



UNITED STATES GENERAL ACCOUNTING OFFICE  
WASHINGTON, D.C. 20548

HUMAN RESOURCES  
DIVISION

OCTOBER 23, 1984

B-214194

The Honorable Daniel K. Inouye  
United States Senate

The Honorable Joseph P. Addabbo  
Chairman, Subcommittee on Defense  
Committee on Appropriations  
House of Representatives

Subject: No Need for the Congress to Reverse 1981 Decision  
to Deny U.S. Merchant Seamen a Government-  
Financed Health Care Program (GAO/HRD-85-2)

This report is in response to your respective January 14 and February 9, 1983, requests that we review the policy issue of whether U.S. merchant seamen should be entitled to a government-financed health care program and the feasibility of expanding an existing government-financed program, such as the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), to include U.S. merchant seamen. As used in this report, the term "merchant seamen" includes seamen working on deep sea, commercial fishing, inland waterway, and offshore drilling vessels. Merchant seamen were eligible for medical care at federal facilities from 1798 to 1981, when their entitlement was repealed by the Omnibus Budget Reconciliation Act of 1981, Public Law 97-35.

We reviewed the rationale and justification for providing medical care to merchant seamen, the methods used to finance it, the reasons for repealing it, and the arguments for restoring some type of government-financed health care. Based on our review, we do not believe there is any compelling reason for the Congress to reverse its 1981 decision.

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--The original justification for providing health care to merchant seamen at federal facilities no longer exists. The Congress authorized federal health care for seamen to combat health problems prevalent in 1798, namely overcrowded health care facilities and uncontrolled communicable diseases which threatened the general population and deterred the development of the American merchant fleet. As health conditions have improved in the last 50 years, the spread of communicable diseases by merchant seamen is not the problem it was in the past. (See enc. I, pp. 6 to 9.)

--Although seamen lost the entitlement to health care at federal facilities, they did not lose their right to health care from shipowners. According to maritime law, the shipowner is liable for medical expenses resulting from an illness or injury that occurs while the seaman is in the service of the vessel. Traditionally, the entitlement to medical care at federal facilities may have relieved the shipowner of the cost, but not of the legal obligation to see that seamen obtained needed medical care. Even though seamen lost their entitlement to medical care at federal facilities, the government continues to subsidize approximately one-third of the privately owned U.S. vessels in the maritime industry through the operating differential subsidy program. This subsidy pays 70 to 72 percent of the health care benefits for seamen employed on these vessels. (See enc. I, pp. 9 to 13.)

--The federal government provides compensation for the merchant seamen's health care, as it does for civilians working in other occupations, during wartime or national emergency when seamen provide services to the government. (See enc. I, pp. 15 to 17.)

--At other times, those seamen likely to be called upon to aid the U.S. defense efforts have access to health care through union health plans financed by various shipping companies. These seamen represent about 12 percent of the seamen formerly eligible for medical care at federal facilities. (See enc. I, pp. 17 to 20.)

Procedural and administrative questions, particularly in the areas of defining and verifying eligibility, would have to be addressed before it would be feasible to provide government-financed health care through a program such as CHAMPUS. We estimate the annual cost of including merchant seamen and their

dependents under the rules of the CHAMPUS program would be about \$312 million. This estimate includes the increased costs that would be incurred by the military's direct care system, but does not include the cost of administering such a program. We did not estimate the cost of providing medical care to retired merchant seamen and their dependents because data on them were not readily available. In addition, our review did not examine the effects disenfranchisement had on the health status of merchant seamen under government care. (See enc. I, pp. 20 to 22.)

Because the report is primarily informational and because of your mutual requests to expedite issuance, we did not obtain agency comments on matters discussed in this report. As arranged with your respective offices, we are sending copies of this report to various federal agencies, maritime unions, shipping companies, and other interested parties. Copies will also be available to other parties upon request.



Richard L. Fogel  
Director

Enclosures - 2



C o n t e n t s

	<u>Page</u>
ENCLOSURE	
I	
NO NEED FOR THE CONGRESS TO REVERSE 1981 DECISION TO DENY U.S. MERCHANT SEAMEN A GOVERNMENT-FINANCED HEALTH CARE PROGRAM	1
Introduction	1
Objectives, scope, and methodology	3
Seamen benefit established because nation needed to address a problem that no longer exists	6
PHS entitlement relieved shipowner of seamen medical care cost	9
Federal government continues to subsidize some merchant seamen health care	13
Tonnage taxes should not be used to finance seamen health care	13
Merchant seamen compensated for health care when providing services to the government	15
Merchant seamen who are likely to serve in war and national emergency have access to health care	17
Cost of including merchant seamen and their dependents in the CHAMPUS program	20
Conclusions	22
II	
ADDITIONAL INFORMATION ON COST ESTIMATES	23

ILLUSTRATIONS

Estimated maritime work force meeting eligibility requirements for PHS medical care, February 1981	3
Estimated cost of providing CHAMPUS benefits to merchant seamen and their dependents	21

ABBREVIATIONS

CDC	Centers for Disease Control
CHAMPUS	Civilian Health and Medical Program of the Uniformed Services
FEHBP	Federal Employees Health Benefits Program
GAO	General Accounting Office
NMU	National Maritime Union
PHS	Public Health Service



NO NEED FOR THE CONGRESS TO REVERSE 1981DECISION TO DENY U.S. MERCHANT SEAMEN AGOVERNMENT-FINANCED HEALTH CARE PROGRAMINTRODUCTION

The U.S. merchant marine consists of two deep sea fleets. The largest, the privately owned and operated commercial fleet, provides waterborne transportation for cargoes moving between U.S. ports and U.S. and foreign ports. It provides American shippers with access to world markets, sources of raw materials, and other foreign products for the U.S. economy. The other fleet, owned by the federal government, consists of an active segment under the control of the Department of the Navy's Military Sealift Command<sup>1</sup> and an inactive segment maintained by the Department of Transportation's Maritime Administration.<sup>2</sup>

Together, these fleets support America's military services in peacetime as a major supply link in the defense network and, in time of war and national emergency, as a transport for people and materials. Civilian personnel who staff these fleets are known as merchant seamen. Licensed seamen are the ship's officers and unlicensed seamen are the nonsupervisory support personnel.

