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Health Insurance Coverage for Retirees

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Summary

Many retired individuals depend on their former employer for retirement health insurance as their sole source of coverage before reaching age 65, or as a supplement to their Medicare coverage once reaching age 65. However, the future of these benefits is uncertain. Burdened by rising costs, some employers have already reduced or eliminated health insurance coverage for their retirees. With the aging of the baby boom generation looming ahead, employers offering coverage to their retired workers will face a huge future financial commitment. For this reason, some employers are re-examining their commitment to providing retiree health benefits to current workers.

An important feature of employer-sponsored health insurance, for retirees and current employees, is that it is voluntary — employers are not required to offer health insurance. There are few protections to prevent employers from cutting or eliminating benefits, unless the employer has made a specific promise to maintain the benefits or has a contractual agreement with either the employee or a labor group. As a result, even among retirees who have employer-sponsored retiree health insurance, benefits are eroding as employers shift costs to retirees by increasing premiums, copayments or deductibles. For companies in bankruptcy, retiree health benefits are particularly vulnerable. Unlike defined benefit pensions that offer some protections for employees of companies in bankruptcy through the Pension Benefits Guaranty Corporation, there are no protections for retiree health benefits.

There are a wide variety of policy options currently being discussed that endeavor to make retiree coverage more available or affordable, or even to require that employers maintain coverage. However, when considering any option, it is also essential to consider the relationship between retirees' health insurance and insurance for current employees. The concept of special treatment aimed solely at protecting the retiree population, without an equivalent treatment for current employees, could lead to inequitable outcomes. Thus, any statutory requirement providing retirees with health insurance coverage should be examined in the broader context of all employer-sponsored coverage.

This report will be updated to reflect legislative activity.

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Health Insurance Coverage for Retirees

Introduction

Many retired individuals depend on their former employer for retirement health insurance as their sole source of coverage before reaching age 65, or as a supplement to their Medicare coverage once reaching age 65. However, given that employers are not required to offer employer-sponsored health insurance in the first place, as well as limited federal protections available for persons losing coverage, the future of these benefits is uncertain. Burdened by rising costs, some employers have already reduced or eliminated their commitment to insure their retirees. With the aging of the baby boom generation looming ahead, employers offering coverage to their retired workers will face a huge future financial commitment. Recent trends indicate that retiree health benefits are increasingly subject to higher beneficiary cost-sharing. Further, among employers who provide health insurance for current retirees, their current workers are less likely to be guaranteed these benefits upon retirement.

Retiree health insurance became prevalent after the passage of Medicare in 1965, as a result of the relatively low cost. Because Medicare is the primary payer for qualified retired beneficiaries aged 65 and older, it was fairly inexpensive for employers to provide retiree health benefits that supplemented the Medicare benefit. In the late 1980s, retiree health benefits became more expensive for employers due to both the rising costs of benefits not covered by Medicare and the changing demographics of the retiree population. For example, employer-sponsored plans often include coverage for prescription drugs, and depending on the cost-sharing arrangements and level of coverage, the cost of including prescription drug coverage can be very expensive. Retiree coverage could see further changes, once Medicare begins to cover prescription drugs in 2006. However, Medicare coverage would only affect those retirees who are over 65 and qualify for Medicare. Many individuals retire before reaching 65 and their retiree health insurance would most likely be their sole source of coverage.

Employer-sponsored retiree health insurance benefits are eroding as employers attempt to control their costs by tightening eligibility requirements and shifting costs to retirees through increased retiree premium contributions, deductibles, and co-payment amounts. In some cases when employers attempt to scale back or eliminate coverage, employees have turned to the courts to try to retain their coverage. The courts have sided with retirees in only limited instances because minimal federal protections exist for retirees when employers decide to change their health insurance coverage.

Demographics of the Retiree Population

Understanding the demographics of the retiree population helps to explain their high health insurance costs. This issue is of growing concern to employers offering retiree health insurance, especially as they face the retirement of their current “baby boom generation” workers. As this group begins to consider retirement, a combination of factors — the size of the group, their increasing life expectancies and the increase in their health costs as they age — will make it financially difficult for employers to offer them retiree health insurance. Furthermore, absent retiree health insurance from a former employer, this group can also generally expect to pay higher amounts for the same or less coverage in the individual market.

In 1965 when Medicare was created, costs were relatively low for employer-based retiree health benefits and there were few retirees compared to the number of active workers. The 18.5 million persons over age 65 comprised only 9.5% of the total population.¹ Most workers waited to retire until the age of 65 when they were eligible for retirement benefits under Social Security and health insurance coverage under Medicare. At retirement, they could expect to live until 79, another 14 years.²

Since that time, Americans are living longer. According to the U.S. National Center for Health Statistics, in 2001, persons reaching age 65 had an average life expectancy of an additional 18.1 years. By 2002, the total number of persons over age 65 had grown to 35.6 million, or 12.3% of the total population. As more people live into old age, the age-profile of the population will continue to shift. The first wave of the baby boom generation (persons born between 1946 and 1964) reached age 55 in 2001 and are beginning to consider options for retirement. This first wave will reach age 65 in 2011. According to U.S. Census Bureau estimates for 2030, when the baby boomers are all over age 65, the total number of persons 65 and older will have more than doubled from 35.6 million to 71.5 million and will comprise 20% of the U.S. population.

As individuals reach their late 50s and 60s, they become increasingly likely to have acute and chronic health conditions such as heart disease, arthritis, and diabetes. According to the National Center for Chronic Disease Prevention and Health Promotion, approximately 80% of all persons over age 65 have at least one chronic condition and 50% have at least two. Furthermore, after adjusting for socioeconomic factors, a lack of health insurance has been linked to an increased risk of a decline in

¹ U.S. Bureau of the Census, *Historical Statistics of the United States Colonial Times to 1970 Bicentennial Edition*, Part 1, Series A 29-42 (Washington, DC, 1975).

² William J. Wiatrowski, *Retiree Health Benefits: Data Collection Issues*, U.S. Department of Labor, Bureau of Labor Statistics, Compensation and Working Conditions Online, Originally posted July 29, 2003, at [<http://www.bls.gov/opub/cwc/print/cm20030711ar01ps.htm>]

overall health among adults in late middle age.³ These long-term illnesses have a negative effect on quality of life and can lead to severe disability.

Retirees who have a greater prevalence of health problems are less able than workers to obtain affordable health insurance should they lose their employer-sponsored insurance before they are eligible for Medicare. Health insurance coverage is thus a major consideration for persons making the decision about whether or not to retire.

