Coordinated along with the Chicago Police Department a Nuisance Abatement Program in four police districts that resulted in closing 1,000 drug houses during the first year of operation.

Provided 387 community groups, 42 police departments, and state and local government agencies with technical assistance to develop community based anti-crime and drug strategies.

Coordinated a national day of Reclaiming Our Neighborhoods in which 38 cities participated February 14, 1994.

Won change in Asset Forfeiture Regulations nationally, allowing communities to receive 15% of seized drug money and real property.

Was awarded $1.2 million cooperative agreement from the Bureau of Justice Assistance, U.S. Department of Justice to coordinate a demonstration program (1992–1995) in 13 cities across the country, Communities in Action to Prevent Drug Abuse.

Was awarded cooperative agreement from the Bureau of Justice Assistance—Department of Justice and the Department of Labor to coordinate Communities in Action to Prevent Drug Abuse II—Reclaiming Our Communities (1995–1997) in 10 cities across the country.

TRAINING

Was awarded a three year national VISTA grant in 1978 which resulted in training of almost 100 community staff in 48 community organizations.

Provided technical assistance and seed funding to 131 community groups since 1980 through the Mott Foundation's Strengthening Citizen Initiatives at the Local Level Program.

Provided training on financial management to community groups in 8 cities through a program developed with Allstate.

Offered week-long training courses since 1974 that have trained over 3,000 participants in community advocacy skills.

Provided on-site consultations that have resulted in development of dozens of new community organizations across the country.

Provided on-site training for at least 40 organizations a year.

Have coordinated national conferences on Housing, CRA, Jobs, Insurance and Drugs providing an area for all the players to come together to discuss their concerns. Each conference attracted over 500 participants.

ENERGY

Provided training and consulting for 147 community groups on natural gas deregulation in the late 1970s and early 1980s.

In the mid 1980s, founded the Affordable Budget Coalition to address the rash of utility shut-offs plaguing Illinois. The ABC became independent in 1987.

Assisted community groups to intervene in utility rate cases before the Illinois Commerce Commission, resulting in almost $2 billion in refunds.

Has been an expert witness in telephone and electric utility cases and performed an analysis of Currency Exchange rates charged to cash government benefit checks for use in rate investigation of the Illinois Department of Financial Institutions.

Currently working with community groups and participating in policy forums on the deregulation of the electrical utility industry in Illinois.

Working with community groups, government agencies and electric and natural gas utility companies to establish a long-term solution to the low income residential energy crisis and the decline of federal energy assistance funding.

Providing training for Community Action Agency's low income board members across the country in cooperation with the Illinois Community Action Agency under a contract from the U.S. Department of Health and Human Services.

INSURANCE

Developed new urban property insurance products and increased urban investments with leading companies, including Allstate and State Farm as a response to NPA advocacy against insurance redlining.

THE HEALTH INSURANCE REFORM ACT OF 1995

Mrs. KASSEBAUM. Mr. President, I ask unanimous consent that the following items with regard to S. 1028 be included in the RECORD.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

COST ESTIMATE

U.S. CONGRESS,
CONGRESSIONAL BUDGET OFFICE,
Washington, DC, September 22, 1995.

Hon. NANCY LANDON KASSEBAUM,
Chairman, Committee on Labor and Human Resources, U.S. Senate, Washington, DC.

DEAR MADAM CHAIRMAN: The Congressional Budget Office [CBO] has reviewed S. 1028, the Health Insurance Reform Act of 1995, as ordered reported by the Senate Committee on Labor and Human Resources on August 2, 1995. CBO estimates that enactment of S. 1028 would not significantly affect the federal budget. (Each state's insurance commissioner would ensure that the requirements of this legislation are carried out by health insurance carriers in their state; CBO has not attempted to estimate the amount by which state government spending could be changed.) Pay-as-you-go procedures would apply because the bill could affect direct spending and receipts. the estimated change in direct spending and receipts, however, is not significant.

This bill would create uniform national standards intended to improve the portability of private health insurance policies. for example, these standards would allow workers with employment-based policies to continue their coverage more easily when changing or leaving jobs. Because most private insurance plans require a waiting period before new enrollees become eligible for coverage, especially for preexisting medical conditions, workers with chronic conditions or other health risks may face gaps in their coverage when they change jobs. Alternatively, such workers may be hesitant to change jobs because they fear the temporary loss of coverage, a situation known as ''joblock.''

S. 1028 would reduce the effective length of exclusions for preexisting conditions by crediting enrollees for continuous coverage by a previous insurer. Insurance companies would be prohibited from denying certain coverage based on the medical status or experience of individuals or groups and would be required to renew coverage in most cases. Insurers could not deny coverage to individuals who have exhausted their continuing coverage from a previous employer. This bill would allow individuals to change their enrollment status without being subject to penalties for late enrollment if their family or employment status changes during the year. To the extent that states have not already implemented similar rules, these changes would clarify the insurance situation and possibly reduce gaps in coverage for many people.[1]

Because the bill would not regulate the premiums that plans could charge, the net number of people covered by health insurance and the premiums that they pay would continue to be influenced primarily by current market forces. In other words, although insurance would become more portable for some people under this bill, it would not become any more or less available in general.

