost coverage a/ | Employer b/ | State and insurer | Slow | Possible tax revenue decline |
| State Administered Insurance Pools (S. 307) | Unemployed and lost coverage a/ | Employee, employer, b/ and insurer | State and insurer | Slow | Possible tax revenue decline |
| Catastrophic Insurance | Recipients and exhaustees of unemployment insurance | Federal government | Federal government | Moderate | $3.5 billion |
| Limited Primary-Care Coverage (H.R. 2552) | Recipients and exhaustees of unemployment insurance | Federal and state government c/ | State government | Moderate | $2.6 billion |
| Expanded Medicaid | Unemployed and noncovered d/ | Federal and state government | Federal and state government | Moderate | $6.4 billion e/ |
| Expanded Medicare | Unemployed and noncovered d/ | Employee and federal government | Federal government | Fast | $4.8 billion |
| | | GRANT OPTIONS | | | |
| Increased Categorical Grants to States | Recipients of health-care programs for the low income | Federal government | State government | Fast | Congressionally appropriated |
| Grants to States for Health Coverage (S. 951) | Recipients or exhaustees of unemployment insurance who lost health coverage a/ | Federal and state government c/ | State government | Fast | Congressional appropriation of $900 million f/ |
| Grants to Financially Distressed Hospitals | Hospitals with large uninsured patient load | Federal government | Federal government | Moderate | Congressionally appropriated |

SOURCE: Congressional Budget Office.

a. Eligible population would be restricted to persons previously covered by employer-provided plans.

b. Costs assessed against employers might be shifted over time to employees through lower wage increases or to customers through higher prices.

c. At state option, participants could be required to pay small amounts.

d. Eligibility not contingent on previous coverage under employer-provided plans.

e. Assumes full federal funding for these benefits.

f. Outlay estimate included in language of S. 951.

In addition, the costs of all options are, to varying degrees, sensitive to the performance of the economy. So long as unemployment rates persist at high levels and recovery is moderate, the costs of providing health insurance to the unemployed would be high. As recovery grows stronger, however, and joblessness falls, these costs would decline accordingly. (Current CBO projections assume an unemployment rate of 9.8 percent in fiscal year 1984--about 0.8 percentage points less than in fiscal year 1983).

In this context, another consideration the Congress may wish to bear in mind in setting a course is whether to tailor its choice to the immediate problem or to address fundamental gaps in health coverage that will continue past the current recession. Legislation designed to assist persons whose joblessness and attendant lack of coverage is ascribed to short-term downturns runs the risk of establishing mechanisms that may be unnecessary in the longer run. Conversely, measures that would provide a long-term remedy for a problem that is already acute may take effect too late to be of significant benefit to those currently in need.

## ENTITLEMENT OPTIONS

Financing and administration of the entitlement approach could be implemented by either the private or public sector alone, or by joint cooperation of both sectors. One option would require employers in all states to allow terminated employees to maintain coverage by paying for their former group health insurance policy. Others would require employers to extend health benefits for some period of time, would establish a trust

fund to finance extended coverage, or would create state insurance pools to cover the unemployed. Options that would involve a significant federal role include providing catastrophic health insurance, offering a limited federal health insurance package, expanding Medicaid eligibility, and extending Medicare to cover the unemployed. Many features of the alternatives discussed below are interchangeable and, in particular, financing mechanisms of specific options could be replaced with other funding sources.

Require Access to Employers' Group Health Insurance Plan

Legislation could require employers that provide health insurance coverage as a fringe benefit to offer laid-off employees the option of continuing coverage if the former employees paid the same premium rate paid for employed workers. Only laid-off employees who had been covered could participate, and those, only on a voluntary basis. Both insurers and benefits would not change, as they now can with conversion policies. This approach would guarantee that the unemployed could obtain coverage at less than the cost of similar benefits purchased individually.

This option would leave the choice--and the cost--of continued coverage to those who would directly benefit. It would increase employers' costs somewhat, however, for two reasons. First, adverse selection would be experienced, with those employees choosing to continue coverage tending to use more medical care than average. This would drive up the plans' premiums, and thus employers' outlays for active workers' coverage.

Second, firms would incur administrative costs of collecting premiums for laid-off employees. Consequently, firms with many laid-off workers could face noticeable increases in costs.