Today's workers face many choices regarding retirement age. Some employees retire as early as age 55, the minimum retirement age allowed by most defined benefit pension plans. Others don't retire until they are 62, the earliest retirement age at which Social Security benefits are first payable, though these are permanently reduced. Fewer workers wait until they reach the "full retirement age" under Social Security which in 2004 is 65 years and four months. (The age at which unreduced Social Security benefits are first payable will gradually rise to age 67.) In 2003, more than 72% of retired-worker beneficiaries had elected to receive Social Security retirement benefits before age 65.⁴ Because availability of health insurance benefits is an important consideration for older workers, still others wait until the Medicare eligibility age of 65 to retire. According to Mercer, in its 2003 Survey Report-National Survey of Employee Sponsored Health Insurance, the median retirement age is 61 in organizations offering retiree health insurance compared to 63 in those that do not.

Because Americans approaching or at retirement age consume more medical services than younger persons, their health care is more expensive. According to the U.S. Administration on Aging's report, *A Profile of Older Americans: 2003*, the elderly averaged \$3,586 in out-of-pocket health care expenditures in 2002. This can be compared to the average out-of-pocket costs for the total population of only \$2,350. Even when near-elderly workers (ages 55 to 64) with health problems are insured and have access to needed health services, they have average annual expenditures of \$5,000, nearly twice the level of their counterparts in excellent or very good health (\$2,548).⁵ Employment-based insurance spreads these costs over all its enrollees in the same plan, but private non-group insurance premiums generally reflect the higher risk attributable to the policyholder's age and health status. A 2001 Commonwealth Fund study found that adults aged 50 to 64 who buy individual coverage are likely to pay much more out-of-pocket for a limited package of benefits than their counterparts who are covered by their employers. An analysis of premium costs for individual coverage in 15 cities showed a median cost of nearly \$6,000 for individual coverage for a 60-year-old. Group rates would have been less than half

³ David W. Baker, Joseph J. Sudano, Jeffrey M. Albert, Elaine A. Borawski, and Avi Dor, "Lack of Health Insurance and Decline in Overall Health in Late Middle Age," *New England Journal of Medicine*, Oct. 11, 2001.

⁴ *2003 Annual Statistical Supplement to the Social Security Bulletin*, Social Security Administration, July 2004.

⁵ Alan C. Monheit, Jessica P. Vistnes, and John M. Eisenberg, "Moving to Medicare: Trends in the Health Insurance Status of Near-Elderly Workers, 1987-1996," *Health Affairs*, Mar./Apr. 2001.

this amount, with a median annual premium cost of employer insurance of \$2,520 for a preferred provider organization (PPO) plan, and workers would have been required to pay only 14% of this amount for single coverage.⁶

Health Insurance Coverage

Retirees with Employer-Sponsored Health Insurance

Retirees from large firms are more likely to be offered health insurance than workers retiring from smaller firms. In fact, the prevalence of retiree coverage increases with firm size. For example, employees under age 65 retiring from firms with 20,000 or more employees are twice as likely to be offered coverage as employees in firms of 500-999 employees. Retirees over age 65 are almost three times as likely to be offered retiree health benefits in the largest firms.⁷

However, regardless of firm size, the percentage of employers offering retiree coverage has been steadily declining over the last decade. The percentage of firms with more than 200 workers that offer retiree coverage fell by almost half between 1988 and 2004, from 66% to 36%.⁸ In 1993, 46% of employers with at least 500 employees offered coverage to their pre-Medicare eligibles and by 2003 this figure declined to 28% of employers. Similarly, 40% of employers with at least 500 employees offered coverage to their Medicare eligibles in 1993, compared to 21% in 2003.⁹ As shown in **Table 1**, there has been a steady decline in coverage over the period.

Table 1. Percentage of Large Firms Offering Retiree Health Coverage, 1993-2003

Year	Pre-Medicare eligible retirees	Medicare eligible retirees
1993	46%	40%
1995	41%	35%
1997	38%	31%
1999	35%	28%
2001	29%	23%
2003	28%	21%

Source: National Survey of Employer Sponsored Health Plans, 2003 Survey Report, Mercer.

⁶ Elisabeth Simantov, Cathy Schoen and Stephanie Bruegman, "Market Failure? Individual Insurance Markets for Older Americans," *Health Affairs*, July/Aug. 2001.

⁷ National Survey of Employer Sponsored Health Plans, 2003 Survey Tables, Mercer.

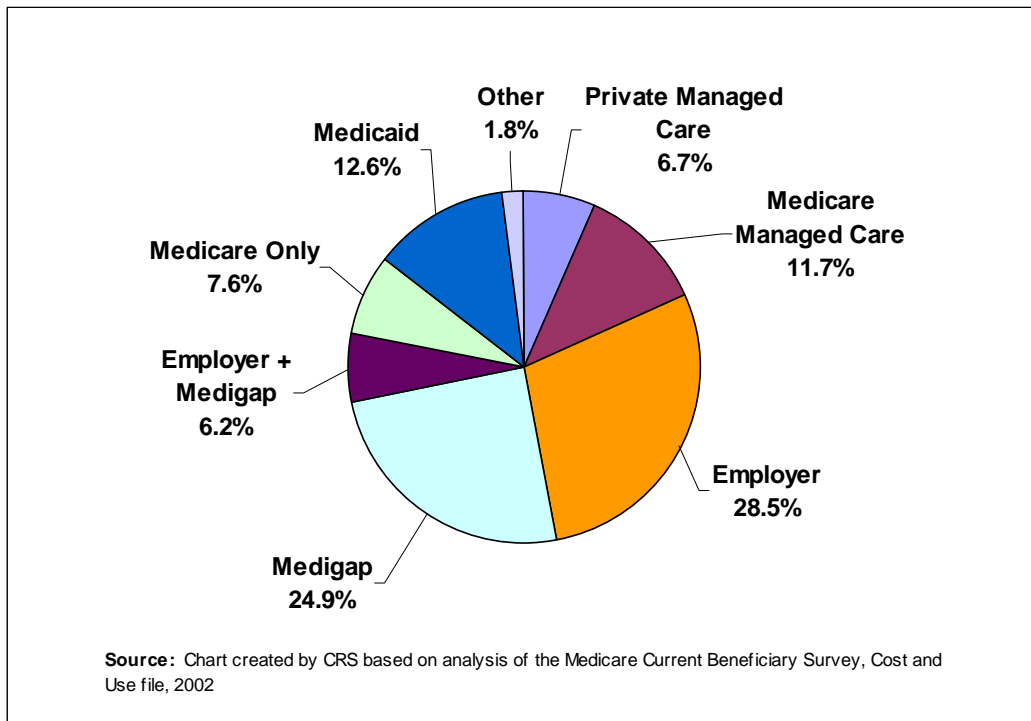
⁸ Kaiser/HRET Employer Health Benefits: 2004 Annual Survey.