The Public Health Service Act, Public Law 78-410, entitled U.S. merchant seamen to health care at federal facilities. Federal health care for merchant seamen was first authorized by the 1798 "Act for the Relief of Sick and Disabled Seamen" (1 Stat. 605). Based on the British concept of providing government hospitals for health care financed through monthly deductions from seamen's wages, the act authorized construction of marine hospitals, later known as Public Health Service (PHS) hospitals, where seamen could obtain temporary relief from illness or disability.

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<sup>1</sup>The Military Sealift Command is responsible for transporting Department of Defense cargoes by sea and operating ships prepositioned with supplies for the armed forces and ships that support combatant navy fleets and scientific agencies.

<sup>2</sup>The Maritime Administration is responsible for aiding the development, promotion, and operation of the U.S. merchant marine. It organizes and directs emergency merchant ship operations and administers a subsidy program to ship operators.

Although originally established for civilian personnel in the merchant marine, federal health care benefits subsequently were extended to other groups. From 1799 until the establishment of a separate naval hospital system in 1811, Navy personnel were eligible for care in marine hospitals. Beginning in 1802, the hospitals provided care on a reimbursable basis to seamen arriving on foreign vessels. Gradually, new categories of beneficiaries<sup>3</sup> were added to include certain seamen working on U.S. commercial fishing vessels, inland waterway vessels,<sup>4</sup> and vessels engaged in the offshore drilling industry.<sup>5</sup>

The Omnibus Budget Reconciliation Act of 1981, Public Law 97-35, eliminated the merchant seamen entitlement to free PHS health care and provided for the closure of the PHS hospital system. At its peak, during the Second World War, PHS operated 30 hospitals, and after that time, the size of the hospital system began to decrease, due primarily to a decrease in the number of merchant seamen. Because of the decline in the demand for inpatient health services, PHS began to close hospitals and replace them with outpatient clinics in the late 1940s. At the time of the system's closure in 1981, there were 8 hospitals and 27 clinics.

In fiscal year 1980, seamen accounted for 44 percent of the total number of PHS hospital inpatient days, a decline from 50 percent in fiscal year 1973. They also accounted for 27 percent of the total number of PHS hospital outpatient visits, a decline from 31 percent in fiscal year 1973.

Between 1905 and the 1981 disentanglement, seamen health care was totally financed by appropriations from the general revenues of the federal government. Prior to 1905, although periodically supplemented by general revenue appropriations, the

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<sup>3</sup>The PHS hospital system also served National Oceanic and Atmospheric Administration officers and crew, PHS commissioned Corps officers, active duty and retired military personnel (including the Coast Guard) and their dependents, low-income patients from the local community, and others.

<sup>4</sup>Includes dry cargo vessels, barges, ore/bulk/oil carriers, bulk freighters, railroad ferries, and tug boats that ply the inland waterways; Great Lakes; Mississippi River System; Gulf Intra-Coastal waterways; and Atlantic, Pacific, and Gulf Coasts.

<sup>5</sup>Includes mobile offshore drilling units and vessels engaged in support of offshore drilling.



care was primarily funded first by a monthly deduction from seamen wages and then by a tonnage tax imposed on shipowners.

PHS estimated the seamen work force and those eligible for medical care at PHS facilities before the disenfranchisement as follows:

Estimated Maritime Work Force Meeting  
Eligibility Requirements for PHS Medical Care,  
February 1981

<u>Segment of the maritime industry</u>	<u>Estimated maritime work force</u>	<u>Percent of total work force</u>	<u>Estimated work force eligible for PHS medical services</u>
----- (rounded) -----			
Deep sea	40,000	7	40,000
Fishing vessel	196,000	37	101,000
Inland waterways	267,000	50	225,000
Offshore drilling industry	<u>34,000</u>	<u>6</u>	<u>32,000</u>
Total	<u>537,000</u>	<u>100</u>	<u>398,000</u>

Almost 75 percent of the estimated seamen work force were eligible for medical care at PHS facilities. PHS had very specific criteria to determine eligibility for care, including (1) employment aboard various specified types of vessels, (2) performance of an on board job that involved the operation (care, preservation, or navigation) of the vessel, and (3) 60 days of continuous service on a vessel during the 180 days immediately preceding the application for benefits or shorter periods of service totaling 60 days as long as the time between jobs did not exceed 60 days. Exceptions to the third criterion were made if the seaman became ill or was injured on board ship while employed.

OBJECTIVES, SCOPE, AND METHODOLOGY

Senator Daniel K. Inouye and Congressman Joseph P. Addabbo, in their respective January 14 and February 9, 1983, letters, requested that we review the need for providing government-financed health care to U.S. merchant seamen and the feasibility of doing so through an ongoing program, such as an expansion of

the Department of Defense's Civilian Health and Medical Program of the Uniformed Services (CHAMPUS). Our objectives were to determine whether

- merchant seamen should be entitled to government-financed health care and
- it would be feasible to include merchant seamen in a government-financed health care program such as CHAMPUS.

For our analysis, we used the term "merchant seamen" in a generic sense to include seamen working in the various segments of the maritime industry formerly eligible for PHS medical services, namely seamen working on deep sea, commercial fishing, inland waterways, and offshore drilling vessels. We conducted our work between February 1983 and April 1984.

To address the first objective, we determined the rationale and justification for providing medical care to merchant seamen, the methods used to finance it, the reasons for repealing it, and the arguments for restoring some type of government-financed health care by:

- Reviewing congressional hearings, federal laws, regulations, and books and other narrative materials concerning provision of federal health care to merchant seamen.
- Reviewing union medical plans for seamen and their dependents.
- Reviewing documents concerning merchant seamen's national defense role.
- Discussing a federal subsidy program and the merchant marine industry with Maritime Administration officials.
- Interviewing officials at the Department of Health and Human Services and the Office of Management and Budget about the former PHS hospital system's operation, cost, beneficiaries, and closure.
- Discussing hospital operations, costs, and seamen health care entitlement with the director of the former PHS hospital in Baltimore, Maryland.
- Interviewing Department of Defense and Military Sealift Command officials concerning the role of merchant seamen as a naval auxiliary and the provision of health benefits.