Only some of the unemployed would retain coverage under this option, because many, accustomed to paying just 20 percent (on average) of premium costs while employed, would choose not to pay the full premium. In 1983, the average monthly family premium for employment-based insurance is about $135, or about 28 percent of the average monthly Unemployment Insurance benefit. 1/

Mandate Continued Coverage Paid by Employers

Employers could be required to offer extended coverage to laid-off employees for at least six months and to pay the same proportion (on average, 80 percent) of the premium that they do for current employees. Mandatory continuation would assure that laid-off workers would in fact retain their health insurance. Extended coverage might pose some work disincentives to unemployed persons, though this effect is not likely to be large.

Though this option would impose high costs on employers, the impact on firms could be lessened by delaying implementation for a year or two. This delay would enable employers to plan for the added costs of extended

---

1. Based on an average weekly UI benefit of about $122 in January 1983.

health-care coverage for employees to be laid off in the future. Eligibility for the mandatory benefits could also be restricted to persons who had been employed by a firm for a minimum duration--three months, for example--and who were covered by the firms's policy at the time of layoff.

Despite this option's administrative simplicity, the added obligations of employers would increase employment costs. In cyclically sensitive industries and in areas where medical care costs are high, this would be especially burdensome for firms with extensive health insurance plans. Added costs could also reduce hiring in some industries by increasing the fixed component of compensation costs. Alternatively, some firms might reduce health insurance benefits to offset these costs, while others might eliminate their health plans altogether. In extreme cases, these additional costs might drive some firms out of business, in which case, coverage would be lost by all employees. As described above, requiring employers to extend coverage would also add to federal deficits by reducing tax revenues.

Employers might seek to have the insurer bear the risks of financing extended coverage by having the cost of the mandatory extended coverage included in the premium paid for those who are working. Thus, as the firm reduced its workforce during slack periods, the cost of providing health insurance would also fall--as it does today. For cyclically sensitive industries, insurers might be reluctant to offer policies subject to such risks, however. Such contracts would have to be of much longer duration than is

now standard. Moreover, uncertainty about the size and timing of losses under such a policy would make it difficult for insurers to establish rates for coverage, and insurers would have difficulty in pooling risks, since many firms would be affected at the same time in a recession. Consequently, in unemployment-prone industries, additional premiums for this coverage would have to be very high.

Establish Trust Funds to Pay Premiums for Laid-Off Workers

Persons meeting certain standards could have the group health insurance premiums of their previous employers paid by a trust fund. To enable firms to spread the costs of continued coverage for the unemployed over the entire business cycle, rather than having costs concentrated in recessionary periods when layoff rates tend to be highest, the federal government could establish state and national trust funds similar to those used to finance Unemployment Insurance (UI). Eligibility for insurance premiums paid out of the trust fund could follow from the UI system, with persons qualifying for UI also qualifying for health insurance continuation for the same duration. Only persons laid off after the program's effective date would be eligible.

To finance such a fund, a percentage tax could be levied on employer-paid health insurance premiums, with most of the revenue accruing to state funds established to pay group health insurance premiums for the unemployed. The tax rate could be "experience rated" on the basis of the layoff and recall rates of firms. A portion of the revenue could support a

federal trust fund that would make loans to state funds that were unable to meet their obligations during periods of high unemployment. These loans could be repaid when employment rose again, or by increased tax rates for employers in states that borrowed.

The costs of this option would be paid not only by employers, but also indirectly by employees to the extent that firms reduced future wage increases to offset the costs of this tax. Thus, those who would benefit from extended coverage would help to finance it, since payments into the trust fund would be proportional to the expected benefits from extended coverage. Implementation would be relatively simple, because this method of providing coverage could make extensive use of existing public and private mechanisms.

This approach has several drawbacks, however. It would be of little benefit to workers now unemployed, because trust fund balances would not reach self-sustaining levels for some time. As with any subsidized extended coverage, a potential work disincentive is another drawback. Unemployment compensation, for example, has been criticized as discouraging the unemployed from seeking jobs; continued health insurance coverage might have similar effects. Also, those who lost jobs prior to establishing eligibility for UI could not qualify, and the 30 percent to 40 percent of UI recipients who exhaust those benefits each year would become ineligible for coverage. Moreover, because of its link to UI, considerable variation among states in coverage would occur--a situation objected to by some. Finally, as occurs in the UI program, there would be some

intrastate subsidy of firms in industries with high unemployment by those with low unemployment, unless adjustments in the tax rate fully reflected the unemployment experience of firms.