⁹ National Survey of Employer Sponsored Health Plans, 2003 Survey Report, Mercer.

Other Sources of Insurance for Retirees

Sources of health insurance are very different for those individuals under age 65 than for those who are over 65 and most likely covered by Medicare. However, according to CRS calculations of Medicare Current Beneficiary Survey Data for 2002, Medicare only covers about half of the medical costs of the 65 and older group.¹⁰ To help defray costs of services not covered by Medicare, most Medicare beneficiaries have additional health insurance coverage, including employee coverage, government coverage, and private supplementary coverage obtained through an individually purchased policy, commonly referred to as Medigap. In 2002, less than 8% of Medicare beneficiaries had no additional coverage, as shown in **Figure 1**. Almost another 12% of Medicare eligibles enrolled in a Medicare managed care plan (Medicare Advantage),¹¹ which while not technically “additional insurance”, does in many cases provide extra services beyond the basic package of Medicare benefits.

Figure 1. Supplemental Insurance Categories for the Medicare Non-Institutionalized Population, 2002



¹⁰ Medicare will cover a larger share of medical costs beginning in 2006, for enrollees who purchase Medicare prescription drug coverage.

¹¹ Medicare eligible individuals who are enrolled in Parts A and B of Medicare, may choose to enroll in a Medicare Advantage plan, and receive their Medicare services through the plan, if one is available in their area.

For retirees who are under age 65, and do not qualify for Medicare based on disability or End-Stage Renal Disease (ESRD),¹² insurance options are more limited. Absent retiree health insurance, insurance through a spouse, or access to Medicaid or other federal programs, these retirees would have to purchase insurance in the individual market if they chose to be covered. Retirees moving from their employer's group plan to an individually purchased product are provided with certain guarantees for health insurance coverage under federal law. However, while federal law guarantees the availability of health insurance for these individuals moving from the group to the individual market,¹³ there are no federal limits on the premium amounts that may be charged. Because individual policies are likely to be subject to underwriting (based on information such as the individual's age and medical history) premiums would also likely be higher, particularly for older and sicker individuals. Some states have passed laws to limit premium amounts, providing varying degrees of protection.

Erosion in Coverage over Time

According to a Kaiser/Hewitt December 2004 survey of large private-sector employers, between 2003 and 2004, 79% of large companies surveyed had increased the share of the premiums paid by the retiree, 53% indicated that they had increased the amount enrollees pay for prescription drugs, 45% had increased cost-sharing requirements for other services, and 8% had eliminated subsidized retiree health benefits for their new employees.¹⁴

Employers are also managing their retiree health insurance costs by providing different benefits for current and future retirees. For example, some employers who offer retiree health insurance to their current retirees will not provide coverage for individuals who retire in the future. Other firms may only provide group access to health insurance for future retirees, requiring them to pay 100% of the premiums. Firms may also use a sliding scale based on factors such as age at retirement, years of service at retirement, or a combination of the two to determine their premium contributions for retirees. According to the 2003 Mercer National Survey of Employer-Sponsored Health Plans, 30% of firms offering retiree health based their

¹² Medicare is available for individuals or their spouses who have worked for at least 10 years in Medicare-covered employment and are 65 years old and a citizen or permanent resident of the United States. Individuals might also qualify for coverage if they are a younger person with a disability or with End-Stage Renal disease (permanent kidney failure requiring dialysis or transplant).

¹³ These individuals are required to meet certain conditions, such as having no breaks in coverage of 63 or more days, and having exhausted any continuation coverage required by the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). For more information about protections and requirements, see CRS Report RL31634, *The Health Insurance Portability and Accountability Act (HIPAA) of 1996: Overview and Guidance on Frequently Asked Questions*, by Hinda Chaikind, Jean Hearne, Bob Lyke, C. Stephen Redhead.

¹⁴ "Current Trends and Future Outlook for Retiree Health Benefits, Now and in the Future, Findings from the Kaiser/Hewitt 2004 Survey on Retiree Health Benefits," *The Henry Kaiser Family Foundation and Hewitt*, Dec. 2004.

share of premium contributions on age and years of service. Among large employers (500 or more employees), about 38% of pre-Medicare retirees pay 100% of their premium, 49% share the premium costs with the employer, and 13% have their total premium paid for by the employer. For the Medicare-aged retirees, 37% pay 100% of their premium, 47% share the costs with the employer and 15% have the total premium paid by the employer.

Role of the Law and Courts

An important feature about employer-sponsored health insurance, for both retirees and current employees, is that employers are not required to offer health insurance. There are few protections to prevent employers from cutting or eliminating benefits, unless the employer has made a specific promise to maintain the benefits or has a contractual agreement with either the employee or a labor group. Employers or other plan sponsors are generally free to adopt, modify, or terminate “welfare benefits,” which includes health insurance, as long as they have preserved their right to modify such plans. Therefore, the documents governing the plan are crucial. According to Employee Retirement Income Security Act of 1974 (ERISA, P.L. 93-406) requirements, employers are required to provide individuals with a copy of the summary plan description (SPD) within 90 days after they become a plan participant. The SPD can change each year, but the SPD in effect when the individual retired may be the controlling document. Employers may explicitly reserve the right in the SPD and in other documents to change the terms of the plan. Additionally, even when these documents promise that health benefits will continue, they may not rule out the possibility for changes such as reduced benefits or increased copayments. Language in the plan may be vague and as a result the courts have been asked to step in to settle disputes. Records, correspondence, brochures, or other documents that contain information about the duration or scope of coverage may be used for clarification, as well as labor agreements that provide documentation clarifying retiree coverage.

As a result of limited if any protections, retirees have turned to the courts to seek relief. However, in cases in which the employer has maintained the right to modify or terminate a plan, the courts have sided with the employers (e.g., *Curtiss-Wright Corp. v. Schoonejongen*)¹⁵ In other instances, when employers have not preserved their right to change a plan (e.g., *Eardman v. Bethlehem Steel*),¹⁶ the courts have sided with the employee.¹⁷

Another issue brought before the courts was whether or not employers could offer health benefits to their Medicare-eligible retirees that differed from those offered to their retirees who were not Medicare eligible. In *Erie County Retirees Association v. County of Erie, Pennsylvania*, a 2000 case involving a group of Medicare-eligible retirees and the Age Discrimination and Employment Act (ADEA), the U.S. Court of Appeals for the Third Circuit found that the county had

¹⁵ 514 U.S. 73 (1995).

¹⁶ 607 F. Supp. 196 (W.D.N.Y. 1984).