- Interviewing representatives from labor organizations that were judgmentally selected based primarily on size and type of union membership, including the Masters, Mates, and Pilots Union; Marine Engineers Beneficial Association; Seafarers International Union; National Maritime Union (NMU); American Radio Association; and Marine Firemen's Union, concerning merchant seamen medical plans and entitlement to government-financed health care.
- Visiting an NMU local hiring hall in Baltimore, Maryland, to discuss merchant seamen entitlement to government-financed health care with the union's local representative.
- Interviewing officials of major maritime management organizations that were judgmentally selected based primarily on geographic location and representation of various shipping companies--including the Tanker Service Committee, the Maritime Service Committee, the Tanker and Maritime Service Corporation, the American Maritime Association, and shipping company officials from Sealand Services, Inc.; Hudson Waterways, Inc.; Victory Carriers, Inc.; Maritime Overseas Corporation; Delta Steamship Lines, Inc.; Puerto Rico Marine Management, Inc.; Ogden Marine, Inc.; United States Lines; Amoco Marine Transportation Company; Farrell Lines; Prudential Lines, Inc.; Moore-McCormack Bulk Transport, Inc.; Trinidad Corporation; and Mobil Oil Corporation--about the cost of merchant seamen's medical care and entitlement to government-financed health care.
- Interviewing the counsel for a group of merchant seamen who served in World War II and have applied for Veterans Administration benefits.

As agreed with Senator Inouye's and Congressman Addabbo's offices, we limited work on the second objective to (1) identifying procedural and administrative questions that would have to be addressed before providing benefits under CHAMPUS and (2) developing cost estimates for a government-financed health care program for merchant seamen and their dependents. Specifically, we

- reviewed a 1981 GAO report on the eligibility of merchant seamen for health care as PHS beneficiaries;

- examined PHS, Maritime Administration, and other data concerning the estimated number and types of merchant seamen, vessels, illnesses, and injuries;
- gathered data on civilian and military health care costs to prepare estimates of a government-financed health care program for merchant seamen and their dependents; and
- worked with the Congressional Budget Office to develop a methodology for estimating costs. (See enc. II for additional information on cost estimates.)

We did not estimate either the costs that would be associated with administering an expanded CHAMPUS program or the cost of including retired merchant seamen and their dependents in the CHAMPUS program as Senator Inouye's office desired because data on them were not readily available. In addition, our review did not examine the effects disentanglement had on the health status of merchant seamen under PHS care.

Much of our analysis concerned civilian personnel in the merchant marine because (1) the authorization to receive health care was originally granted to them and (2) they appear to have the strongest arguments for government-financed health care because of their wartime missions. Our conclusions, however, are applicable to all merchant seamen, including not only those working on deep sea vessels but also seamen working on commercial fishing vessels, inland waterway vessels, and vessels engaged in the offshore drilling industry.

Our review was made in accordance with generally accepted government audit standards.

SEAMEN BENEFIT ESTABLISHED BECAUSE  
NATION NEEDED TO ADDRESS A PROBLEM  
THAT NO LONGER EXISTS

The 1798 act establishing federal responsibility for the health care of merchant seamen originated because

- seamen frequently died because few facilities existed to provide needed medical care and
- the general population was exposed to communicable diseases carried by seamen.

Accordingly, to serve sick and disabled seamen and thereby control the spread of communicable diseases throughout the general

population, the Congress established marine hospitals. The spread of disease by seamen, however, is no longer as serious a threat to the nation. In addition, communities that had PHS hospitals appear to have the capacity to meet the health needs of seamen.

According to a history of the Boston, Massachusetts, PHS hospital, seamen suffering from a job-related injury or disease could expect very little skilled attention in the post-revolutionary period. The ship captain usually tried to provide what amounted to basic first aid, but if this did not work, the injured or sick seamen were left at the nearest port where it was hoped a family would provide care. Usually, to protect its citizens, the town would quarantine the seamen in a facility where minimal care was available.

In 1797, a congressional committee found that U.S. and foreign seamen arrived at U.S. ports in such a disabled condition that they either became a great burden to any existing hospitals or were left to die because proper attention could not be provided. About a year later, the Congress passed the act establishing the hospital system where seamen could receive treatment. Since that time, the concept has prevailed, according to PHS, that where national health needs are not being met elsewhere, the federal government has an obligation to help. According to an article in the January 20, 1983, New England Journal of Medicine, this act not only addressed a major health problem of the time, but also aided the development of an American merchant marine which would engage in foreign commerce and support our country in war.

According to "Medical and Hospital Care for Merchant Seamen," a historical review published by the Labor-Management Maritime Committee, seaports and seamen represented a constant source of danger to society's general health and welfare because waterborne commerce has traditionally been a carrier of communicable diseases. Once society recognized this threat to its health and welfare, it began to assume responsibility for certain medical needs of seamen.

Smallpox and yellow fever, the diseases of most concern to Colonial America according to the Maritime Committee review, were directly introduced into the United States by the seafaring community. To protect the general population from the introduction of such diseases, the colonies enacted quarantine restrictions that prevented "sickly vessels" from entering their ports.

These restrictions, however, were unsuccessful in controlling the fatal impact of some diseases. For instance, evidence indicates that yellow fever was a tenacious health problem for this country during the 18th and 19th centuries. A disastrous outbreak of yellow fever occurred in Philadelphia in 1793 (then the capital of the United States), and in 1878 yellow fever reached epidemic proportions killing more than 100,000 people. Bubonic plague, another disease introduced into the United States by the seafaring community, threatened the public health despite quarantine attempts.

A major function of PHS was to treat communicable diseases and help prevent their importation. As early as 1799, the Congress authorized federal officers to help state and local authorities enforce their quarantine laws. Over the years, marine hospital physicians helped communities treat severe epidemics like yellow fever which had been brought to this country by seamen. Prior to 1878, quarantine laws and regulations were the responsibility of the state and local governments. By 1893, the Congress gave PHS full responsibility for foreign and interstate quarantine measures.

The Department of Health and Human Services' Centers for Disease Control (CDC), an agency of PHS, is responsible for the management of communicable disease problems. The Quarantine Division, now part of CDC, is the oldest division in PHS and was created in 1798 as part of the marine hospital system.