Establish State Reinsurance Pools

Extending a practice already in effect in some states, the Congress could require all states to establish reinsurance pools to extend the health coverage of laid-off workers. 2/ Under S. 307, introduced by Senator Riegle, a reinsurance pool would offer at least three basic health insurance plans to unemployed persons. 3/ These plans would have to cover the services covered by Medicare, and they could include an annual deductible no higher than $500. The laid-off worker would pay a premium set at about 20 percent of the cost of coverage, with the remaining costs financed by payments from insurers, each of which would pay for the pool's expenses in proportion to its share of the employment-related health insurance in the state. Insurers would presumably pass this expense on to employers. Expenses associated with pool coverage would be waived for firms that chose to provide their employees with coverage for an adequate period following layoff. 4/

---

2. In general, the reinsurance approach allows a large risk--in this case the cost of providing coverage to the unemployed--to be shared by more than one insurer.

3. This reinsurance option is only one part of S. 307, which also contains an emergency health insurance benefit to provide assistance to persons currently unemployed.

4. Under provisions of S. 307, the Secretary of Health and Human Services would determine the length of extension necessary to waive the expenses of the reinsurance pool for individual firms.

Laid-off workers previously covered by employers' health insurance plans could obtain coverage under the pool-based plan as long as they paid the required premiums. In addition, employees with new jobs but not immediately eligible for coverage under the new employers' plans would be able to continue coverage under the pool's plan for up to 60 days after starting new jobs.

This option would provide extended health insurance coverage to many persons now not covered as a result of unemployment. Moreover, program financing would come from the individuals who would benefit or from their former employers. By allowing individuals to retain coverage for some time while still not included in a new employer's plan, this proposal would close another gap in coverage.

High premium costs under pool arrangements could, however, reduce participation by unemployed workers and their families. Firms would encounter increased labor costs, and those in cyclically sensitive industries could find this option particularly burdensome, though the severity of this effect cannot be estimated. Employers with relatively stable employment, as well as some who already provide extended coverage, might decide not to participate in reinsurance pools, because they could meet the bill's standards for their own extended coverage more cheaply. This would be equivalent to adverse selection--in this case, with firms that anticipate lower costs in providing continued coverage themselves causing higher premiums for the remaining firms that supported the pools. As in the case of mandated extensions of benefits, this option would reduce federal revenues.

Provide Catastrophic Insurance

Following a precedent now in effect in a few states, the Congress could create a catastrophic health insurance plan for those receiving UI benefits and their families. This could, for example, pay all of a family's medical expenses above $2,500 in one year (excluding nursing home care and dental care). Laid-off workers would pay premiums equal to a portion of the cost of coverage--perhaps 20 percent--with the remainder financed by general federal revenues. The program could be administered as a part of Medicare by the Health Care Financing Administration.

If fully implemented in fiscal year 1984, 4.6 million families plus 3.7 million single persons would be assisted at a total federal cost of $3.5 billion. The monthly premium for family coverage in 1984 would be about $15, if set at 20 percent of the total cost of coverage. Federal costs would decline after the first year, if the economy improved and the number of laid-off workers declined. Federal tax revenues would also rise slightly because of reduced medical expense deductions from personal income taxes. 5/

Critics of such a plan might argue, however, that catastrophic coverage is not the most appropriate form of coverage for the unemployed. A catastrophic threshold of $2,500 per family would still leave many

---

5. A universal catastrophic health insurance program, such as contained in H.R. 7000 (the Jones-Martin bill) introduced in the 97th Congress, would alleviate equity problems encountered in using general revenues to cover only those who were unemployed. Such a program would be more costly, however.

families with medical expenses that consume a major share of household income. Further, an emphasis on extraordinarily large medical expenses would not ease most persons' access to basic primary health-care services. Some observers maintain that foregoing primary care allows some medical conditions to progress and eventually results in the use of high-cost treatment.