S. 1028 could affect the federal budget in two primary ways. First, if the bill changed the amount of employer-paid health premiums, total federal tax revenues could change. For example, if the amount employers paid for premiums rose, cash wages would probably fall, thereby reducing income and payroll tax revenues. If individuals paid more for individually-purchased insurance, they could increase their itemized deductions for health expenses. Second, if the bill caused people insured by Medicaid or government health programs to purchase private coverage, then federal outlays for those programs could change.

According to the General Accounting Office [GAO], 38 states have enacted legislation to improve the portability and renewability of health plans among small employers.[2] The state laws do not apply to employees of larger firms with self-funded insurance plans, however, and the GAO report finds that state laws generally do not apply to the market for individually-purchased insurance.

Because many insurance reforms have already been implemented by the states, GAO assumes that the new national standards created by S. 1028 would not significantly change the insurance market for most people. Although the national standards created by S. 1028 would improve the portability of health insurance for some additional groups or individuals, GAO assumes that the incremental change in the insurance marketplace would be minor. Any changes to overall insurance coverage or premiums caused by the bill would probably be small, and the direction of the change is uncertain. Most people subject to the new insurance rules would have had coverage under the old rules, so their total health spending would probably not be noticeably different. Therefore federal revenues would be unlikely to change.[3]

CBO estimates that federal outlays for Medicaid would not change because any persons eligible for free coverage from Medicaid under current law would also seek out Medicaid coverage if S. 1028 was enacted. CBO also estimates that the bill would cause no appreciable changes to federal outlays for Medicare, Federal Employees Health Benefits, or other federal programs.

If you wish further details on this estimate, we will be pleased to provide them. The CBO staff contact is Jeff Lemieux.

Sincerely,

JAMES L. BLUM
(For June E. O'Neill, Director).

FOOTNOTES

[1] For additional discussion, see GAO testimony ''Health Insurance Regulations, National Portability Standards Would Facilitate Changing Health Plans,'' July 18, 1995, before the Senate Committee on Labor and Human Resources.

[2] Health Insurance Regulation: Variation in Recent State Small Employer Health Insurance Reforms (GSO/HEHS–95–161FS, June 12, 1995).

[3] CBO cooperates with the Joint Committee on Taxation to produce estimates of revenue changes under proposals that would change the private health insurance market. Following CBO's estimate that S. 1028 would not significantly change spending for private health insurance, the Joint Committee assumes that federal revenues would not change.

U.S. CONGRESS,
CONGRESSIONAL BUDGET OFFICE,
Washington, DC, March 22, 1996.

Hon. NANCY L. KASSEBAUM,
Chairman, Committee on Labor and Human Resources, U.S. Senate, Washington, DC.

DEAR MADAM CHAIRMAN: The Congressional Budget Office has prepared the enclosed

Footnotes at end of letter.

mandate cost statements for S. 1028, the Health Insurance Reform Act of 1995, as reported by the Senate Committee on Labor and Human Resources on October 12, 1995.

Enactment of S. 1028 would impose both intergovernmental and private sector mandates. The cost of the intergovernmental mandates would not exceed the applicable $50 million threshold, but the costs of the private sector mandates would exceed the applicable $100 million threshold.

If you wish further details on this estimate, we will be pleased to provide them.

Sincerely,

JUNE E. O'NEILL, *Director*.

Enclosure.

CONGRESSIONAL BUDGET OFFICE ESTIMATED COST OF INTERGOVERNMENTAL MANDATES

1. Bill number: S. 1028.

2. Bill title: The Health Insurance Reform Act of 1995.

3. Bill status: As reported by the Senate Committee on Labor and Human Resources on October 12, 1995.

4. Bill purpose: S. 1028 would make it easier for people who change jobs to maintain adequate coverage by requiring issuers of group health plans and sponsors of health plans for employees to: Limit exclusions for preexisting conditions to 12 months (18 months for late enrollees) with a one-for-one offset against the exclusion for continuous coverage; not impose eligibility requirements based on health status or other medical information; and offer special enrollment periods when an employee experiences a change in family composition (e.g., the birth of a child) or a family member of an employee loses health coverage under another health plan because of a change in employment status.

In addition, the bill would require health plans sponsored by employers to: extend COBRA coverage an additional 11 months if an employee becomes disabled during the 18 months of the original COBRA coverage or has disabled dependents, and provide immediate coverage to newborns or adopted children under a parent's COBRA policy.