¹⁷ See John C. Garner, *Health Insurance Answer Book*, 6th ed. (New York: Aspen, 2001).

distinguished impermissibly between its Medicare-eligible retirees and its younger retirees with respect to their health insurance coverage based on the age of the retirees.¹⁸ Despite the apparent violation, the case was remanded to determine whether the county's actions were protected by the ADEA so-called equal benefit safe harbor provisions.¹⁹ Later a settlement was reached between the county and the Medicare-eligible retirees. Along this line, the Equal Employment Opportunity Commission (EEOC) issued a proposed exception to ADEA allowing employers to alter, reduce, or eliminate retiree health benefits when retirees become eligible for Medicare. The EEOC was planning to release a final rule, when the American Association of Retired Persons was granted a preliminary injunction on the regulation. On March 30, 2005 a federal district judge blocked the rule, issuing a permanent injunction to prohibit federal officials from publishing or implementing the regulation. EEOC reportedly plans to appeal the ruling to the Third Circuit. If issued as a final regulation, employers would be allowed to segment their retiree population, providing different retiree coverage for those over 65 than for those under 65. This could become even more significant once the new Medicare prescription drug program begins in 2006. For example, plans could eliminate their prescription drug coverage for their Medicare eligible retirees, requiring these individuals to enroll in Medicare Part D if they wanted to continue to receive prescription drug coverage. However, the standard Medicare Part D prescription drug benefit is generally less generous than coverage offered by employers.

Reasons for Eroding Coverage and Issues

The erosion of health insurance coverage for the retiree population is based on several factors. As previously discussed, the demographics of this group foreshadow that employers may be facing coverage for a larger number of individuals who are expected to live longer and therefore use a lot more health care services than originally anticipated when these companies first began to offer retiree health coverage. In addition, several other factors, described below, contribute to the erosion of retiree health insurance, including increasing costs, especially for prescription drugs, the economy, and changes in accounting practices.

Costs of Health Insurance

According to the Kaiser/Hewitt January 2004 survey, among their surveyed 333 employers with more than 1,000 employees, total costs for employer-sponsored retiree coverage were \$18.1 billion in 2002, including costs paid by the retiree and

¹⁸ 220 F.3d 193 (3rd Cir. 2000).

¹⁹ Satisfying the equal benefit test requires that a plan not provide lesser benefits for older participants compared to younger participants, and also that employers not require older participants to pay a greater percentage of the premium cost. Employers do not violate the act by permitting certain benefits to be provided by the government, that is, it is not necessary for an employer to provide health benefits which are otherwise provided by Medicare for certain participants.

the employer. This figure increased by 13.7%, growing to an estimated \$20.6 billion in 2003.²⁰

The cost to employers for providing these benefits has been increasing, due to an increasing number of retirees, as well as increased per capita costs. According to Mercer, between 2002 and 2003, retiree medical costs for pre-Medicare eligibles increased by 14% (with premiums increasing from \$6,956 to \$7,948) and by 11% (with premiums increasing from \$2,702 to \$3,003) for Medicare eligible retirees.²¹

Looking at an overall premium increase for employer-sponsored health insurance (not solely premium increases for retiree health insurance), according to the Kaiser/HRET 2004 annual survey, increases in health insurance premiums are outpacing increases in both workers' earning and overall inflation. For example, premiums increased by 11.2% from 2003 to 2004, compared with a 2.2% increase in earnings and a 2.3% increase in inflation.²² In the early 1990s premium increases were smaller each year, bottoming out at less than a 1% increase in 1996. However, increases have gotten progressively larger since then, reaching double digits in 2001. There was a slowdown in the increase between 2003 and 2004 from 13.9% to 11.2%, although still a double digit increase. Double digit increases in premiums are expected to continue, in part due to the anticipated continuation of the upwards turn in the underwriting cycle, and in part due to increasing costs (inflation and utilization) of medical claims.²³ The largest of these increases appear to be concentrated in the smallest firms.

Prescription Drug Coverage

While most firms providing retiree coverage offer prescription drug coverage, it is more prevalent for larger firms. On average, 94% of these large employers (at least 500 employees) offering retiree coverage include prescription drug coverage. Among firms with 500-999 workers, 92% offer coverage, increasing to 98% for firms with more than 20,000 employers.²⁴

The annual increase in prescription drug spending has outpaced that of overall medical benefits, in large part because of increased prescription drug utilization. As a result, employers have looked for ways to hold down their costs for providing

²⁰ "Retiree Health Benefits Now and in the Future: Findings from the Kaiser/Hewitt 2003 Survey of Retiree Health Benefits," *The Henry Kaiser Family Foundation and Hewitt*, Jan. 2004.

²¹ "National Survey of Employer-Sponsored Health Plans," *2003 Survey Report*, Mercer.

²² "Employer Health Benefits, 2004 Annual Survey," *The Henry Kaiser Family Foundation and Health Research and Educational Trust*.

²³ The underwriting cycle for health insurance is characterized by years of small increases in premiums followed by years of larger increases. At some point, increases become smaller and the cycle begins again. The cycles are in part the result of health insurance providers first lowering increases in order to remain competitive and then raising increases as profit margins drop and/or reserves are depleted.

²⁴ "National Survey of Employer-Sponsored Health Plans," *2003 Survey Tables*, Mercer.

prescription drug coverage, by ratcheting down these benefits. Plans have continued to develop cost-saving mechanisms, such as increasing cost-sharing or requiring a mail-order prescription refill. Plans are also increasingly using three-tier payment arrangements, such as one tier with lower out-of-pocket costs for the enrollee purchasing generic drugs, and two tiers for non-generic drugs (preferred and non-preferred).

Beginning in 2006, Medicare beneficiaries will be offered a new voluntary benefit providing prescription drug coverage, as established in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, P.L. 108-173. Medicare beneficiaries will be able to purchase either “standard coverage” or alternative coverage with at least actuarially equivalent benefits. In 2006, “standard coverage” will have a \$250 deductible, 25% coinsurance for approved drug costs between \$251 and \$2,250, then no coverage until the beneficiary has out-of-pocket costs of \$3,600 (\$5,100 in total spending). Once the beneficiary reaches the catastrophic limit, the beneficiary will pay nominal cost sharing. Coverage can be provided through prescription drug plans or through a Medicare Advantage plan for individuals enrolled in such a plan offering prescription drug coverage.

Once Medicare begins to cover prescription drugs, employers may decide to make changes to their health plans for retirees with respect to prescription drug coverage, or even to their entire benefit package. Employers who continue to provide retiree prescription drug coverage that is actuarially equivalent to or better than Medicare coverage may be eligible for a federal subsidy, as long as the retiree is eligible for but does not sign up for the Medicare prescription drug benefit. Subsidy payments will equal 28% of a retiree’s gross²⁵ covered retiree plan-related prescription drug costs over the \$250 deductible up to \$5,000. (The dollar amounts would be adjusted annually by the percentage increase in Medicare per capita prescription drug costs.)