Provide Limited Primary-Care Coverage

Under an option that would respond to the criticisms noted above, the Congress could create a limited primary-care insurance package for unemployed workers and their families. Current UI recipients and persons who have exhausted UI benefits during the past 24 months, as well as the families of both groups, would be eligible for coverage.

Such a plan is included in H.R. 2552, introduced by Representative Waxman. That bill would provide ten annual visits to physicians and nine days of inpatient care for each eligible person, and would be administered through state Medicaid programs. This program of limited primary-care benefits would enable the families of the unemployed to obtain such services, thereby possibly avoiding more serious illness and more costly treatment. Although the benefits would be provided with only limited cost sharing, any tendency to overuse services would probably be curbed by sharp limits on the total quantity of services covered. Beneficiaries could not be certain that current medical needs are more urgent than future medical needs and thus might forgo discretionary use of services.

Costs would be financed in large part with federal general revenues. In some states where unemployment is highest, the full costs would be paid by the federal government. The federal government would pay 95 percent in other states with unemployment rates in excess of 10 percent. States with unemployment rates below 10 percent would receive federal matching payments of less than 95 percent--with the rate for a particular state being determined by its unemployment rate. In fiscal year 1984, the federal cost of such a program would be about $2.6 billion, assuming that the bill was implemented on January 1, 1984.

A major advantage of this type of proposal is that assistance could be provided to many of the unemployed and their families at relatively low costs to them. In 1984, about 18.2 million persons would be eligible for coverage. About 13.5 million of those eligible would be noncovered UI recipients and their families, and the remainder would be those who exhausted UI benefits over the past two years and their families.

Some states might be reluctant to participate in the program because of future state expenditures that might be necessary to continue it. In the future, some states would face significantly lower federal matching rates because of declines in their unemployment rates. Another drawback is that the high cost of catastrophic illness would continue to fall on the small number of individuals who experience high-cost illness and on health-care providers, because catastrophic illnesses that deplete families' financial resources can at times lead to bad debts for doctors and hospitals. Limited

hospital benefits could leave hospitals somewhat less reluctant than many now are to provide services to jobless workers and their families, however. Finally, states and local governments that have financed public hospitals or medical care for the general assistance population could substitute federal funds provided through this program for their own expenditures.

Expand Medicaid Eligibility

Coverage could be provided for unemployed workers and their families by allowing states to include these individuals, according to modified criteria, in their Medicaid programs. Under this option, beneficiaries would not be subjected to the income and asset standards of Medicaid. The federal government could pay a portion of each state's cost, depending on the state's current Medicaid matching rate. 6/

Eligibility for Medicaid would improve access to care for the unemployed because of that program's broad range of allowable benefits--Medicaid provides first-dollar coverage for outpatient, as well as inpatient, services. In fact, for many beneficiaries, Medicaid would offer a more extensive array of benefits than the group health insurance plan of a previous employer.

Many states with the highest levels of unemployment--and, hence, the worst fiscal positions--would probably not choose to extend Medicaid in this

---

6. Under this option, state expenses associated with provision of care to the unemployed would not be included in determining whether the state met its target rate established by the Omnibus Budget Reconciliation Act of 1981 (P.L. 97-35).

way, however, because it would be difficult to finance. Only about half the states have taken advantage of federal matching support to extend AFDC and Medicaid to low-income families with an unemployed parent. As a result, this option might have limited effect in reducing the lack of coverage among the unemployed during the current recession, and its future effect would depend on the number of states choosing to expand Medicaid eligibility when their financial positions improved during the recovery. Another disincentive to include this population in a state's Medicaid program is that the program's relatively broad benefit package together with limited cost-sharing makes it costly.

If the federal government were to assume all of the cost of coverage, a Medicaid option would reach a larger proportion of the uninsured unemployed, because states would almost certainly choose to cover them. In fiscal year 1984, the cost to the federal government of expanding Medicaid in this way would be $6.4 billion.

Provide Medicare Benefits

Under a similar approach, unemployed workers and their families could be brought into the Medicare program. Medicare coverage could be financed from general federal revenues and from the premiums for Supplementary Medical Insurance (SMI) paid by those choosing to acquire this coverage. (SMI is the component of the Medicare program that pays physicians' charges.) General revenues could be increased to fund this

option by a tax on employer-paid health insurance premiums. Benefits would be those of the Medicare program, including payment by patients for the first day of hospitalization and 20 percent coinsurance for physicians' services.