Furthermore, S. 1028 would increase the portability of health insurance from group coverage to individual coverage by requiring issuers of individual health insurance to provide coverage if an individual has had 18 months of continuous coverage. In addition, the bill would assist employers and individuals in establishing voluntary coalitions for purchasing group health insurance and preempt some state laws dealing with purchasing cooperatives. Finally, if the bill is enacted, states would have the option of enforcing the bill's requirements regarding group and individual health insurance. If a state chooses not to enforce the requirements, the federal government would enforce them.

5. Intergovernmental mandates contained in bill: S. 1028 contains several intergovernmental mandates as defined in Public Law 104–4, primarily the new requirements that would be imposed on health plans sponsored by employers. State and local governments who offer their employees health insurance would have to abide by these requirements.

6. Estimated direct costs to State, local, and tribal governments:

(a) *Is the $50 Million a Year Threshold Exceeded?* No.

(b) *Total Direct Costs of Mandates:* S. 1028 would increase the cost of health insurance for covered employees of state and local governments, but this cost would primarily be borne by the employees themselves and not by state or local taxpayers. Although CBO cannot provide a precise estimate, any increase in the cost of health insurance for employees of state and local governments would amount to less than $50 million annually. As a result of higher health care costs, state and local governments would reduce other elements of their employees' compensation packages by a corresponding amount. The amount of total compensation paid by the state and local governments would thus remain unchanged in the long run. Except for an initial transition period, during which state and local governments may not be able to change other elements of their employees' compensation packages, state and local governments would not be required to spend additional funds to comply with these mandates.

(c) *Estimate of Necessary Budget Authority:* None.

7. Basis of estimate: Based on a limited survey of State and local governments, CBO found that the health insurance plans currently offered by State and local governments are generally in compliance with S. 1028. However, some State and local governments would have to make minor adjustments to their plans. Almost all plans already limit to 1 year, or do not include, exclusions for preexisting conditions, but only a few of the plans that have exclusions allow an offset against the exclusion for continuous coverage. In addition, some plans do not offer special enrollment periods when a family member of a participant loses his or her health insurance under another plan because of a change in employment. Finally, the expansion of COBRA coverage would affect all plans.

CBO estimates that the cost of S. 1028 to the private sector for the group health insurance reforms would total about $300 million. A simple calculation, based on the number of employees involved, would indicate that the cost of S. 1028 for employees of State and local governments would be $60 million. CBO believes that the cost would actually be significantly less than this, however, because health plans sponsored by State and local governments are generally more liberal than plans sponsored by private sector employers. State and local governments therefore would be confronted with fewer changes as a result of S. 1028. The cost of the mandates imposed on State and local government would clearly be less than $50 million, a change of about 0.1 percent in the approximately $40 billion that is now spent on health insurance for employees of State and local governments.

Economists generally believe, and CBO's cost estimates have long assumed, that workers as a group bear most of the cost of employers' health insurance premiums. The primary reason for this conclusion is that the supply of labor is relatively insensitive to changes in take-home wages. Because most workers continue to work even if their take-home pay declines, employers have little trouble shifting most of the cost of additional health insurance to workers' wages or other fringe benefits.

8. Appropriation or other Federal financial assistance provided in bill to cover mandate costs: None.

9. Other impacts on State, local and tribal governments: States would have the option of enforcing the requirements of S. 1028 on issuers of health insurance in the group and individual markets. If a State decides not to enforce the new requirements, the Federal Government would do so. Because enforcement would be voluntary, this provision would not impose an intergovernmental mandate as defined in Public Law 104–4. However, the enforcement provisions would have a budgetary impact on State governments. States currently regulate the group and individual markets, and CBO does not expect any State to give up this authority and responsibility. States thus would incur additional costs as they enforce the new requirements. In 1995, according to the National Association of Insurance Commissioners, States spent $650 million regulating all forms of insurance (health and others). CBO expects that S. 1028 would increase these costs only marginally.

10. Previous CBO estimate: None.

11. Estimate prepared by: John Patterson.

12. Estimate approved by: Paul N. Van de Water, Assistant Director for Budget Analysis.

CONGRESSIONAL BUDGET OFFICE ESTIMATE OF COSTS OF PRIVATE SECTOR MANDATES

1. Bill number: S. 1028.

2. Bill title: Health Insurance Reform Act of 1995.

3. Bill status: As reported by the Senate Committee on Labor and Human Resources on October 12, 1995.

4. Bill purpose: The purpose of S. 1028 is to increase access to health care benefits for workers and their families both while the workers are employed and after they leave employment. It would also increase the portability of health insurance when workers change jobs, and make other changes affecting health care benefits.

5. Private sector mandates contained in the bill: S. 1028 contains several private sector mandates as defined in P.L. 104–4 that would affect the private health insurance industry. Three general areas of coverage would be affected: (1) the group and employer-sponsored health insurance market, (2) the extensions of health insurance required under the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985, and (3) the market for individual health insurance.

