



Health Insurance Coverage for Retirees

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Summary

Many retirees depend on their former employer for retirement health insurance, either as their sole source of coverage for those under age 65 or as a supplement to their Medicare coverage once they reach 65. However, the future of these benefits is uncertain. With the retirement of the baby boom generation looming ahead, employers offering coverage to their retired workers will face a huge future financial commitment. For this reason, many employers are re-examining their commitment to providing retiree health benefits. Some employers have already reduced or eliminated health insurance coverage for their retirees. Further, among employers who provide health insurance for current retirees, their current workers are less likely to be guaranteed these benefits upon retirement.

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. Additionally, 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 currently 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 similar 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 workers. The concept of special treatment aimed solely at protecting the retiree population, without an equivalent treatment for current workers, 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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Introduction

Many retirees depend on their former employer for retirement health insurance, either as their sole source of coverage for those under age 65 or as a supplement to their Medicare coverage once they reach 65. However, given that employers are not required to offer employer-sponsored health insurance, as well as limited federal protections available for persons losing coverage, the future of these benefits is uncertain. With the retirement of the baby boom generation looming ahead, employers offering coverage to their retired workers will face a huge future financial commitment. Some employers have already reduced or eliminated their commitment to insure their retirees. 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. With the implementation of Medicare prescription drug coverage in January 2006, retiree coverage may see further changes as employers gain experience with the interaction between Medicare's and their plan's prescription drug coverage. However, Medicare coverage affects only those retirees who are over 65, disabled, have End Stage Renal Disease (ESRD) and also qualify for Medicare. Many individuals retire before reaching 65, and their retiree health insurance would most likely be their sole source of health insurance coverage, including prescription drug 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 premium contributions, deductibles, and co-payment amounts.¹ 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 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

¹ As an example, General Motors (GM) and Ford have made the decision to scale back retiree health benefits. The changes made by these firms, known for their generous employee and retiree health benefits, are seen by some as an acceleration in employer-wide erosion in retiree health benefits. GM estimated that its revised health-care benefit plan for salaried retirees in the U.S. would reduce the company's liability by about \$4.8 billion and its annual health-care expense by almost \$900 million.

increasing life expectancies and their increasing 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.² 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 had an average life expectancy of 14 more years, living to age 79.³ Since that time, Americans are living longer. According to the U.S. National Center for Health Statistics, 2002 data indicates that persons reaching age 65 had an average life expectancy of an additional 18.2 years, living beyond age 83. According to the U.S. Census, the total number of persons over age 65 has almost doubled since 1965, reaching 35.6 million, or 12.3% of the total population by 2002. This trend is projected to continue and, according to U.S. Census Bureau estimates for 2030, when the baby boomers are all over age 65,⁴ the total number of persons 65 and older will have more than doubled again, growing from 35.6 million to 71.5 million, comprising 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 overall health among adults in late middle age.⁵

Americans approaching or at retirement age can expect to consume more medical services than younger persons. According to the Administration on Aging, in 2003, the elderly averaged \$3,741 in out-of-pocket health care expenditures, compared to the average out-of-pocket costs of only \$2,416 for the total population.⁶ 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. 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. 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 this amount, with a median annual premium

² 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, D.C., 1975).

³ 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/cm20030711ar01p1.htm>.

⁴ Members of 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.

⁵ 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.

⁶ U.S. Department of Health and Human Services, Administration on Aging, *A Profile of Older Americans: 2004*.

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.⁷

Today's workers face many choices regarding retirement age. Some workers retire as early as age 55, the minimum retirement age allowed by most defined benefit pension plans. 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 2004 survey on employer-sponsored health insurance, the median retirement age was 60 in organizations offering retiree health insurance, compared to 64 in those that do not.⁸ While the discussion of the significance of this age difference only focuses on whether or not firms offer retiree health insurance, there may be other factors, such as overall benefit package and salary levels that contribute to an individual's decision of when to retire.