While this option would improve the position of the unemployed and their families who had lost health insurance coverage, it could cost the federal government as much as $4.8 billion in 1984--though again, perhaps less in ensuing years. Besides costs, a potential work disincentive is another drawback.

The equity problems posed by a federal program to provide health insurance for the unemployed could be reduced by taxing, as income to employees, employers' payments for health insurance in excess of a certain level. The level at which premiums would be taxed could be established so that the revenue from this source would fully fund extended coverage for the unemployed. 7/ The tax would not affect persons who have no employment-related coverage or whose coverage is limited. On the other

---

7. The Administration's budget for fiscal year 1984 includes a proposal that employer contributions to health insurance be taxed as income to employees. The tax would apply to employer-paid premiums that exceed $175 per month for family coverage and $70 per month for single coverage. Such a tax would have certain health policy merits. Specifically, taxing high employer-paid premiums would tend to affect persons who have the most extensive health insurance plans and, thus, it would discourage their purchase, thereby lowering use of health care services and ultimately slowing the rate of increase in their prices. For a more detailed discussion of taxation of employer-paid health insurance premiums, see Congressional Budget Office, Containing Medical Care Costs Through Market Forces (May 1982).

hand, the tax would have uneven effects not completely accounted for by the scope of benefits included in an employer's group health plan. High employer-paid health insurance premiums can reflect high local costs of medical care and demographic characteristics of the employer's work force, as well as the richness of the benefit package. Finally, firms with below-average unemployment experience would subsidize benefits for employees in firms with higher levels of unemployment.

Reliance on revenue from this specific source would postpone the date when benefits could be paid, because administration of this tax could not begin immediately. Individuals and firms would need to be given an opportunity to adjust their level of health insurance coverage in response to the new tax.

## GRANT OPTIONS

The Congress could use existing grant programs or enact a new one to subsidize care for the unemployed through the public sector. It could make block grants directly to states and give them discretion in the specific use of these funds. Alternatively, grants could be provided directly to hospitals that serve many persons who are uninsured and unable to afford the cost of care. As with the entitlement options, these alternatives could be financed through general revenues or through new taxes.

Increase Funding of Certain Categorical Grants to States

Additional funds under existing programs could provide for some of the medical and health needs of the unemployed. For example, funding could be increased for three programs: Special Supplemental Food Programs for Women, Infants, and Children (WIC), the Maternal and Child Health Services Program (MCH), and the Community Health Centers (CHC) Program. These additional funds could be allocated to states experiencing particularly high levels of unemployment. This approach was taken in the recently enacted Emergency Jobs Bill which included increases of $100 million for WIC, $105 million for MCH, and $70 million for CHCs for fiscal year 1983.

An advantage of further increasing funding for these ongoing programs is that provision of services could be increased more quickly than a new program could be launched. In addition, these particular programs have generally been successful in achieving their specific objectives, and each is targeted toward low-income persons who do not have financial access to mainstream medical care. The WIC program, for example, appears to have improved the health of infants and also to have increased use of medical services by pregnant women and newborn infants. 8/ Under CHCs, the availability of care in medically underserved areas has increased.

A drawback to using these categorical programs is that they are not aimed primarily at the unemployed, and some of them impose additional

---

8. See Congressional Budget Office, Feeding Children: Federal Child Nutrition Policies in the 1980s (May 1980), p. 61.

eligibility criteria. For example, the WIC program has an income criterion. Access to CHC services to unemployed persons would, in addition, depend on the presence of a community health center within a reasonable distance of their homes. On the other hand, regardless of employment status, more low-income persons could receive services if funding for these programs were increased. This would reduce problems of equity posed by using general revenues to fund programs targeted strictly toward the unemployed.

### Provide Grants to States to Provide Health Care Coverage for the Unemployed

The Congress could authorize a program of grants to states for the purpose of providing health-care coverage to those who have lost health insurance due to job loss. Such a plan was introduced by Senator Dole as S. 951. This would authorize $750 million for payment of medical expenses and $150 million for administrative costs in each of two consecutive years beginning on June 1, 1983. Each state's share would be based on its proportion of the nationwide number of persons receiving UI benefits and on its proportion of the long-term unemployed.