Mandates on group insurers and employee health benefit plans

The bill would require sellers of group health insurance to cover any group purchaser who applies. Group insurers could stop selling coverage only under certain conditions, such as ceasing to offer coverage to any additional group purchasers. Under those circumstances, they could resume offering coverage only after a 6 month cessation and would be required to resume on a first-come-first-served basis. Those availability provisions would apply separately to the ''large group'' and ''small group'' markets—that is, an issuer would be allowed to serve only one of those markets. Group insurers would also be required to renew coverage at the option of the group purchaser, except in certain circumstances including nonpayment of premiums, or fraud or misrepresentation on the part of the group purchaser. Network plans would not be required to renew coverage to people living outside the geographic area covered by the plan as long as this action is done on a uniform basis, without regard to the health status of particular individuals.

Several provisions of the bill would apply both to sellers of group insurance and to employee health benefit plans that are ''self-insured'' by firms. Eligibility, enrollment, and requirements relating to premium contributions could not be based on the employee's health status, claims experience, or medical history.

In addition, the bill would limit the use of pre-existing condition exclusions—clauses that exempt the plan from paying for expenses related to a medical condition that already existed when an enrollee first joined the plan. Under the bill, twelve months would be the maximum allowable duration of a pre-existing condition exclusion (eighteen months for employees who did not join the plan at their first enrollment opportunity). Furthermore, month-for-month credit against that exclusion would have to be given to enrollees for continuous coverage that they had prior to joining a new plan. (Insurers and health benefit plans would be required to keep records to document the previous coverage.) In addition, pregnancy could not be excluded by a pre-existing condition clause, and children who were signed up with a plan within thirty days of birth could not have any existing conditions excluded from coverage. (A similar provision applies for adopted children.)

Affiliation periods, in which new enrollees pay no premium but receive no benefits, could be used if pre-existing condition exclusions were not part of the plan. However, such periods would be limited to sixty days (ninety days for late enrollees).

Finally, the bill would require that health plans offer special enrollment periods for participants or family members for various changes in family or employment status.

Mandates extending COBRA continuation coverage

Under certain circumstances, the bill would compel firms to extend so-called ''COBRA'' coverage to former employees or their family members for a longer period of time than is currently required. Under current law, firms that offer health insurance as part of their employee benefits package and employ 20 or more people must allow employees (and family members) to continue coverage for 18 months after leaving employment (or for certain other reasons), at a cost that cannot exceed 102 percent of the premium for regular employees. Under certain circumstances, such as if a worker is disabled when he or she first qualifies for COBRA coverage, an additional 11-month extension of coverage also must be made available.

The bill would extend COBRA coverage by specifying an additional condition that would qualify former employees (or their insured family members) for the 11-month extension period after the initial 18-month period. In particular, if a former employee were to become disabled during the first 18 months of extended coverage, then they would qualify for the additional 11-month period. Disability of an insured family member also would be a qualifying condition for continuation of CORBA coverage. Under the current law COBRA provisions, a premium of 150 percent of the premium for regular employees could be charged to former employees in the additional 11-month period.

Mandates affecting the individual insurance market

Under S. 1028, sellers of individual health insurance policies would be required to cover individuals who wanted to enroll in an individual health plan, regardless of their medical history or claims experience, if they had at least 18 months of continuous prior coverage by one or more group health plans or employee health benefit plans. To be eligible for such group-to-individual market ''portability,'' the individual applicant also would have to be ineligible for coverage by another group health plan, employee health benefit plan, or COBRA continuation coverage. The bill would leave the determination of premiums to the applicable state laws or regulations.

Issuers of individual plans also would be required to renew policies at the option of the insured individuals, except for certain circumstances including nonpayment of premiums or fraud.

To the extent that state laws or regulations were a suitable substitute for the provisions of the bill, the federal rules would not apply. Examples of such substitutes could include laws providing for state-sponsored high-risk pools that provide coverage to those who could not otherwise obtain private coverage, open enrollment by one or more health plan issuers to facilitate coverage in the individual market, and guaranteed issue of insurance to all individuals regardless of their health status.

6. Estimated direct cost to the private sector: CBO estimates that the direct cost of the main private sector mandates in S. 1028 would be approximately $350 million in the first year the provisions were effective, rising to about $500 million annually in the fifth year. Those mandate costs represent about one-quarter of one percent of total private sector health insurance expenditures, although their distribution among health insurance plans would be uneven. (Plans that cover public sector employees are not included in this analysis.) These estimates are subject to considerable uncertainty because a number of underlying assumptions rely on limited data or judgments about future changes in health insurance markets.

The specific mandates examined in this estimate are: Limiting the length of time employer-sponsored and group insurance plans could withhold coverage for pre-existing conditions; requiring that periods of continuous prior health plan coverage be credited against pre-existing condition exclusions of a new plan; extending the conditions under which an employer would have to offer 11 additional months of COBRA coverage for disabled people; and requiring issuers of individual health insurance policies to offer coverage to all individuals who meet specific requirements, including 18 months of prior continuous group of employer-sponsored coverage.