Health Insurance Coverage

Retirees with Employer-Sponsored Health Insurance

The prevalence of retiree coverage increases with firm size, so that retirees from large firms are more likely to be offered health insurance than workers retiring from smaller firms. For example, employees under age 65 retiring from firms with 20,000 or more employees are almost twice as likely to be offered coverage as employees in firms of 500-999 employees. Retirees over age 65 are almost two and one-half times as likely to be offered retiree health benefits in the largest firms.⁹

However, regardless of firm size, the percentage of employers offering retiree coverage has been declining since the late 1980s. Kaiser/HRET's 2005 survey of employees¹⁰ found that the percentage of firms with more than 200 workers offering retiree coverage fell by half between 1988 and 2005, from 66% to 33%.¹¹ As shown in **Table 1**, Mercer's 2004 survey found that while coverage has been steadily declining for more than a decade, the trend has leveled off more recently. In 1993, 46% of employers with at least 500 employees offered their pre-Medicare eligibles coverage, compared to 29% in 2001. Since that time, coverage has remained fairly

⁷ Elisabeth Simantov, Cathy Schoen and Stephanie Bruegman, "Market Failure? Individual Insurance Markets for Older Americans," *Health Affairs*, July/Aug. 2001.

⁸ National Survey of Employer Sponsored Health Plans, 2004 Survey Report, Mercer.

⁹ National Survey of Employer Sponsored Health Plans, 2004 Survey Tables, Mercer.

¹⁰ This report primarily uses three sources of data for examining the current state of retiree health insurance, although other sources are also utilized. The first is the *National Survey of Employer Sponsored Health Plans, 2004 Survey*, conducted by Mercer, a representative survey of all U.S. employers offering health insurance who have 10 or more employees. Some survey results are displayed separately for large and small employers, using 500 employees as the cut-off. The sample includes private employers as well as government agencies. The second source is the "*Employer Health Benefits, 2005 Annual Survey*," conducted by the Henry Kaiser Family Foundation and the Health Research and Educational Trust. This survey samples private and public employers with three or more workers. Firms with 200 or more employees are considered large. The third source, also from Henry Kaiser Family Foundation and the Health Research and Educational Trust, is a survey of 300 large (1000+ employees) private-sector companies offering retiree health benefits. This is the *2005 Survey on Retiree Health Benefits*. While the trends indicated by the surveys are generally consistent, there are instances in which the survey results differ more significantly.

¹¹ "Employer Health Benefits, 2005 Annual Survey," *The Henry Kaiser Family Foundation and Health Research and Educational Trust*.

constant, dropping to 28% in 2004. Similarly, 40% of employers with at least 500 employees offered coverage to their Medicare eligibles in 1993, compared to 23% in 2001, dropping slightly to 20% by 2004.¹²

Table 1. Percentage of Large Firms Offering Retiree Health Coverage, 1993-2004

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%
2004	28%	20%

Source: National Survey of Employer Sponsored Health Plans, 2004 Survey Report, Mercer.

Other Sources of Insurance for Retirees

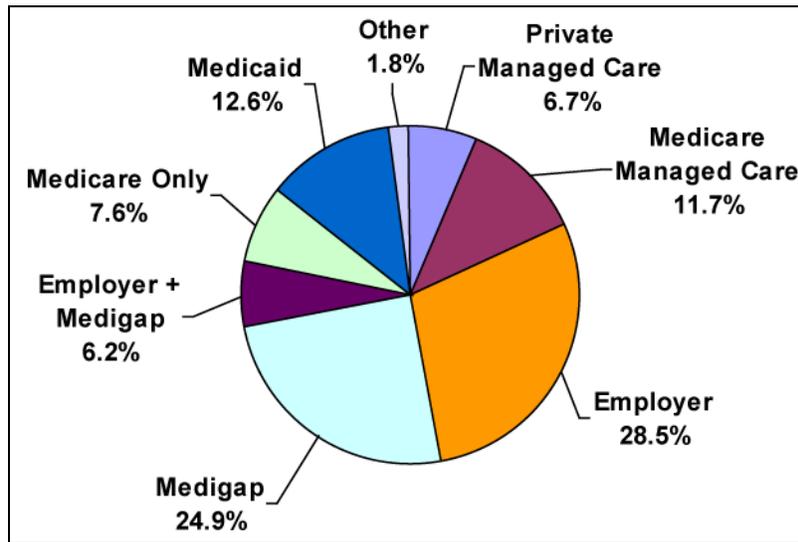
Sources of health insurance are very different for those individuals under age 65 than for those who are over 65 and therefore most likely covered by Medicare. However, according to CRS calculations of Medicare Current Beneficiary Survey Data for 2002, Medicare only covers about half of the medical costs of the 65 and older group.¹³ 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),¹⁴ which while not technically “additional insurance,” does in many cases provide extra services beyond the basic package of Medicare benefits.