In the Kaiser/Hewitt December 2004 survey, the majority of responding employers indicated that they were likely to continue to offer prescription drug coverage, even after Medicare coverage begins. However, once the program is in place, employers may wish to reassess their decision as to whether or not to continue retiree coverage for either the entire retiree health package or just the prescription drug coverage. For example, if the subsidy covers a significant portion of the employer’s cost for providing prescription drug coverage, then the employer’s continued coverage might be a financially viable option. On the other hand, some employers may no longer be willing to provide either prescription drug or even any retiree coverage, once Medicare prescription drug coverage is available. Some employers may only have been willing to provide retiree coverage in the past because it was generally a retiree’s sole source for prescription drug coverage. With the inclusion of some coverage under Medicare, even if it is more limited than the employer’s coverage, an employer may no longer feel a responsibility to provide coverage to its retirees. Employers could drop the drug coverage or even choose to drop all health insurance for retirees. The employer does have the option of

²⁵ The employer’s subsidy covers “gross” costs, which includes any co-payments or co-insurance paid for by the retiree.

discontinuing its prescription drug coverage and paying the Medicare prescription drug premium for its employees.

Finally, younger retirees, those under 65, will still depend on their employers for prescription drug coverage. If the EEOC eventually issues its proposed exception to ADEA, then employers could provide prescription drug benefits for only their younger retirees and not their Medicare eligible retirees.

Financial Downturn

During the booming economic years of the late 1990s, some employees were shielded from the increasing health insurance costs. Firms were willing to absorb these costs in order to remain competitive in a tight labor market. However, as costs continued to escalate, and the economy took a downward turn employers found themselves less able to absorb these costs. Furthermore, as the job market weakened and workers had a more difficult time finding or switching jobs, employers did not need to provide as many incentives to attract employees, and thus were less likely or willing to absorb increasing health insurance costs. This issue is especially critical for small firms, who often operate on narrow margins with little room to absorb increased costs. Not surprisingly, the decline in offering health insurance coverage is most notable among these small firms.

Accounting Rules (FASB and GASB)

Effective for fiscal years beginning after December 15, 1992, the Financial Accounting Standards Board (FASB) established new requirements for the reporting of non-pension retiree benefits in FAS 106, which includes health benefits. This rule significantly changed the practice of pay-as-you-go accounting for these post-retirement benefits to accrual accounting. The employer's expense for these benefits is now incurred at the time the employee renders the services necessary to earn their post-retirement benefits, that is the employer must account for the cost of retiree health insurance while the employee is working for the firm, rather than waiting until the employee retires and enrolls in the retiree health insurance plan. This accounting standard requires companies to more closely examine health insurance costs for their retirees and this examination may have led them to realize the magnitude of these costs.

In response to FAS 106, some companies announced changes in benefit programs, such as eliminating retiree health coverage, establishing caps on their dollar contribution, increasing cost-sharing, and linking the level of benefits with the years of service. FAS 106 may have provided a convenient rationale for reducing or eliminating retiree coverage. It may have also made some employers realize that their commitment to retiree health insurance was open-ended and growing at a rapid pace.

Establishing caps, as a practical matter, limits the open-ended nature of a firm's liability, and thus constrains the dollar amounts that they would have to recognize as a result of the FAS 106 rules. Firms often set the caps at a level they expected to reach at some future date, possibly even 10-20 years in the future. However, given

the rapid rate of increase in health insurance costs, employers may find that they exceed the cap even sooner than anticipated, presenting an interesting dilemma for the provision of retiree health benefits. First, firms could raise the caps; however, this would require higher spending.²⁶ Alternatively, they could choose to adhere to the caps, thus eroding retiree health insurance, by either increasing the retiree's contribution, or reducing benefits.

Another potential issue is the convergence of the cap and the employer's subsidy for actuarially equivalent prescription drug benefits under Medicare. Some firms may initially meet the standards required for receiving the subsidy in 2006. Over time, as the cost of insurance increases, some firms will reach and exceed their cap, thus possibly facing a problem, because once the cap is exceeded, the value of their benefits would decline. As a result, employers who at one time met the actuarial equivalent standard required under Medicare law, may no longer meet that standard. Then they may no longer qualify for the 28% employer subsidy.²⁷

On the other hand, when companies reduce their retirees' health benefits, they are not only spending less for these benefits, they are also able to report smaller post-retirement health costs. For example, in response to Medicare prescription drug coverage in 2006, some companies are planning to maintain their prescription drug coverage and will receive a 28% subsidy, which would reduce their post-retirement health costs. Other companies may reduce their health plan costs, by eliminating or reducing prescription drug coverage, which would also reduce their liability.

Recently, the Government Accounting Standards Board (GASB) adopted statement No. 43, which changed the accounting rules for the costs of various post-employment benefits for state and local governments. The new standard is similar to FAS 106 standards in that it requires accrual accounting, but provides greater flexibility. For example, FAS 106 prescribes a single actuarial method for the calculation of post-retirement health costs, while GASB 43 allows a choice between several different actuarial methods. The application of GASB 43 could have a similar impact on employers' commitment, causing them to rethink their retirees' health insurance coverage. However, because this group of employees is state and local government workers, they may have more bargaining power, or union protections, than some of the groups in the private sector that were affected by FAS 106.

²⁶ In addition, under FAS 106, a pattern of repeatedly raising the caps would lead the company's auditors to conclude that the employer's substantive commitment is to provide retiree health benefits without a cap, thereby cancelling the expense reducing effect of the cap.

²⁷ Although the regulations issued by the Centers for Medicare and Medicaid Services (CMS) on the 28% subsidy appear to allow employers considerable leeway in meeting the actuarial standards, employers will have to wait and see how the regulations are actually implemented.

Policy Options

Out of concern for maintaining health insurance coverage for retirees, legislative proposals have been offered to provide them some protections. There are a wide variety of policy options currently being discussed that endeavor to make retiree coverage more available or affordable, or even to require that employers maintain coverage. However, when considering any option, it is also essential to consider the relationship between retirees' health insurance and insurance for current employees. Special treatment for retirees, compared to current workers could lead to inequitable outcomes. For example, one policy option often discussed to protect retiree health insurance is to require employers to continue to provide previously promised health insurance coverage to their retiree population. Without a parallel requirement for current workers, employers could find themselves in a situation where they were financially unable to cover workers, but required to cover retirees. Thus any statutory requirement to provide retiree health insurance coverage should be examined in the broader context of all employer-sponsored coverage.