Basis of the estimate: The direct costs of those mandates consist of the additional health expenses that would be covered by insurance as a direct result of their implementation. Expenses for pre-existing conditions that would have to be paid by insurers under the bill but would not have been insured under current law, for example, are included in aggregate direct costs. In contrast, insured expenses that would be transferred among different insurers because of the bill are not included in aggregate direct costs.

In making this estimate, CBO did not attempt to value any social benefits that might result from expansions in insurance coverage. That is, the estimate accounts only for the additional insurance costs of the mandates, not the value of additional insurance coverage to beneficiaries. Nor was there an attempt to quantify any indirect costs or benefits. Such indirect effects could include, for example, loss of coverage if an employer ceases to offer group coverage when premiums rise, or increases in worker mobility (or reduced ''job lock'') with greater portability of benefits. It would be important to weigh all such factors in considering the bill, but only estimates of the direct costs of the mandates in the bill are required by P.L. 104–4, the Unfunded Mandates Reform Act.

Direct costs of mandates on group insurers and employee health benefit plans

Two of the principal mandates in S. 1028 affect group and employee health benefit plans: (1) limiting the maximum length of pre-existing condition exclusions, and (2) requiring that health plans reduce the length of pre-existing condition exclusions for people with prior continuous coverage under other health plans. CBO estimates that the direct cost of those two mandates would total about $300 million in each of the first five years the provisions would be effective. This cost is approximately 0.2 percent of the total premium payments in the group and employer-sponsored market.

Limiting the Maximum Length of an Exclusion. The mandate to limit exclusions for pre-existing conditions to 12 months (18 months for late enrollees) is estimated to have a direct private-sector cost of about $200 million per year. This estimate is based on two components: (1) the number of people who would have more of their medical expenses covered by insurance if exclusions were limited to one year or less, and (2) the average cost to insurers of that newly insured medical care.

CBO used data from the Survey of Employee Benefits in the April 1993 Current Population Survey (CPS) to estimate the number of people with conditions that are not now covered because of a pre-existing condition exclusion of more than one year. The survey asks respondents whether they or a family member have a medical condition that their employment-based plan is not covering because of a pre-existing condition exclusion. It also asks respondents how long they have been with their present firm. For people with medical conditions excluded by a pre-existing condition clause, responses to the second question are used to estimate whether the exclusion period exceeds one year.

A number of adjustments were made to the data. In particular, CBO's estimate of the number of people affected by S. 1028 excluded people who said they were limited by a pre-existing restriction but who also had other health insurance coverage, because the other insurance plan might have covered their pre-existing conditions. Under those circumstances, the limitation imposed on employment-based plans by S. 1028 would not raise their aggregate costs.

The second modification to the CPS data adjusted for changes in the insurance market that have occurred since the survey date of 1993. In particular, since that time, about 40 states have implemented laws affecting the small group insurance market that would limit pre-existing condition exclusions to one year or less and require that previous coverage be credited against those exclusions. Those laws generally apply to groups of 50 or fewer employees and do not include self-funded health benefit plans. Because plans covered by such state laws would not have to change their provisions as a result of S. 1028, CBO lowered its initial estimate of the number of people affected by the bill.

CBO's analysis led to the conclusion that approximately 300,000 people would gain coverage under S. 1028 for some condition that would otherwise be excluded by a long (more than one year) pre-existing condition clause. This estimate represents less than 0.3 percent of people with private employment-based coverage.

The other component of the estimated private-sector cost is the average cost of the coverage that would become available under S. 1028. A recent monograph from the American Academy of Actuaries (referred to as the Academy) indicated a surge in claims costs of 40 to 60 percent when a pre-existing

condition exclusion period expired for a sample of people with high expected medical costs.[1] That range is consistent with information from Spencer and Associates indicating that the costs of policies for former employees who have chosen to take extended COBRA coverage are 55 percent higher than those of active employees.[2] Applying those percentages to the average premium cost in the employer-sponsored market yields a potential range of additional costs of $600 to $900 a year per person who would gain coverage under S. 1028.

Crediting Prior Coverage Against Current Exclusions. Another provision in S. 1028 would require insurers under certain circumstances to credit previous continuous health insurance coverage against pre-existing condition periods. That provision is estimated to have a private sector cost of about $100 million per year. The key components of this estimate are: (1) the number of people who would receive some added coverage, and (2) the additional full-year cost of coverage, adjusted to reflect the estimated number of months of that coverage.

CPS data were used to estimate the number of people who would receive some added coverage under this mandate. These are people who would otherwise face some denial of coverage under a pre-existing condition exclusion period of one year or less, and who would qualify for a shortened exclusion period based on prior continuous coverage. CBO estimates that about 100,000 people would receive some added coverage under this provision of the bill. The relatively small size of this estimate is due largely to the difficulty of meeting the restrictive eligibility criteria for the reduction in the exclusion period—particularly the requirement that at most a 30-day gap separate prior periods of insurance coverage from enrollment in the new plan.