Today, the spread of communicable diseases by merchant seamen is not as serious a threat to the nation as it was in 1798. We discussed the spread of communicable diseases by merchant seamen and the Quarantine Division role in preventing it with the Chief of the Program Operations Branch, Division of Quarantine. He told us that the division has not quarantined a ship in many years--certainly not since the disentanglement. Furthermore, he said that he was not aware of any data to indicate any increased threats of communicable diseases in communities around the country, as a result of the PHS closure, which would be attributable to seamen.

The CDC official explained that a representative from the Division of Quarantine met every boat and plane arriving in the United States from a foreign port (except Canada) to check for communicable diseases until about 1971 when this practice was no longer considered necessary. CDC currently contracts with private physicians and trained customs agents to examine the potential cases of communicable diseases. Today, according to the CDC official, all major U.S. ports have a steamship company

agent who will contact a physician if a crew member is sick on board ship. Furthermore, he explained that federal regulations require that, prior to landing, CDC be notified by radio if a crew member has symptoms of a public-threatening disease so a CDC physician can examine the crew member.

The CDC official pointed out that health conditions worldwide have improved significantly in the last 50 years. For example, he said smallpox was eradicated worldwide 5 years ago. He added that closure of the PHS hospitals has not necessitated changes in CDC's monitoring efforts.

The lack of treatment facilities for seamen no longer appears to be the problem it was in the 1790s. At the time of the disentitlement, each of the eight PHS hospitals was located in a community which had excess hospital beds. According to Department of Health and Human Services data, the excess ranged from about 532 in Norfolk, Virginia, to over 10,000 in New York City. Using a Department of Health and Human Services national guideline of 4 beds per 1,000 population to meet community health care needs, the hospital bed supply for the communities that had PHS hospitals ranged from 5.5 beds per 1,000 population in the New York City area to an estimated 13 beds per 1,000 population in the Galveston, Texas, area.

PHS ENTITLEMENT RELIEVED SHIPOWNER  
OF SEAMEN MEDICAL CARE COST

Although the merchant seaman entitlement to health care at PHS hospitals and clinics generally relieved the shipowner of the cost, it did not relieve the shipowner of the legal obligation to see that proper medical care was provided. Under maritime law, the shipowner is liable for medical expenses resulting from any sickness or injury occurring while the seaman is in the service of the vessel. In addition to medical expenses, the shipowner is required to pay for a seaman's maintenance and cure benefits, which are paid during periods when seamen are not hospitalized and continue until they are found fit for duty or have reached the maximum attainable cure. The rate of these maintenance and cure payments is usually negotiated with the shipowner by the seamen's unions.

Prior to the disentitlement, PHS paid for seamen medical care provided by the 8 PHS hospitals and 27 clinics or by other medical care providers (280 physicians and 82 hospitals) under contract to PHS. In addition to hospitalization, the PHS facilities provided medical, surgical, and dental treatment for all

eligible seamen. PHS did not pay shipowner expenses incurred during the voyage for the care of sick and disabled seamen. In other words, PHS did not pay for medical care given in foreign ports or at non-PHS hospitals and clinics unless they were under contract. PHS contracted with private health care providers for emergency care, services not available at its facilities, and routine ambulatory care for beneficiaries not located near a PHS facility.

To obtain PHS medical care, a seaman had to provide satisfactory evidence of meeting eligibility criteria (see p. 3) by presenting a properly executed master's certificate,<sup>6</sup> a continuous discharge book,<sup>7</sup> or a certificate of discharge.<sup>8</sup> Owner-operators and employees of commercial fishing boats which were registered under federal maritime laws were eligible for PHS care if they accompanied the vessel on fishing trips and a substantial part of their duties were comparable to those of seamen. According to PHS directives, PHS could not require any person alleging to be a commercial fishing boatowner-operator or employee to provide more information than required on the master's certificate. However, owner-operators of sport-fishing vessels, pleasure boats, and similar vessels not engaged in commercial-fishing operations were specifically excluded from PHS eligibility.

Although comments varied, the majority of the shipping company officials we interviewed said that merchant seamen should be entitled to government-financed health care because the dis-entitlement increased shipowners' medical care costs at a time when the industry was in a state of decline. For example, the American Maritime Association, an organization that represents certain shipping companies during collective-bargaining sessions with maritime labor unions, believed the federal government should continue to pay for merchant seamen care because negotiations over the years were based on the assumption that the

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<sup>6</sup>A master's certificate of service was a PHS form to be completed by the master or agent of a vessel certifying that the seaman met eligibility requirements.

<sup>7</sup>A discharge book is a history of employment maintained by a merchant seaman and signed by a vessel's master or agent at the completion of each employment.

<sup>8</sup>A certificate of discharge is a certificate-of-employment form given by a vessel's master or agent to a merchant seaman. The form is evidence of extended employment on a merchant vessel.



medical cost for seamen would be carried by PHS. Instead, with the termination of seamen entitlement to health care through PHS, the government imposed additional medical care costs on the maritime industry. According to the American Maritime Association, if the shipowners had known the full impact of these additional costs, labor contracts would have been different.

A vice president for the Tanker and Maritime Service Corporation, another organization that negotiates labor contracts with maritime unions for other shipowners, stated that health benefit negotiations since 1950 have been based on the knowledge that PHS care was available. Now that the costs of the negotiated benefits have increased, the shipowners are being burdened with the additional costs associated with the disentanglement. Shipowner representatives also felt that medical care at government facilities had become an American tradition which was abruptly terminated at a time when the shipping industry could scarcely afford the added expenses because of low-cost foreign competition and reduced government operating subsidies.

We do not believe that increased medical costs to a depressed industry as a result of the disentanglement is sufficient justification for a federally financed health care entitlement. Certainly employers in other depressed industries could claim an entitlement for their employees because they are also facing increased health care costs. Also, like other employers, shipowners can offset their increased health care costs to some extent by claiming them as a business expense on their income tax returns. Furthermore, we do not believe that an entitlement is justified by past negotiations based on assumptions that are no longer valid. While the disentanglement may have been abrupt, current and future negotiations should recognize that the government is no longer paying for seamen's medical care through PHS.