Modify COBRA

Under Title X of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA, P.L. 99-272), an employer with 20 or more employees must provide employees and their families with the option to continue their coverage under the employer's group health insurance plan in the case of certain events.²⁸ The former employee is responsible for paying the premium, which is limited to 100% of the rate charged to current employees, plus an additional 2% for administrative costs. In general, when a covered employee experiences a termination or reduction in hours of employment, including retirement, the continued coverage for the employee and the employee's spouse and dependent children must be offered for 18 months.

If a firm offers retiree health insurance coverage, retirees would most likely decline the temporary coverage provided under COBRA in favor of the retiree coverage, which may be less expensive (if the employer pays part of the premium) and would not be limited to only 18 months. However, if an individual chooses retiree coverage and the firm later discontinues this coverage, the retiree (no longer a current worker) would not be eligible to elect COBRA. Only those retirees who lose retiree health insurance benefits due to the bankruptcy (reorganization under Chapter 11) of their former employer may elect COBRA coverage that can continue until their death. Their spouses and dependent children may continue COBRA coverage for an additional 36 months after the death of the retiree. Furthermore, COBRA coverage is only available as long as the firm continues to offer health insurance to its current workers. As a result, when firms declare bankruptcy and cease operations, there are no current workers and no health insurance, so that the retirees (as well as displaced workers) have no health benefits available to purchase under COBRA. Unlike defined benefit pensions that offer some protections for

²⁸ For a more detailed description of health insurance coverage under COBRA, see CRS Report RL30626, *Health Insurance Continuation Coverage under COBRA*, by Heidi G. Yacker.

employees of companies in bankruptcy through the Pension Benefits Guaranty Corporation, there are no protections for retiree health.

One option often discussed for providing health insurance coverage to individuals who retire before reaching age 65 (eligibility age for Medicare) is to expand COBRA by allowing younger retirees to continue to purchase their coverage through their former employer, until they reach 65. There are some advantages and disadvantages for both retirees and employers of expanding COBRA coverage. For retirees, the greatest advantage may be their ability to purchase the same coverage they were offered as employees. Although the Health Insurance Portability and Accountability Act (HIPAA, P.L. 104-191) requires that certain individuals moving from the group to individual market are guaranteed the right to purchase health insurance coverage, HIPAA does not limit premiums. Older individuals, especially those with more health care needs, may find that the available individual market coverage is very expensive. Even the COBRA premium costs (up to 102% of premiums) may be prohibitively expensive for individuals whose incomes decline once they retire, complicated by the fact that while they were working their employers most likely paid a large share of the premium. For some employers, there may be an incentive to substitute this expanded COBRA coverage for other retiree coverage, thus decreasing the share of retiree health insurance they offer. Employers, on the other hand, have argued that the 2% administrative allowance does not adequately cover their additional burden. Furthermore, individuals who choose COBRA are likely to be less healthy than the rest of the employee population, so that 102% of premiums that employers are allowed to charge could be significantly lower than the claims's incurred for the COBRA enrollees.

Tax Deductions or Credits

Under current law, the tax treatment of premiums paid by employers makes it attractive for both employers and employees to purchase employer-sponsored health insurance. Any amount that an employer pays towards premiums is not counted as taxable income for the employee and not subject to payroll taxes by both the employer and employee. Additionally, some employees are able to pay any required premium contribution from pre-tax dollars. Retirees, unlike current workers, cannot pay for their share of any premium from pre-tax dollars. For most individuals who purchase their health insurance outside of their job, the only allowable tax deduction is available to those who itemize and have health care expenditures exceeding 7.5% of adjusted gross income.

Expanding tax options, such as allowing a tax deduction for premiums paid by retirees or for those taxpayers who do not itemize, may make these premiums more affordable whether the retiree has to pay all of the premium or some lesser share. Additionally providing tax credits is another option for reducing taxes, thus making premiums more affordable. Currently, there is a tax credit available on a limited basis for a select group of individuals.²⁹ Credits could be expanded and designed to

²⁹ The Trade Act of 2002 (P.L. 107-210) authorized a federal health coverage tax credit (HCTC) for certain individuals who are eligible for Trade Adjustment Assistance (continued...)

cover a retiree's entire share of premiums, could be limited to a specific dollar amount, could be linked to income or any combination of the three. However, establishing tax credits for health insurance raises complex issues. One important question is whether the credit would be the same for all taxpayers or more generous for those with lower incomes. The credits would need to be large enough to encourage individuals to buy the insurance, but might also have the adverse effect of providing employers with an incentive to reduce their commitment to health insurance. Additionally, if individuals with tax credits did not have access to the group market, they might have limited and/or only expensive options for buying health insurance, thus limiting the buying power of the credit.

Tax-Advantaged Accounts for Health Care Expenditures

There are a number of tax-advantaged accounts permitted under current law that can be used for unreimbursed qualified medical expenses such as deductibles, copayments and services not covered by health insurance.³⁰ The newest of these types of accounts is the Health Savings Account (HSA) established in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, (P.L. 108-173). HSAs are personal savings accounts for qualified medical expenses not covered by insurance or otherwise reimbursable. They can be established and contributions made only when the account owners are covered by a qualifying high deductible insurance plan and have no other coverage, with some exceptions. Annual contributions to HSAs are limited to the lesser of the deductible or a federally established limit. Additional "catch-up" contributions (limited to \$600 in 2005 and reaching \$1,000 by 2009) are allowed for individuals who are at least 55 years of age but not enrolled in Medicare. Unused portions of HSAs may be carried over from one year to the next, so that even though Medicare-enrolled individuals are not allowed to add money to an HSA account, they may continue to use any accumulated funds indefinitely. The HSA may be used to pay for the plan's cost sharing, long-term care insurance premiums, COBRA premiums, Medicare Part B premiums, and other qualified medical expenses as defined by the Internal Revenue Service. HSA funds may also be used for non-medical expenditures, subject to income tax and, for those under 65, a penalty.

²⁹ (...continued)

allowances because they have lost manufacturing jobs due to increased foreign imports or shifts in production outside the United States and for other individuals whose defined benefit pension plans were taken over by the Pension Benefit Guaranty Corporation due to financial difficulties. The refundable and advanceable credit is for 65% of what eligible taxpayers pay for qualified health insurance for themselves and their family members. For more information, see CRS report, RL32620, *Health Coverage Tax Credit Authorized by the Trade Act*, by Julie Stone-Axelrad and Bob Lyke.