The average number of months of coverage these people would gain is constrained by the one-year limit on the exclusion period that would be required under the bill. Based on information from a 1995 study by KPMG Peat Marwick, CBO estimates that people who would qualify would gain coverage for an average of 10 months.[3] CBO's estimate of the additional insured costs per person is based on evidence from the Academy, which suggested that people with pre-existing condition exclusions may not seek treatment during the exclusion period but have rapid increases in expenses when that period expires. That behavior would reduce the effectiveness of exclusion periods in protecting insurers from treatment costs. The shorter the exclusion period, the less effective the pre-existing exclusion is at reducing the insurer's costs. CBO consequently assumed that full-year insured costs of people getting coverage for pre-existing conditions under this provision would rise by less than 40 percent.

Other Considerations. The estimated direct cost of the mandate to limit the length of pre-existing condition exclusions is about $200 million annually, and the cost of the mandate to credit previous coverage against pre-existing condition exclusions is about $100 million. Together, those mandate costs amount to about 0.2 percent of total premium payments in the group and employer-sponsored market.

Those estimates are subject to considerable uncertainty for several reasons. First, they are based on individuals' responses to surveys, which should be treated with caution. In addition, unforeseen changes in health insurance markets could result in the estimates being too low or too high. Larger than expected increases in medical costs would result in higher direct costs than estimated. On the other hand, the growth of managed care plans would lower the direct costs of the bill. The magnitude of this effect would depend on the relative growth of HMOs, which generally do not use pre-existing condition exclusions, as compared to PPO and POS plans, many of which do use preexisting condition exclusions.

The distribution of the direct costs of the mandates would be uneven across health plans. Only plans that currently use pre-existing condition exclusions of more than 12 months would face the $200 million direct cost of the first mandate. Data from the Peat Marwick survey indicate that 2.5 percent of employees are in such health plans. Consequently, the costs to health plans that use long pre-existing condition exclusions would be about 4.5 percent of their premium costs. Likewise, only health plans that use pre-existing condition exclusions would face the direct cost of the mandate to credit previous coverage against the pre-existing exclusion. The data indicate that almost half of employees are in such plans—implying that the plans directly affected by this mandate would have direct costs equal to about one-tenth of one percent of their premiums under current law.

Employers could respond in a number of ways to the additional insured costs that would arise under these provisions of the bill. They could reduce other insurance benefits, increase employees' premium contributions, or reduce other components of employee compensation. Employers would be likely to respond in different ways, and these changes could take time. Some employers that currently offer health insurance to their employees might drop that coverage if the costs became too large, although the magnitude of such a reaction would probably be modest. These employer responses, which would offset the costs of the mandates, are indirect effects and do not enter into our estimates of the direct costs to the private sector of the insurance mandates.

Direct costs of mandates extending COBRA continuation coverage for the disabled

CBO estimates that the aggregate direct costs of the COBRA extension for disabled people would be negligible. Although individuals qualifying for the extension would be expected to have covered health expenses about three times greater than their premium payments, very few people would actually participate.

CBO used two approaches to estimate the number of people who would take advantage of the new COBRA extension. The first method used evidence on the number of employees electing COBRA coverage under current law who are disabled. A study by Flynn found that only 0.09 percent of COBRA elections are by disabled people.[4] Even under the assumption that the number of disabled people having COBRA coverage would double as a result of the new extension, fewer than 5,000 people a year would be covered by that extension.

In the second approach, CBO used data from the 1992 Survey of Income and Program Participation (SIPP) to examine the prior insurance status of people who became covered under Medicare disability coverage. That analysis also suggested that the number of people qualifying for the additional COBRA coverage under S. 1028 would be extremely small.

The costs of coverage for disabled people were estimated using information from the 1987 National Medical Expenditure Survey, which indicated that non-elderly disabled people had medical expenditures four to five times greater than non-disabled people. Those higher costs would be partly offset by additional premiums that would be collected from persons using the COBRA extension. COBRA allows insurers to charge those people up to 150 percent of the premium for regular employees. Consequently, assuming the full COBRA premium was assessed, the insured costs of disabled people taking the new extension would be about three times higher than the premiums they would pay.

Direct costs of mandates affecting the individual insurance market

S. 1028 would require issuers of individual health insurance policies to offer coverage to all people who have had group or employer-sponsored coverage continuously for at least 18 months immediately prior to enrolling, but who are not eligible for additional COBRA or other group coverage. CBO estimates that this group-to-individual portability provision would impose aggregate direct costs on the private sector of less than $50 million in the first year the law was effective. Those aggregate direct costs would rise to about $200 million annually in the fifth year.