While one shipping company representative stated that from a profit standpoint the company would like the government to pay for seamen's medical care, he does not believe merchant seamen need to be singled out from other occupations. He also commented that laws change as conditions change and that the PHS entitlement was an antiquated law. Two representatives of the same company stated that it is time to start allowing the maritime industry to be treated like other industries. The president of the Maritime Engineers Beneficial Association believed that the government should no more intervene in the health care of the maritime industry employees than in the health care of the airline industry employees.

The seamen disentanglement to health care at PHS cost has also affected maritime union members. For example, members of the Seafarers International Union transferred a 7.5-percent wage increase, scheduled for June 1983, to their union welfare plan to meet the increased costs of their health benefits. In addition, the NMU president said that increased health care costs would affect the unions' ability to negotiate advantageous labor-management welfare plans for their members because shipping operators would use increased health care costs as a basis for negotiating less benefits in other bargaining areas.

According to union and shipping company officials, the increased costs resulting from the disentanglement can be attributed primarily to unlicensed seamen. They explained that the disentanglement affected unlicensed more than licensed seamen because, traditionally, unlicensed seamen were required to use, or opted to use, PHS facilities for their medical care whereas licensed seamen, who could choose between PHS or private care, chose private care. The president of the Masters, Mates, and Pilots union told us his licensed seamen did not want to use PHS facilities because they resented having to wait in line for treatment. The president of the Marine Engineers Beneficial Association, also representing licensed seamen, said Association members did not like PHS hospitals because the care provided in them was similar to that found in socialized countries; if the hospital was full, you could not get in, but if it was empty, you could not get out and make a living. According to the Masters, Mates, and Pilots' vice president and the administrator of the Marine Engineers Beneficial Association's Medical and Health Benefits Plan, their members' use of PHS facilities had steadily declined over the years.

As could be expected, the overall financial impact of the disentanglement seems varied, but appears to have had more of an effect on plans for unlicensed seamen. According to NMU's Pension and Welfare Plan assistant administrator, the NMU plan experienced approximately a 25-percent (or a \$5 million) increase in total welfare benefits<sup>9</sup> disbursed in 1982 due to the disentanglement. For seamen alone, the plan paid about \$953,000 per month in 1982 whereas the average monthly payment for 1981 was \$445,997. The Seafarers International Union's special counsel told us that total union welfare benefit costs for calendar year 1983 were \$24 million--more than a 100-percent increase since the disentanglement. For seamen alone, the plan paid about

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<sup>9</sup>Includes such benefits as hospital, major medical, optical, dental, prescription drugs, and a scholarship program.

\$1.1 million per month in 1983 whereas, before the disentanglement, the per month cost averaged \$79,416.

Officials from the Mobil Company, the American Radio Association, the Maritime Engineers Beneficial Association, and the Masters, Mates, and Pilots Union told us, however, that the PHS disentanglement had an insignificant effect on their health care costs. This appears reasonable because, as noted earlier, licensed seamen made more limited use of PHS as compared to unlicensed seamen. It should be pointed out that while most of the increases for the unlicensed seamen health plans may have been due to the disentanglement, some can also be attributed to rising health care costs which are not unique to the maritime industry.

FEDERAL GOVERNMENT CONTINUES TO SUBSIDIZE  
SOME MERCHANT SEAMEN HEALTH CARE

Even though seamen lost their entitlement to medical care at federal facilities, the federal government continues to subsidize some merchant seamen's health care for those shipowners participating in the operating differential subsidy program. Through this program, the federal government compensates U.S. flag vessel operators for the difference between the operating cost of the U.S. flag vessel and a foreign flag vessel serving the same trade routes. The primary difference in the operating cost is the cost of U.S. labor which includes merchant seamen's wages and welfare benefits. The major portion of the welfare benefit is for seamen and their dependents' health care.

As of July 1983, nearly one-third of the privately owned U.S. vessels in the maritime industry received a government operating differential subsidy. The subsidy covers about 70 to 72 percent of a seaman's wages and benefits, but generally only goes to seamen working on deep sea vessels. Maritime Administration officials in the Office of Ship Operating Costs estimated that the fiscal year 1982 government subsidy for seamen's welfare benefits was \$10.4 million. They explained that this was not a final amount because, at the time of our review, the Maritime Administration was still reviewing and comparing the competitive rates for foreign vessels before calculating a finalized payment to the shipowners.

TONNAGE TAXES SHOULD NOT BE USED  
TO FINANCE SEAMEN'S HEALTH CARE

Shipowners have been paying a tonnage tax to the federal government since 1789. For a relatively short period of time

(1884-1905), PHS hospital expenses were primarily met through tonnage tax receipts. Since 1905, when there was a change in law, these receipts have not been authorized specifically for seamen's health care. Since the 1981 disentanglement, some maritime industry representatives have taken the position that there is a legal basis to use the tonnage tax receipts for seaman health care. We believe this contention is without legal merit.

Many shipowners pay a tonnage tax based on vessel weight or capacity. It is a tax placed on American and foreign vessels entering U.S. ports from a foreign port to engage in trade. Vessels engaged in the fishing industry are exempt from the tax as are certain other vessels, such as those used exclusively in scientific activities. The tax was first levied by the Act of July 20, 1789, which did not mention a specific purpose for this tax, such as using it to finance health care for merchant seamen. However, an 1884 act directed that the tonnage tax be used in lieu of a deduction from seamen's wages to finance seamen's medical care. The legislation did not require nor did we find anything in the legislative history to suggest that the tonnage tax be used only for merchant seamen's medical care. Other appropriations could be made from tonnage tax revenues. In 1905, the Congress repealed the 1884 act's designated use of tonnage taxes for merchant seamen hospital expenses, but did not repeal the tonnage tax itself.

Some maritime industry representatives believe there is a legal basis to use tonnage taxes currently collected to finance seamen's health care. The Seafarers International Union, in particular, contends that the tonnage tax was established in 1884 to finance merchant seamen's health care and, since it has not been repealed, should be used as a partial offset to federal appropriations for their medical care.

Although shipowners still pay the tonnage tax, we do not believe the maritime industry has a legal claim to it for seamen's medical expenses because the authorization to use tonnage taxes for medical expenses was repealed in 1905.