³⁰ There are four types of these tax-advantaged accounts permitted under current law: Health Care Flexible Spending Accounts (HCFSA), Health Reimbursement Accounts (HRA), Archer Medical Savings Accounts (MSA) and, Health Savings Accounts (HSA). For more detailed information, see CRS Report RL32467, *Health Savings Accounts*, by Bob Lyke, Chris Peterson, and Neela Ranade, and CRS Report RL32656, *Health Care Flexible Spending Accounts*, by Chris Peterson and Bob Lyke.

Thus any unused accumulated HSA funds may be very beneficial for retirees. If the rules for contributing to HSAs were expanded, these funds have the potential of being even more useful, although opponents of HSAs already are concerned with their potential for syphoning off the healthier population and increasing insurance costs for people with the highest healthcare needs. Expanding opportunities to contribute to these funds could exacerbate these problems. While these issues must be considered, HSAs have the potential to be altered and expanded for individuals to help them pay for their own retiree health insurance coverage. For example, individuals could be allowed to contribute even higher amounts each year (over the deductible), could be allowed to make even larger contributions after reaching age 55, or even to continue making contributions after enrolling in Medicare. If individuals were allowed to put larger sums into the account for medical expenses, then the structure of the fund might need to be changed, so that withdrawals could only be used for medical expenses.

As an example, the Employee Benefit Research Institute (EBRI) calculated contributions to an HSA for 10, 20, or 30 years, along with the allowed catch-up payments for individuals over 55 years old. They assumed that the funds in the HSA would earn 5% interest and that individuals would be allowed to contribute the maximum of \$2,600 per year, indexed for inflation. They did not assume that any withdrawals would be made for medical or other expenditures, although some or all of these funds would almost certainly be withdrawn over the years. In their example, a 55-year old individual contributing \$2,600 (an estimate of the allowed contribution in a given year), plus catch up payments, earning 5% on funds held in the HSA, with the maximum allowable contribution indexed for inflation, could accumulate a maximum of \$44,000 by age 65. If the individual were allowed to contribute for 20 years, the fund would grow to \$101,000 and after 30 years it would grow to \$190,000.³¹ These figures only represent the contributions and earned interest, but no withdrawals.

Another tax-advantaged account is a Flexible Spending Account (FSA). Contributions to an FSA are voluntary, with accounts usually funded by an employee (although employers aren't prohibited from contributing) from his or her pre-taxed salary, thereby reducing taxable income. Funds in a Health Care FSA (HCFSA) can be used to pay for qualified medical expenses that are not reimbursed or covered by any other source. Qualified medical expenses include coinsurance amounts, copayments, deductibles, dental care, glasses, hearing aids, as well as certain over-the-counter medical supplies that are not cosmetic in nature. One significant limitation of the HCFSA is that funds cannot be carried over from one year to the next so that unused funds are forfeited at the end of the year.³² Another limitation is that only current employees and not annuitants are eligible to contribute to an FSA

³¹ EBRI Issue Brief no. 271, July 2004.

³² On May 18, 2005, the Treasury Department and the IRS issued Notice 2005-42 which will allow employers to modify FSAs to extend the deadline up to 2 ½ months after the end of the plan year. Although helpful, this additional time would not add a significant amount of time to FSA spending deadlines.

on a pre-tax basis.³³ Allowing these funds to be carried over from year to year and accumulate, allowing retirees to also contribute to FSAs on a pre-tax basis, or allowing FSA funds to be used for premiums of retirees, are all options that could help retirees pay for their own health insurance.

Similar to expanding these funds, proposals have been discussed that would allow withdrawals above the current limit from other tax-favored accounts for retirement savings, such as IRAs and 401(k) plans, as long as the withdrawals were for medical expenses.

Medicare Buy-in

Most persons age 65 and older, and certain disabled individuals, are automatically entitled to Medicare Part A, Hospital Insurance. These individuals, or their spouses, established entitlement by paying the HI payroll tax on earnings for the required number of quarters of Medicare-covered employment. Enrollment in Medicare Part B, Supplementary Medicare Insurance (SMI), and Medicare Part D, prescription drug coverage (available in 2006), are voluntary and qualified individuals choosing to enroll are required to pay a monthly premium.

One option for increasing coverage for the younger retirees is to allow individuals to purchase Medicare, prior to their attaining age 65. However, similar to COBRA coverage, the premiums could be prohibitive, and as a result several options for lowering premiums have been discussed. For example, one option would be to spread out the premiums over time, so that the premium charged to an individual under age 65 would cover only part of the costs. Once attaining Medicare eligibility, the individual would pay the standard Medicare Part B premium plus an additional monthly amount for the rest of his or her life, to compensate for the costs of the earlier care. A similar arrangement could be developed for the prescription drug benefit, Part D of Medicare. Initially the total program costs would be higher than revenues, but as the population aged, revenues from the older individuals paying the incremental premium amount would offset the unmet expenses of the younger group.

Federal Employees Health Benefits Program Buy-In

Federal employees, Members of Congress, annuitants, and qualified dependents are entitled to participate in the Federal Employee's Health Benefits program (FEHBP). FEHBP is the largest employer-sponsored health insurance program, covering about 8.2 million individuals. FEHBP offers enrollees a choice of nationally available fee-for-service plans, HMOs serving limited geographic areas, as well as high deductible health plans coupled with tax advantaged accounts (e.g., HSAs). The government's share of premiums, which is the same for workers as it is for retirees, is 72% of the weighted average premium of all plans in the program, not to exceed 75% of any given plan's premium. Although there is no core or

³³ Employers may contribute to the FSA for their retired workers, even though the workers may not. However, few employers make these contributions for their workers and given the decline in health insurance coverage, this is not a likely option for retired workers.

standard benefit package required for FEHBP plans, all plans cover basic hospital, surgical, physician, and emergency care. Plans are required to cover certain special benefits including prescription drugs (which may have separate deductibles and coinsurance); mental health care with parity of coverage relative to general medical care coverage; child immunizations; and protection of enrollee out-of-pocket costs for “catastrophic” health care costs.

Similar to the Medicare buy-in, Congress has considered proposals to allow small businesses and individuals, whether they are working or retired, to buy into FEHBP. Some of these proposals would require that plans choosing to participate in FEHBP would also be required to make these same plans available to the newly qualifying group of individuals or businesses. Most often these proposals separate the risk pools for the newly qualifying eligibles from the currently existing pool of eligibles. In this case, premiums for the new group could potentially be higher than premiums for the existing federal pool, because the new pool wouldn’t have the advantage of spreading the risk across 8.2 million people. As a result, premiums for the expanded FEHBP might not be significantly less expensive than other individual or small group options available in the market today. On the other hand, if risk was spread across the entire group of new enrollees, essentially developing a new large group entity, then premiums could be less than these entities could find on their own. The key advantage of the expanded FEHBP might be that it offered this new group availability, choice and a guarantee that the products being purchased (the same offered to federal employees, annuitants and Members of Congress) included a reasonable set of benefits.