¹² National Survey of Employer Sponsored Health Plans, 2004 Survey Report, Mercer.

¹³ Beginning January 2006, Medicare can most likely expect to cover a larger share of medical costs for enrollees who purchase and use Medicare Part D prescription drug coverage.

¹⁴ 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.

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



Source: Chart created by CRS based on analysis of the Medicare Current Beneficiary Survey, Cost, and Use file, 2002.

For retirees who are under age 65, and do not qualify for Medicare based on disability or End-Stage Renal Disease (ESRD),¹⁵ 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,¹⁶ 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 laws limit premium amounts, providing varying degrees of protection.

Erosion in Coverage over Time

According to a Kaiser/Hewitt December 2005 survey on retiree health benefits, between 2004 and 2005, of the 300 firms in their survey with more than 1000 employees, 71% of those companies had increased the share of the premiums paid by the retiree, 34% had increased retiree

¹⁵ 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).

¹⁶ 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 (name redacted) et al.

coinsurance or copayments, 39% indicated that they had increased the amount enrollees pay for prescription drugs through increased drug copayments or coinsurance, and 12% had eliminated subsidized retiree health benefits for their new employees.¹⁷

Employers are also managing their retiree health insurance costs by providing different benefits for current and future retirees. Following the same trend, although less dramatic than the findings in the Kaiser/Hewitt survey, the Mercer National Survey of Employer-Sponsored Health Plans 2004 study found that about 30% of its respondents (slightly higher rates reported for Medicare-eligible retirees) reduced their retiree health benefits by raising retiree contributions, increasing cost sharing, or limiting coverage. Conversely, about 3% of firms increased retiree health benefits. 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. As shown in **Table 2**, 28% (for pre-Medicare retirees) and 30% (for Medicare-age retirees) of firms offering retiree health based their share of premium contributions on age and years of service. Among large employers (500 or more employees) pre-Medicare retirees are more likely to pay 100% of their health insurance than their Medicare counterparts.

Table 2. Employer Premiums Contributions for Retiree Health Insurance

Employer share of premiums	Pre-Medicare retirees (under age 65)	Medicare age retirees (65 and older)
Base share of premiums on age and years of service	28%	30%
Employer pays no premium	40%	32%
Employer shares premium with employee	44%	53%
Employer pays 100% of premium	16%	15%

Source: 2004 Mercer National Survey of Employer-Sponsored Health Plans, 2004 Survey Tables.

Role of the Law and Courts

An important characteristic of 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

¹⁷ “Prospects for Retiree Health Benefits as Medicare Drug Coverage Begins, Findings from the Kaiser/Hewitt 2005 Survey on Retiree Health Benefits,” *The Henry Kaiser Family Foundation and Hewitt*, Dec. 2005.

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*).¹⁸ In other instances, when employers have not preserved their right to change a plan (e.g., *Eardman v. Bethlehem Steel*),¹⁹ the courts have sided with the employee.²⁰

Another issue brought before the courts is whether or not employers may offer health benefits to their Medicare-eligible retirees that differ from those offered to their retirees who are not Medicare-eligible. In *Erie County Retirees Ass'n v. County of Erie*, 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 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.²¹ 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.²² 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 appealed the ruling. On September 27, 2005, a federal trial judge ruled that the EEOC had not abused its discretion in issuing the regulation; however, the judge granted AARP's petition to keep the injunction in place (not allowing the EEOC to publish the regulation) pending the decision by the U.S. Court of Appeals for the Third Circuit. The case is set for oral argument in February 2007.

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 have significant consequences now that the new Medicare prescription drug program is in effect. 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. Employers could choose to maintain prescription drug coverage for only their younger retirees. However, because the standard Medicare Part D prescription drug benefit is generally less generous than coverage offered by employers,

¹⁸ 514 U.S. 73 (1995).

¹⁹ 607 F. Supp. 196 (W.D.N.Y. 1984).

²⁰ See John C. Garner, *Health Insurance Answer Book*, 6th ed. (New York: Aspen, 2001).

²¹ 220 F.3d 193 (3rd Cir. 2000).

