

CHAPTER 4. HEALTH INSURANCE

- 4-1. HEALTH MAINTENANCE ORGANIZATIONS. The Health Maintenance organization Act of 1973, subpart H, Sec. 1310, details requirements for employers offering qualified health maintenance organization plans (HMOs). These "dual choice" regulations contain two requirements: (1) the circumstances under which employers are required to offer their employees the options of enrolling in a federally qualified HMO, and (2) how much an employer had to contribute toward coverage of employees who elected to enroll in a federally qualified HMO plan. The 1973 HMO Act was amended in 1988. The essence of the original Act was retained; however, the amended law contained two major modifications -- a seven-year "sunset" provision that would repeal the "dual choice" requirements and a provision that would modify the language in regard to employer contributions on behalf of employees who enroll in qualified HMO plans. The effective date of both modifications is October 24, 1995. Consequently, as of October 24, 1995, a federally qualified Health Maintenance Organization (HMO) can no longer mandate employers to offer a "dual choice."
- 4-2. CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT OF 1985 (COBRA). COBRA's impact is briefly discussed below.
- a. Continuation of Group Health Benefits. Group health benefit plans provided by HAs having 20 or more employees including full and part-time) are required to offer employees and their dependents, who would otherwise lose coverage, the chance to continue in the group health benefit plan for a specified period by paying the full cost calculated at group rates. HAs that normally employed fewer than 20 employees on a typical business day during the preceding calendar year are exempt, but may elect to extend the COBRA provisions to its group health benefit plan.
 - b. Working Aged. The "Working Aged" provisions of the Social Security Act and The Age Discrimination in Employment Act are extended to active employees and spouses regardless of age.
 - c. Reimbursement to U.S. Government. Insurers and other third-party payors are required to reimburse the U.S. Government for care rendered to insured armed services retirees and dependents in military hospitals (for nonservice related disabilities).
 - d. Participation in Part A Medicare. State/local government employees hired (or rehired) after March 31, 1986, must participate in Part A Medicare even though covered by Social Security. Part A Medicare will be secondary to a HA-financed group health benefit plan for all active employees and their spouses regardless of age. Medicare is primary for retired employees covered by a group plan.
 - e. Assistance. Advice of legal counsel and/or the group health benefit plan representative should be obtained.
 - f. Performance Funding System (PFS) Impact on Eligibility for Additional Operating Subsidy. Under Sec. 990.108(c) of the PFS Regulations, provision is made for an increase in operating subsidy in cases where a change in Federal (but not state) law or regulation results in a significant increase in expenditures of a continuing nature. The HA rental housing program's share of the cost of Part A

Medicare for HAs not already covered by Social Security under the new requirements, as well as expenses not covered from the administrative fee (added to the group health benefit plan

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premium), may be covered by revising Line 28b of Form HUD-52723 after the end of the HA's fiscal year to incorporate the actual amount of eligible increased expenditures. This procedure will be repeated at the end of each fiscal year. No entry for these costs will be made on Line 04 of Form HUD-52723. In order to qualify for funding under this provision, the HA must charge the covered employees and qualifying beneficiaries the maximum allowed for continuing coverage (ie., 102 percent of the premium applicable to similarly situated participants). Should additional administrative costs be incurred in implementing these new requirements, such costs will be eligible for funding under the provisions of Sec. 990.108(c) of the PFS Regulations only to the extent that the costs are necessary to implement and maintain the new Federal statutory coverage on an ongoing basis. All requests for funding pursuant to Sec. 990.108(c) shall be fully documented and are subject to HUD Field Office approval.

- 4-3. PERSONAL POLICIES. Where a HA would have too few eligible employees to obtain (or participate in) a group policy, it should consider contributing on a nondiscriminatory basis toward a portion of the cost of a personal policy (which may include coverage for dependents) obtained by the employee personally.
- 4-4. VOLUNTARY EMPLOYEES' BENEFICIARY ASSOCIATION (VEBA). A VEBA may be used to provide for the payment of life, sickness, accident or other benefits to the members of such association or their dependents or designated beneficiaries, provided no part of such association inures (other than through such payments) to the benefit of any individual (IRC Sec. 501(c)(9)).
- 4-5. IRC Sec. 125 CAFETERIA PLANS. A Sec. 125 cafeteria plan allows an employee the opportunity to pay nontaxable benefit premiums for health insurance with before--tax dollars through salary reduction rather than with after-tax dollars. Where practical, employees may also be offered the opportunity to select from among various types and levels of benefits at specified prices on the basis of individual need. More complex plans may give employees the opportunity to establish an account through salary reduction to be used to reimburse noncovered, out of pocket expenses such as dependent care and health care (medical, dental, vision, hearing). Salary deferrals under Sec. 125 cafeteria plans are not subject to Social Security (FICA) tax or unemployment (FUTA) tax (Social Security Act Sec. 3121(a)(5), 3306(b)(5), and 209(e) as amended by TRA'86 Sec. 1151(d)(s)). The term "cafeteria plan" does not include any plan which provides for deferred compensation such as a IRC Sec. 457 plan (IRC Sec. 125(c)(2)(A)).
- 4-6. COST CONTAINMENT. The cost of medical insurance has increased significantly over recent years. Some of the increase is due to availability of innovations in health care service and to the cost of providing these as well as customary services. Also, there has been a significant increase in the utilization of health care. The need for cost containment is dictated in part by personnel needs, the perception of moral obligations, and financial necessity. To help contain the rising

cost of health insurance, HAs should consider adopting one or more ways and means which have been shown effective methods of cost containment. A variety of these methods include development of alternative choices such as regional, state or local multi-agency programs, self-funding, inclusion of cost containment programs such as case management and prescription drug plans, increasing employee copayment, and providing cash inducements to employees who receive coverage for both themselves and their dependents through their spouse's plan.