We asked a Department of the Treasury official about transferring tonnage tax receipts to an agency, such as the Maritime Administration, to use in conjunction with a government-sponsored health care program for seamen. According to the Deputy Assistant Secretary of the Treasury for Operations, Treasury opposes the earmarking of taxes and duties because it is inconsistent with sound budgetary principles and limits the flexibility of the President and the Congress to evaluate and determine needs of government programs on the basis of current priorities.

MERCHANT SEAMEN COMPENSATED FOR HEALTH CARE  
WHEN PROVIDING SERVICES TO THE GOVERNMENT

The federal government compensates merchant seamen for services provided to it in wartime or national emergencies. During these times, merchant marine vessels needed for national defense are operated either by seamen who are civilian employees of the federal government or by civilian seamen working for shipping companies that contract with the government or act as the government's agent for the transport of people and materials. In either case, the federal government pays for the services of the seamen. Included in the payment for seamen services is an amount for medical care. For example, seamen who are federal employees are paid directly by the government and can choose to participate in one of the various health plans in the Federal Employees Health Benefits Program (FEHBP). In this program, the employees and the employer--the federal government--share the expense, with the government contributing the majority of it. In the case of a government contract or agent, the government pays the contractor or agent for the services, part of which is for the seamen's medical care.

Some critics of granting an entitlement contend that merchant seamen should be treated no differently than individuals working in other occupations. They believe the government should compensate merchant seamen for their services, as it does for individuals working in other occupations, but should not provide a federal entitlement to health care at all times. In its proposal to repeal the entitlement, the administration noted that the entitlement had been expanded over the years to include tugboat operators, fishermen, offshore drilling crewmen, and others in addition to the oceangoing seamen. Therefore, the administration concluded that the program had developed into a free government health delivery program for selected classes of occupations.

Several maritime industry officials said that the merchant seamen are a quasi-military force and that the government should provide for their health care as it does for personnel in the uniformed services. For example, shipping company representatives, Seafarers International Union, and NMU officials said that merchant seamen are the "nation's fourth arm of defense" and, therefore, the federal government should provide them the same medical care benefits as military personnel. Furthermore, Seafarers International Union and NMU officials said that seamen eligibility for health care at federal facilities was based solely on the national interest to maintain a healthy merchant marine to serve in time of war and national emergency.

Seamen, however, are not legally considered part of the U.S. Armed Forces. Under the law (10 U.S.C. 101), the Armed Forces include only members of the Army, Navy, Air Force, Marine Corps, and Coast Guard.

When merchant seamen lost their entitlement to health care at PHS facilities, the Coast Guard, whose members also used these facilities, did not lose an entitlement to health care. According to the Coast Guard's Office of Health Services, active duty Coast Guard personnel, unlike merchant seamen, are part of the Armed Forces and are subject to all the military duties, rules, and regulations. Therefore, they are provided the same health care as other military personnel.

As civilians, however, merchant seamen may apply to the Secretary of Defense to obtain veterans' status and eligibility for benefits, including health benefits. Under the GI Bill Improvement Act of 1977, members of a group which rendered service to the U.S. Armed Forces in a civilian employee or contractual capacity will be considered active duty for the purpose of all laws administered by the Veterans Administration, if the Secretary of Defense determines that the service of the group constituted active military service. In addition to other benefits, a favorable determination for merchant seamen would entitle them to Veterans Administration's health care. In making the determination, the Secretary considers the extent to which members of the group (1) received military training and acquired a military capability or provided a service that was critical to the success of the military mission; (2) were subject to military justice, discipline, and control; (3) were permitted to resign; (4) were susceptible to a combat zone requirement; and (5) had reasonable expectations that their service would be considered active military service.

In January 1982, the Department of Defense denied veterans' status and benefits to members of the American Merchant Marine who were in active oceangoing service<sup>10</sup> during World War II because the service provided by merchant seamen did not sufficiently meet the criteria for active military service. The denial stated that merchant seamen were critical to the success

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<sup>10</sup>The term "active oceangoing service" covers service on oceangoing vessels under the flag or control of the United States which operated on coastal and foreign routes. It does not cover service that was limited to the intercoastal waterways and/or the inland waterways, including harbors, rivers, canals, bays, sounds, the great lakes, and other lakes.

of the American war effort, but they did not acquire a distinctive military capability because their service was not devoted exclusively to the furtherance of a military mission. The Department of Defense recognized that most members received some military training and were subjected to some military control. Nonetheless, the degree of training and control was too limited to be considered active military service.

The counsel representing the merchant seamen said that they met the criteria, such as having military training and discipline, more so than many of the 13 civilian groups already awarded veterans' status by the Secretary of Defense. The president of the Marine Engineers Beneficial Association believed that the high cost of providing benefits was the real, but unwritten, reason for the denial of veterans' status.

A select group of World War II merchant seamen who were in a military invasion have reapplied to the Secretary of Defense for veterans' status. According to the counsel for these merchant seamen, the case was pending as of August 16, 1984.

MERCHANT SEAMEN WHO ARE LIKELY TO  
SERVE IN WAR AND NATIONAL EMERGENCY  
HAVE ACCESS TO HEALTH CARE

Despite the disentanglement to PHS medical care, seamen who are likely to aid the U.S. defense efforts have access to health care even when they are not working for the government. This access is provided through union health plans whose benefits are generally funded by shipping companies.

Ships in the U.S. Merchant Fleet consist of vessels of 1,000 gross tons or more which would be capable of serving as a naval and military auxiliary in war and national emergency. Although the President of the United States, under the Merchant Marine Act, can requisition any vessel or watercraft owned by U.S. citizens to meet the Navy's needs, a Maritime Administration official told us that the Navy's needs are primarily for deep sea cargo vessels. He said these vessels are operated only by deep seamen and a small percentage of inland waterway seamen and that it was unlikely the other groups of seamen in the maritime industry would be asked to serve.

The former seamen entitlement to PHS medical care, however, extended to all segments of the maritime industry--not just deep seamen and a few inland waterway seamen. Deep seamen represented about 10 percent of the estimated work force eligible for PHS care. Additionally, using Maritime Administration personnel

data for the Great Lakes region and PHS data, we estimate that about 3 percent of the inland waterway seamen formerly eligible for PHS care are likely to be asked to serve during time of war or national emergency. In total, we estimate that less than 12 percent of all seamen formerly eligible for PHS care are likely to be called upon in time of war or national emergency.