²² For more information, see CRS Report RS21845, *Final Equal Employment Opportunity Commission Rules on Retiree Health Plans and the Age Discrimination in Employment Act*, by (name redacted).

Medicare-eligible retirees who lose employer-sponsored retiree prescription drug coverage would likely pay more or have less generous coverage or both.

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 a Kaiser/Hewitt January 2005 survey on retiree health benefits, among their surveyed 300 employers with more than 1,000 employees, total costs for employer-sponsored retiree coverage were \$20.8 billion in 2004, including costs paid by the retiree and the employer, and were estimated to increase to \$22.9 billion for 2005.²³ 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 2003 and 2004, per-person retiree medical costs for pre-Medicare eligibles increased by 8% (from \$7,634 to \$8,247) and by 7.8% (from \$3,060 to \$3,300) for Medicare-eligible retirees.²⁴

Looking at the overall premium increase for employer-sponsored health insurance (not solely premium increases for retiree health insurance), according to the Kaiser/HRET 2005 annual survey, increases in health insurance premiums are outpacing increases in both workers' earning and overall inflation. For example, premiums increased by 9.2% from 2004 to 2005, compared with a 2.7% increase in earnings and a 3.5% increase in inflation.²⁵ In the early 1990s premium increases were smaller each year, bottoming out at less than a 1% increase in 1996. However, increases soon became progressively larger over time, reaching double digits by 2001. Recently, the increases have slowed to 11.2% between 2003 and 2004, and to 9.2% between 2003 and 2004. Increases in premiums are expected to continue, in part due to increasing costs (inflation and utilization) of medical claims.²⁶ The largest of these increases appear to be concentrated in the smallest firms.

²³ "Prospects for Retiree Health Benefits as Medicare Drug Coverage Begins, Findings from the Kaiser/Hewitt 2005 Survey on Retiree Health Benefits," *The Henry Kaiser Family Foundation and Hewitt*, Dec. 2005.

²⁴ "National Survey of Employer-Sponsored Health Plans," *2004 Survey Report*, Mercer. (Because of low survey response on this particular question, results should only be viewed as a general indicator of plan costs.)

²⁵ "Employer Health Benefits, 2005 Annual Survey," *The Henry Kaiser Family Foundation and Health Research and Educational Trust*.

²⁶ 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.

Prescription Drug Coverage

While most firms providing retiree coverage offer prescription drug coverage, it is more prevalent for larger firms. On average, in 2004, 90% of large employers (at least 500 employees) offering retiree coverage included prescription drug coverage. Among firms with 500-999 workers, 86% offered coverage, increasing to 98% for firms with more than 20,000 employees.²⁷ Except for the very largest firms (those with more than 20,000 employees), coverage declined relative to 2003.

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, and 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 multiple-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).

As of January 2006, Medicare beneficiaries may now participate in the new voluntary Part D program providing prescription drug coverage, as established in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, P.L. 108-173. Medicare beneficiaries may purchase either “standard coverage” or alternative coverage with at least actuarially equivalent benefits, depending on availability in their area of residence. In 2007, “standard coverage” has a \$265 deductible, 25% coinsurance for approved drug costs between \$266 and \$2,400, then no coverage until the beneficiary has out-of-pocket costs of \$3,850 (\$5,451.25 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.

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 equal 28% of a retiree’s gross²⁸ covered retiree plan-related prescription drug costs over the \$265 deductible up to \$5,350. (The dollar amounts are adjusted annually by the percentage increase in Medicare per capita prescription drug costs.)

The majority of responding employers in the Kaiser/Hewitt December 2005 retirement survey indicated that for 2006, they were likely to continue to offer prescription drug coverage. Among the respondents, 79% indicated that they were likely to choose the subsidy, 10% planned to supplement Medicare coverage, 2% planned offer their own Part D plan, and 9% planned to discontinue prescription drug coverage.²⁹ However, as employers gain a better understanding of the interaction between their coverage and Medicare prescription drug program, in future years they may decide to make changes to their health plans for retirees with respect to prescription drug coverage, or even to their entire benefit package. For example, if the subsidy covers a significant portion of the employer’s cost for providing prescription drug coverage, then the

²⁷ “National Survey of Employer-Sponsored Health Plans,” *2004 Survey Tables*, Mercer.