The mandate costs are added insurance costs of people who would gain coverage minus premium payments that the newly covered individuals themselves would make to insurers. Premium payments are subtracted because they would directly offset part of the cost of the mandate imposed on insurers.

A key element of this estimate is the calculation of the number of people who would both qualify for and desire to purchase individual market insurance under the provisions in S. 1028, but who would not be extended insurance coverage under current law. CBO analyzed data from the 1992 SIPP to determine the number of people who: (1) had 18 months of prior continuous group coverage, and (2) would purchase an individual policy if insurers were not permitted to exclude them on the basis of health. We assumed that uninsured survey respondents who indicated that they were too sick to obtain insurance would fulfill the latter condition. The data suggest, however, that only about 25 percent of such people would meet S. 1028's requirement of 18 months of continuous prior group coverage.

Because the SIPP survey used in this analysis ended in late 1993, we made two additional adjustments to our estimate. First, we corrected for changes in the number of uninsured since 1993. Second, we reduced our estimate to account for state legislation that supersedes the S. 1028 provision. Many states undertook reforms of their individual insurance markets prior to the time of the survey, and a few additional states have implemented such laws since then. We assumed that all states with comparable laws would get waivers from the S. 1028 provisions affecting the individual market. Accordingly, the estimate assumes that the mandate would only be effective in states accounting for about 5.4 million of the estimated 13.4 million people currently having individual coverage.[5] (Note that estimates of the number of people insured through the individual market vary considerably. CBO's assumption is consistent with that of the Academy.)

CBO concludes that approximately 40,000 people would become covered by the end of the first year the bill would be effective because of the group-to-individual portability provision. The number of covered people would grow gradually over time as more people who, in the absence of S. 1028, would have been denied coverage because of poor health would meet the 18-month continuous group coverage requirement and choose to purchase individual insurance. In about four years, the number of people covered because of those portability provisions would plateau

Footnotes at end of article.

at around 150,000 people. Those estimates refer only to the number of people who gain insurance coverage as a result of S. 1028. The estimates do not include people who might decide to move into individual insurance coverage under S. 1028 but would have had insurance coverage from elsewhere in the absence of the bill. It would not be appropriate to count such people toward the aggregate direct costs of the bill because their medical expenses would have been insured anyway.

In order to complete the estimate, we calculated the direct mandate costs per person who would obtain individual coverage because of this bill. Those costs equal the difference between the added insurance costs of the people who would gain coverage and the premium payments that those newly covered people would make to insurers. Neither the additional insurance costs, nor the additional premium revenue, can be estimated with a high degree of confidence.

S. 1028 would prohibit the denial of coverage because of health status or claims experience. Consequently, people gaining coverage through the portability provisions of S. 1028 would cost more, on average, than the typical person who currently purchases an individual policy. But, because of the multiple eligibility criteria required by S. 1028, surveys of health expenditures do not provide an adequate basis for a specific estimate of those higher costs.

Likewise, the premiums that insurers might charge newly covered people are highly uncertain because they depend on the unknown responses of state insurance regulators that are likely to vary among the states. At one extreme, state regulators might not allow insurers to charge higher premiums for people qualifying under the S. 1028 portability provisions. The loss on those people would then be relatively large. At the other extreme, state regulators might allow insurers to charge them their full expected costs. In that case, there would be no loss to insurers, and consequently no aggregate costs from that mandate.

Previous studies offer divergent views on these issues. The Academy assumed that people obtaining individual coverage through the portability provisions would have costs two to three times as high as standard risks.[6] They also assumed that the premiums those people would pay would range from 125 to 167 percent of the average individual premium. That is, the Academy assumed that states would limit what insurers could charge to less than the full cost of the benefit.

The Health Insurance Association of America (HIAA) assumed that newly covered people who exhausted their COBRA coverage would have costs between two and three times the average, while the cost of those not eligible for COBRA coverage would be 1.5 to two times the average[7] HIAA made no specific assumptions about the rating rules that states would impose on health plans in the individual market.

Although neither the costs nor the insurance premiums associated with the newly covered individuals are known, it is not unreasonable to assume that state insurance commissioners would take the additional costs, and their potential effects, into account in regulating the individual market. If, for example, the expected costs of the newly insured people were high relative to others in the individual market, insurance regulators might allow insurers to charge such people relatively high premiums. Conversely, if the expected costs of the newly insured people were not much higher than others in the individual market, state regulators might not allow their premiums to deviate much from the market average.

This relationship can be viewed in terms of a target ''loss'' percentage that regulators might seek. That percentage would be the difference between the cost of coverage and the premium, expressed as a share of the average premium in the individual market. Based on a wide range of possible cost and premium factors, CBO assumed that the insurers' loss percentage associated with the newly covered individuals would be about 70 percent. That is, the difference between premium income and insurance costs for the newly insured people is expected to be about 70 percent of the average premium paid by others in the individual market.