According to PHS estimates, all deep seamen and at least 7 percent<sup>11</sup> of the inland waterway seamen have some type of group health insurance. Health insurance coverage for these seamen is provided through union plans. The health benefits provided in the union plans are negotiated between the unions and the shipping companies that employ the union members. An actuary determines the cost of supplying the negotiated benefits, and the employing shipping company, such as Mobil or U.S. Lines, pays a specific dollar amount (based on days worked) to the union plan to meet the cost of seamen's health benefits.<sup>12</sup>

As noted in our June 1981 report,<sup>13</sup> we found that in addition to seamen who had access to health care through union health plans, others had coverage through employers, Medicare, Medicaid, or through private health insurance plans. We reported that responses to a questionnaire submitted to seamen inpatients at two PHS hospitals indicated that 57 percent at one and 42 percent at the other had coverage through their union or other health plans. We also reported that, according to a PHS official, 22 percent of all seamen admitted to PHS facilities in 1979 were eligible for Medicare.

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<sup>11</sup>According to a PHS consultant's analysis of the estimates, the estimate of PHS eligible inland waterway seamen covered by additional health insurance failed to take into account the prevalence of insurance plans offered by companies shipping on the inland waterways. The consultant derived a total of 120,500 insured seamen (or 54 percent of the work force) employed on inland waterway vessels.

<sup>12</sup>According to a PHS consultant's April 1981 comparison of health plans, seamen union health plans available at the time offered a level of coverage comparable to plans available to large segments of the American public.

<sup>13</sup>Cost Cutting Measures Possible if Public Health Service Hospital System is Continued, HRD-81-62, June 10, 1981.



Seafarers Health Improvement Program  
work group recommended an industry-  
wide health plan for merchant seamen  
funded by the maritime industry

Since the merchant seamen disentanglement to PHS care, a Seafarers Health Improvement Program work group found that merchant seamen have adequate access to health care ashore. They recommended the development of an industry-wide health plan for merchant seamen funded by the maritime industry.

The Seafarers Health Improvement Program is a forum for consideration and discussion of health-related matters of interest to the maritime community. Started in 1978, the program reflects a broad representation of maritime industry segments, including management, labor, and government agency representatives. Program goals include the improvement of seamen's health status and the stimulation of communication and dissemination of information among relevant parties responsible for various aspects of the health and safety of seamen.

Various program work groups have studied seamen's health and safety issues, such as physical standards for entry and retention in the maritime industry, health care at sea, and safety aboard ship. One work group studied access to health care ashore for seamen who became ill or injured while ashore or in the service of a vessel.

The work group concluded that adequate patterns of health care have evolved since the closing of PHS' hospitals and clinics. The work group recognized that seamen have been receiving good quality health care since the disentanglement, but also recognized the need for a health care insurance program covering the seamen when they are injured or ill, on and off the vessel, and funded by the industry. The work group reported that a preliminary investigation revealed that there are insurance companies interested in such a program if health care standards for seamen are enforced. Therefore, the work group recommended that an industry-wide health insurance program be developed through the cooperation of larger union memberships and shipping companies to assure a broader beneficiary base, lower premiums, and a more effective cost-containment program.

A Military Sealift Command force medical officer, who is also an Executive Committee member of the Seafarers Health Improvement Program, agreed with the findings of the work group. He told us that the cost of health care, not the seamen's access

to health care, is the problem. He explained that adequate insurance and welfare plans for seamen exist today but that their cost is overwhelming. He believes a joint union-management organization formed to support policies and health standards for seamen would work in the United States.

COST OF INCLUDING MERCHANT  
SEAMEN AND THEIR DEPENDENTS  
IN THE CHAMPUS PROGRAM

As shown in the table on the next page, we estimate that the annual cost of providing health care to 398,000 merchant seamen and their dependents under the rules of the CHAMPUS program would have been about \$312 million in 1984. This estimate includes the total government cost of inpatient and outpatient care at uniformed services medical facilities<sup>14</sup> (\$153 million) and at civilian facilities (\$159 million).

CHAMPUS is a health care program for dependents of active duty members of the uniformed services,<sup>15</sup> retirees and their dependents, and surviving dependents of deceased active duty members or retirees. The program provides medical care through civilian hospitals, physicians, and other civilian providers on a cost-sharing basis. CHAMPUS is intended to serve as a supplement to the military's direct medical care system. It shares the cost of medically necessary services and supplies provided on an inpatient and outpatient basis when care cannot be obtained from a uniformed services facility. Since including merchant seamen and their dependents under CHAMPUS would necessitate increased costs to the military's direct care system, we prepared estimates for the cost of care at civilian facilities and uniformed services facilities to arrive at a total estimated cost of providing benefits.

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<sup>14</sup>Uniformed services medical facilities include the federally owned military hospitals and clinics and about 10 hospitals and clinics privately owned, but designated as uniformed services facilities.

<sup>15</sup>The uniformed services covered by CHAMPUS are the Army, Navy, and Air Force, Marine Corps, Coast Guard, commissioned Corps of the PHS, and the National Oceanic and Atmospheric Administration.

Estimated Cost of Providing CHAMPUS Benefits  
to Merchant Seamen and Their Dependents

	<u>Inpatient and outpatient care at civilian facilities</u>	<u>Inpatient and out- patient care at uniformed services medical facilities</u>	<u>Total estimated cost of care</u>
Seamen	\$ 58,108,000	\$ 54,732,960	\$112,840,960
Seamen dependents	<u>101,012,400</u>	<u>98,519,328</u>	<u>199,531,728</u>
Total	<u>\$159,120,400</u>	<u>\$153,252,288</u>	<u>\$312,372,688</u>

It should be emphasized that our cost estimates do not reflect the cost of replicating the former merchant seamen entitlement to health care in PHS facilities. Under the PHS entitlement, the seamen's dependents were not eligible for medical care. Our estimates include the cost of providing care to the seamen's dependents because CHAMPUS covers dependents. Also, under the PHS system, seamen did not contribute toward health costs. As already mentioned, however, CHAMPUS has certain cost-sharing features, and the CHAMPUS data used to prepare the estimates do not reflect the costs incurred by CHAMPUS beneficiaries. (See enc. II for additional information on the cost estimates.)