Enhance Medicare

Medicare is the primary payer for qualifying retirees over age 65. If a retired Medicare enrollee also has employer-sponsored retiree health insurance coverage, that insurance would “wrap around” the Medicare benefit paying for coinsurance, deductibles, and services covered by the plan but not Medicare. Expanding Medicare might replace or reduce the costs of retiree health insurance for this population. Although employers cannot divide their retiree population into Medicare and non-Medicare retiree groups, more Medicare coverage translates into overall reduced costs for employer’s covering retirees, as this coverage would be secondary to Medicare for the Medicare eligible group. As previously mentioned, Medicare covers only about one-half of a beneficiary’s average medical expenses. This percentage may increase, with the expansion of Medicare to include prescription drug coverage, beginning in 2006. However, even for retirees covered by Medicare, there are services that Medicare does not cover, such as long-term care expenses. Also, Medicare does not have a catastrophic limit on beneficiary out-of-pocket expenditures for covered services, (with the exception of Part D prescription drug services and regional Medicare managed care plans, beginning in 2006). Medicare could be enhanced to expand coverage or to offer a catastrophic limit. However, as Medicare will begin to offer a new costly prescription drug benefit in 2006, it is unlikely that other large expansions will take place in the near future that might serve to replace or reduce the costs of retiree health insurance.

Employer Mandates

Employer-sponsored health insurance is offered voluntarily by employers and in general,³⁴ they have the right to change coverage at any time. This includes changes such as raising copayments, increasing deductibles, requiring larger premium contributions from employees, using formularies for prescription drug coverage, or even eliminating coverage entirely. Employer mandates could be established to require that any retiree coverage offered to either current retirees and/or promised to current workers upon retirement could not be changed or eliminated. However, employers who wanted to reduce their health insurance costs, and were not allowed to change the coverage for their retirees would be forced to reduce costs only for their workers. In this situation, the retiree coverage would not change while the worker's would, possibly resulting in more generous benefits for retirees than workers. Although rather unlikely, in the most extreme case, employers could drop coverage for workers, while still providing coverage for retirees. The more likely outcome of a such a requirement is that employers could reduce benefits, increase premium contributions, deductibles, or coinsurance for current workers, while still being required to maintain the more generous package for their retired workers. Furthermore, faced with restrictions, employers might discontinue offering the promise of retiree health benefits to newly hired individuals, so that at least for this group of employees, they would not be required to offer retiree benefits when these workers eventually retire.

Pre-funding Retiree Health Benefits

Unlike defined benefit pension plans, there is no requirement that employers pre-fund their retiree health benefit plans. The ideal pre-funding vehicle would allow employers to take a tax deduction for contributions to the fund, permit sufficient amounts to be contributed for orderly accumulation of funds to discharge future obligations, and allow for investment income on the fund to be tax-free. These are all advantages enjoyed by defined benefit pension trusts.

Under current law, such an ideal funding vehicle is only available for certain employee populations. Specifically, an employer sponsoring a retiree health plan for a collectively bargained employee population may set up a Voluntary Employee Beneficiary Association (VEBA) to pre-fund retiree health benefits for this population. Such a VEBA has comparable advantages to a defined benefit pension trust. Investment income on a VEBA established to pre-fund retiree health benefits for non-union employees, on the other hand, is subject to the unrelated business income tax. Moreover, health care inflation may not be taken into account in determining the contribution to such a VEBA. Some employers have used a 401(h) sub-account of a defined benefit pension plan for the pre-funding of retiree health benefits. While the investment income on assets in such a sub-account is tax-free, only limited amounts can be contributed to it. To date, employers who have pre-

³⁴ Employees who have contractual agreements with employers or arrangements with unions may have guarantees for health insurance coverage and may also limit an employer's ability to make changes to that coverage.

funded retiree health plans have tended to be utilities such as gas and electric companies who could include the cost of pre-funding in rates charged to consumers.

Legislative Proposals

Bills that address retirees' health insurance coverage are included in the discussion below. These include legislation that has been introduced in the 109th Congress. This list may not include all relevant bills. These bills cover a wide variety of options for making retiree coverage more available and affordable such as, options to expand Medicare or FEHBP coverage to certain retirees, prohibit group plans from reducing benefits for retirees, or provide tax relief. Several bills address the needs of specific groups of retirees. Other legislation provides for comprehensive health insurance for all Americans, not just retirees.

Expand Medicare or FEHBP coverage

- **H.R. 55** would make FEHBP available to individuals age 55 to 65 who would not otherwise have health insurance.
- **H.R. 2072** would provide access to Medicare benefits for individuals ages 55 to 65 and would amend the Internal Revenue Code of 1986 to allow a refundable and advanceable credit against income tax for payment of such premiums.

Protect retirees who lose their health coverage

- **S. 329** would increase the amount of unsecured claims for salaries and wages given priority in bankruptcy to provide for cash payment to retirees to compensate for lost health insurance benefits resulting from bankruptcy of their former employer.
- **H.R. 1322** would prohibit profitable employers from making any changes to retiree health benefits once an employee retired. The bill would require plan sponsors to restore benefits for retirees whose health coverage was reduced before enactment of the bill, and create a loan guarantee program to help firms restore benefits. It would not restrict employers from changing retiree health benefits for current employees.

Provide tax relief

- **H.R. 218** would allow a deduction for amounts paid for health insurance and prescription drug costs of individuals.
- **H.R. 2176** would provide a 100 percent deduction for the health insurance costs of individuals.
- **H.R. 2089, H.R. 765, and S. 160** would allow individuals a refundable credit against income tax for the purchase of private health insurance, subject to income and other limitations.
- **H.R. 1872 and S. 978** would provide tax incentives for the purchase of qualified health insurance.

Protect specifically defined groups of retirees through a variety of methods

- **H.R. 299 and S. 162** would clarify that certain coal industry health benefits may not be modified or terminated.
- **H.R. 602 and S. 407** would restore health care coverage to certain retired members of the uniformed services.
- **H.R. 322** would allow a refundable credit to military retirees for premiums paid for coverage under Medicare Part B.
- **H.R. 994 and S. 484** would allow federal civilian and military retirees to pay health insurance premiums on a pretax basis and allowed a deduction for TRICARE supplemental premiums.

Provide comprehensive employer or national health insurance

- **H.R. 15, H.R. 676, H.R. 1200, and H.R. 2133** would establish national health insurance programs.
- **H.R. 1955, S. 637, and S. 874** would establish a national health program administered by the Office of Personnel Management to offer health benefits plans to individuals who are not federal employees.