Multiplying the loss percentage by the average individual market premium under current law and by the number of newly covered people yields the estimated aggregate direct costs of the group-to-individual portability provision. Those costs are expected to be less than $50 million in the first effective year of the legislation and to rise to about $200 million annually by the fifth year.

Other Considerations. For those states in which the individual market mandates are expected to apply, premiums are estimated to be around 0.5 percent higher than otherwise by the end of the first year of implementation and to be approximately 2 percent higher than otherwise by the end of the fifth year. Those premium increases represent the excess costs that presumably would be passed on to people who would have acquired individual policies in the absence of this bill. The estimates of premium increases are limited to those costs attributable to people who obtain insurance in the individual market who would have been uninsured in the absence of S. 1028.

If individual insurance premiums rose sufficiently as a consequence of S. 1028, some people with individual coverage would probably drop their insurance. Those most likely to do so would be lower-income people who were not in poor health. CBO used an analysis by Marquis and Long to estimate the number of people who would drop out of the individual insurance market in response to higher premiums.[8] By the fifth year after S. 1028 became effective, about 35,000 people who would have purchased individual policies in the absence of this legislation would not do so. Overall, however, the number of people with insurance in the individual market would probably rise as a result of S. 1028.

CBO's estimate assumes that states that already meet the individual market standards in S. 1028 would be granted waivers of those requirements. Initiatives such as guaranteed issue laws and state-sponsored risk pools to provide insurance for high-risk people may qualify states for waivers. The Academy has suggested, however, that states may not seek those waivers even when they are eligible. States might see the provisions of S. 1028 as a mechanism to transfer some individuals out of partially state-subsidized high-risk insurance pools into the private market, where their additional costs would be picked up entirely by the private sector.

7. Appropriations or other Federal financial assistance: None.

8. Previous CBO estimate: None.

9. Estimate prepared by: James Baumgardner.

10. Estimate approved by: Joseph Antos, Assistant Director for Health and Human Resources.

[1] See American Academy of Actuaries, ''Providing Universal Access in a Voluntary Private-Sector Market,'' February 1996.

[2] Charles D. Spencer and Associates, Inc., ''1995 COBRA Survey: Almost One in Five Elect Coverage, Cost is 155% of Actives' Cost,'' Spencer's Research Reports (August 25, 1995).

[3] Based on unpublished tabulations from KPMG Peat Marwick, LLP, Survey of Employer-Sponsored Benefits, 1995.

[4] Patrice Flynn, ''COBRA Qualifying Events and Elections, 1987–1991,'' Inquiry, vol. 31, no. 2 (Summer 1994), pp. 215–220.

[5] Calculations based on consultations with the Congressional Research Service/Hay Group concerning state individual insurance market laws.

[6] American Academy of Actuaries, ''Comments on the Effect of S. 1028 on Premiums in the Individual Health Insurance Market,'' February 20, 1996.

[7] Health Insurance Association of America, ''The Cost of Ending 'Job Lock' or How Much Would Health Insurance Costs Go Up if 'Portability' of Health Insurance Were Guaranteed; Preliminary Estimates,'' July 26, 1995.

[8] M. Susan Marquis and Stephen H. Long, ''Worker Demand for Health Insurance in the Non-Group Market,'' Journal of Health Economics, vol. 14, no. 1 (May 1995), pp. 47–63.

SEXUAL OFFENDER TRACKING AND IDENTIFICATION ACT OF 1996

Mrs. HUTCHISON. Mr. President, in response to the number of repeat crimes that are committed by convicted sex offenders, Senator GRAMM and I are offering legislation to require all such individuals to register with the FBI.

Society needs to know where these predators are at all times. Individual States are creating registries of convicted sex offenders and devising other measures to address the problem—my home state of Texas has moved forward aggressively on this front.

Unfortunately, for my State and others, there is a continuing worry despite such progress: individuals convicted of 1,000 cases of child molestation scheduled to be released in Texas this year alone.

Currently, 47 States have registry laws which apply to sex offenders, but these track such felons only within the individual State. There is no national registry. There is no formal network for law enforcement agencies to communicate with each other about know sexual predators. As a result, a convicted rapist or child molester released in Texas can move to, say, Vermont—which has no registry law—and disappear from law enforcement records. This ability to move from one State to the next unmonitored has provided tens of thousands of sex offenders with the opportunity to commit yet more deviant acts.

The legislation Senator GRAMM and I are introducing would close this immense loophole by creating a national computer registry to track convicted sex offenders. Our bill would:

Require all sex offenders to register with the FBI for 10 years following their release from prison, drawing on State registries.

Authorize the FBI to register and track offenders living in States with no registry program.

Require the FBI to ensure that local authorities are notified every time a sex offender moves into or out of their jurisdiction.

Allow private and community organizations access to the sex offender files through their local law enforcement agencies;

Preserve State authority in determining whether (or how) the public at large will be notified of the presence of sex offenders in a community.

Provide penalties for those who fail to register.