States would be required to use these funds to provide health-care coverage to UI recipients and their families who have lost insurance because of job loss. They would have flexibility to determine what portion of their UI populations to cover, but after UI benefits have been exhausted, coverage could be extended for no more than six months. States would also have discretion to limit the amount and duration of medical services the program covered. Eligibility would be determined, and medical benefits provided, through each state's Medicaid program.

The number of persons covered under this approach would be high, with the exact number depending on the specific state-established eligibility criteria. The potentially eligible population could be as large as 13 million persons in fiscal year 1984. Another advantage of this option is that it could be implemented quickly, since existing agencies would administer the program and relatively little federal government approval would be required after enactment.

A drawback is that a significant portion of the unemployed population would not qualify because of not having been covered by group health insurance plans when employed. No more than about 75 percent of all active employees are covered by group health insurance plans provided through employment. 9/ Moreover, some who met the federal eligibility criteria might not receive benefits because of additional eligibility standards adopted by their states. Finally, some critics would consider it unfair to spend public funds only on persons who previously had coverage.

In attempting to provide medical benefits to the potentially eligible population, states could face significant additional costs. If states covered all persons meeting federal eligibility standards and delivered the full benefit package, state costs would exceed federal grants by about $2.1 billion.

---

9. While 90 percent of employees in the nonagricultural sector work for firms that offer health insurance plans, not all of them are eligible--for example, because they work part time--and some employees choose not to be covered.

States would have three options for dealing with these costs: charging premiums to participants, limiting eligibility and benefits, or providing state funding. Under the provisions of S. 951, states could charge a premium of not more than 8 percent of weekly UI benefits. If used to the maximum degree permitted, however, revenues from this source would cover only $1.7 billion of the shortfall. Also, cost sharing--in the form of deductibles and coinsurance--could be imposed on recipients, but these amounts could not, on average, exceed 10 percent of the state's average UI benefit.

States could reduce eligibility by including only persons who have been receiving UI for, say, three months. Also, the benefits could be limited, such as by covering only a fixed low number of inpatient hospital days (as under H.R. 2552). Such restrictions to limit state outlays, however, would also reduce the potential success of the program in assuring access to medical care.

Alternatively, states could provide funding to supplement the federal grant. But this could result in cuts in other services targeted toward the poor. For example, state and local funds that support medical care for the general assistance population and the operation of public hospitals could be diverted to support health insurance for the unemployed.

Fund Grants to Financially Distressed Hospitals. Hospitals, rather than individuals, could be the recipients of grant assistance--that is, a federal program could direct grants toward financially distressed hospitals

that provide substantial amounts of care for which they are not directly reimbursed. The rationale for such a program is that extended high unemployment has increased the number of uninsured patients admitted as charity cases or whose bills are likely to become bad debts. One way to target aid would be to provide it to hospitals that have had deficits in the last two years and that have simultaneously experienced a significant increase in patients for whom they are not directly reimbursed.

Targeting assistance to hospitals with chronic deficits because of charity care and bad debts could reduce the financial pressures to close some facilities. This would increase the care available to all uninsured patients by more than the amount directly funded by the federal government. It could also increase the willingness of hospitals to serve the uninsured. On the other hand, a grant program for distressed hospitals would provide assistance to only a limited number of unemployed persons and others who have no health insurance. Another drawback is that state and local governments might cut their support for public hospitals, and private philanthropy might also decline.

Provide Block Grants to States. The Congress could enable the states to assist the unemployed who have lost insurance by offering a block grant for this purpose, with funding based at least in part on state unemployment levels. Funds could be used to provide additional direct services for states' low-income populations, to establish and subsidize catastrophic health insurance for the unemployed, or to extend Medicaid benefits.

Use of a block grant could lead to the development or expansion of programs that would be most consistent with state efforts now under way. Specific effects would vary, however, depending on how states chose to use the funds. For example, the extent to which benefits were targeted toward the unemployed would probably vary, unless federal guidelines required that all funds from such grants be used to serve the unemployed and their families. Also, in some states, the additional funds might substitute for state funds and, thus, produce little or no increase in health care available to the unemployed.