If the Congress decided to provide government-financed health care to merchant seamen and their dependents through an expanded CHAMPUS program, certain procedural and administrative questions should be addressed, such as:

- How would eligibility be determined and verified?
- Who would be responsible for verifying eligibility?
- Would seamen and their dependents be required to obtain a nonavailability statement (that needed care cannot be provided in uniformed services facilities) before being allowed to obtain care at civilian facilities?

As we pointed out in a report on cost-cutting issues, which was published shortly before PHS hospitals stopped operating, PHS experienced difficulties with verification of seamen eligibility for health care as PHS beneficiaries. Although individuals claiming to be seamen and seeking health care as PHS beneficiaries had to present evidence of eligibility, PHS hospital

and clinic staffs did not require all persons to furnish documented evidence of eligibility, were lenient in reviewing evidence submitted, and rarely verified the accuracy of evidence given. As a result, some patients who were not eligible beneficiaries were provided health care.

We believed that if PHS had required and reviewed eligibility data for all claimants seeking care as seamen, it would have precluded some ineligibles from receiving free care. PHS officials stated, and we concurred, however, that no practical means existed to verify the accuracy of documented evidence of seamen eligibility based on the then-existing eligibility criteria.

### CONCLUSIONS

There is no compelling reason for the Congress to reverse its 1981 decision and provide a federally financed health care program for U.S. merchant seamen through an expanded CHAMPUS program or any other program. The Congress originally authorized medical care for seamen at federal facilities for reasons which, while sound in the 1790s, are no longer valid. Our research leads us to believe that the original authorization was not based solely on the national interest in maintaining a healthy merchant marine to aid in time of war and national emergency. Rather, while the Congress may have seen this as a desirable benefit that would result from its actions, it appears that the motivating factor was the protection of the general population from sickness and disease being imported by seamen. Authorizing federal health care for merchant seamen helped foster the U.S. trade and defense capabilities to some extent.

Although seamen lost an entitlement to federally financed health care, they did not lose their right to health care. According to maritime law, shipowners (as employers) are responsible for the health care of seamen working on their vessels. With the disenfranchisement, the federal government effectively terminated a federal subsidy program to shipowners, but did not terminate a seaman's right to health care from shipowners.

Regarding the role of merchant seamen as an auxiliary to our uniformed services, we believe it is appropriate for the federal government to continue compensating merchant seamen for their health care when they are serving in this role. Recognizing, however, that other occupations also aid our defense efforts, we do not believe that it would be appropriate for the federal government to finance the health care of merchant seamen at all times.

ADDITIONAL INFORMATION ON COST ESTIMATES

To develop cost estimates for a government-financed health care program for merchant seamen and their dependents, we used the CHAMPUS program as a model. Under the rules of CHAMPUS, beneficiaries use both civilian and uniformed medical facilities. Accordingly, we estimated the cost increases that would result at both types of medical facilities. We based our estimates on projected fiscal year 1984 health care costs for military retirees and their dependents because the average age of military retirees and merchant seamen are comparable, making utilization rates of retirees and dependents more reliable, in our opinion, than those of active duty members and their dependents.

To estimate the fiscal year 1984 cost for inpatient and outpatient care at civilian facilities, we (1) multiplied the number of merchant seamen and dependents by average fiscal year 1982 CHAMPUS costs per military retiree and dependent and (2) adjusted the figures based on the fiscal year 1983 consumer price index increase for medical services and the Congressional Budget Office's projected fiscal year 1984 increase.

For the number of merchant seamen, we used the 1981 PHS estimates of seamen eligible for PHS care (see enc. I, p. 3, the last column in the table). Because data on the number of merchant seamen's dependents were not available, we used the number of dependents per uniformed service retiree. We believe the average number of dependents per uniformed service retiree and merchant seamen might be comparable because their average ages are comparable.

We computed the fiscal year 1984 estimated cost for seamen and dependent inpatient and outpatient care at uniformed services medical facilities by multiplying the number of merchant seamen and dependents by an average fiscal year 1984 uniformed services inpatient and outpatient cost as estimated by the Department of Defense for military retirees and dependents. The inpatient cost was calculated on the basis of average bed days for military retirees, dependents, and survivors and 50 percent of the average cost per hospital day in a uniformed services facility. The outpatient cost was calculated on the basis of average outpatient visits per eligible retiree and dependent and 50 percent of the average cost per outpatient visit in a uniformed services facility. We used 50 percent of the average cost per hospital day and outpatient visit because an earlier Department of Defense study of changes in medical care workloads made the relatively conservative assumption that each new

patient would cost at least one-half as much as its current patients.

In making our estimates, we assumed that merchant seamen and their dependents would be treated in the same manner as uniformed services' retirees and dependents. On a space available basis, they would have access to the uniformed services medical facilities and clinics after active duty members and their dependents and Reserve Officers' Training Corps personnel. Additionally, we assumed that merchant seamen and their dependents, like military retirees and their dependents, would be required to report to CHAMPUS any other medical coverage they might have, such as through a union, because CHAMPUS acts as secondary payor.

Our estimates of the direct care cost increases assume that space in direct care facilities will be available to the same extent it has been available to military retirees and dependents. We believe that this assumption results in a conservative total estimate. Although the military's direct care system generally has available space for inpatient services, its outpatient facilities are overloaded. Therefore, it is likely that total costs would be higher because (1) merchant seamen and their dependents would use civilian facilities more than military retirees and their dependents and (2) outpatient care in civilian facilities is more expensive than that provided in the military's direct care system.

We did not estimate the costs that would be associated with administering an expanded CHAMPUS program, nor did we estimate the cost of including retired merchant seamen and their dependents in the CHAMPUS program because data on them were not readily available.

We believe our cost estimates of including merchant seamen and their dependents under the CHAMPUS program would be conservative, if the Congress were to finance health benefits for all merchant seamen estimated to have been eligible under the PHS entitlement because, as noted in enclosure I, many fishermen and inland waterway seamen do not have alternative health plans that would be the primary payor. Therefore, they could be expected to rely almost exclusively on the CHAMPUS program. However, we believe the estimates would be overstated if the Congress decided to give health benefits only to deep seamen (those most likely to be called upon to serve in time of war or national emergency) because (1) fewer people would be insured and (2) they have alternative plans that would be the primary payor.