²⁸ The employer’s subsidy covers “gross” costs, which includes any co-payments or co-insurance paid for by the retiree.

²⁹ “Prospects for Retiree Health Benefits as Medicare Drug Coverage Begins, Findings from the Kaiser/Hewitt 2005 Survey on Retiree Health Benefits,” *The Henry Kaiser Family Foundation and Hewitt*, Dec. 2005.

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. 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 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 workers 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.

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.

Employer Caps on Retiree Health Insurance

Some employers have established caps on their contributions to retiree health insurance in order to limit the open-ended nature of their liability. This also allows employers to constrain the dollar amounts that they have to recognize as a result of the FAS 106 rules. Although firms often set the caps at a level they expect to reach at some distant future date, given the rapid rate of increase in health insurance costs, employers may find that they exceed the cap even sooner than anticipated. This presents an interesting dilemma for the provision of retiree health benefits. According to the Kaiser/Hewitt study of retiree health benefits, among the surveyed firms, about one-half have caps in place, and of those with a cap, 59% have already reached the cap. Another 19% estimate that they will hit the cap in the next three years.³⁰ To alleviate this situation, firms can raise the caps; however, this would require higher spending.³¹ Alternatively, they can 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 Part D of 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 first meet the actuarial equivalent standard required under Medicare law may over time no longer meet that standard. Then they may no longer qualify for the 28% employer subsidy.

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 new Medicare prescription drug coverage, some companies will maintain their prescription drug coverage and receive a 28% subsidy, which will 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. Both of these options would help employers to lower their expenses and possibly remain under their cap.

³⁰ "Prospects for Retiree Health Benefits as Medicare Drug Coverage Begins, Findings from the Kaiser/Hewitt 2005 Survey on Retiree Health Benefits," *The Henry Kaiser Family Foundation and Hewitt*, Dec. 2005.

³¹ 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 canceling the expense reducing effect of the cap.

Policy Options

There are a wide variety of policy options 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 workers. 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 an awkward situation in which 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.³² 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 employees of companies in bankruptcy through the Pension Benefits Guaranty Corporation, there are no similar 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

³² 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.

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 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, allowing retirees to pay for premiums from pre-tax dollars, or allowing a deduction 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.³³ Credits could be expanded and designed to 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

³³ 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 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*, by (name redacted).

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 certain services not covered by health insurance.³⁴ 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 a federally established limit (for 2007, the limit is \$2,850 for self coverage and \$5,650 for family coverage). Additional “catch-up” contributions (limited to \$800 in 2007 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 high deductible insurance 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.

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 are already 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, 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 example of the potential for growth in contributions to HSAs, 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 (as the current limit for 2007 is actually higher, the amount in the HSA account

³⁴ 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 (name redacted), (name redacted), and Neela K. Ranade, and CRS Report RL32616, *Health Care Flexible Spending Accounts*, by (name redacted) and (name redacted), and CRS Report RL32617, *Savings Accounts: Overview of Rules for 2009*, by (name redacted).

would be even larger), 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, 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 \$190,000.³⁵ 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, at best, funds can only be carried over for a limited time after the end of the plan year.³⁶ Any money remaining in the fund at the end of this time is forfeited. Another limitation of health care FSAs is that only current employees and not annuitants are eligible to contribute to an FSA on a pre-tax basis.³⁷ Allowing these funds to be carried over and accumulate without any deadlines, allowing retirees to also contribute to FSAs on a pre-tax basis, or allowing FSA funds to be used for retiree premiums, 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 aged 65 and older 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. Additionally certain disabled individuals and persons with End Stage Renal Disease may also qualify for Medicare. Enrollment in Medicare Part B Supplementary Medicare Insurance (SMI), and Medicare Part D prescription drug coverage 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.

³⁵ EBRI Issue Brief no. 271, July 2004.

³⁶ On May 18, 2005, the Treasury Department and the IRS issued Notice 2005-42 allowing employers to modify FSAs to extend the deadline up to 2 ½ months after the end of the plan year. Although helpful, this action does significantly extend the FSA deadline.

³⁷ Employers may contribute to the FSA for their retired workers, even though the retirees 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.

For example, one option would be to spread out the cost of the premiums over time, so that the premium charged to an individual under age 65 would cover only part of the costs. Once reaching age 65, the official age for Medicare aged 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 coverage. 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 million individuals, offering 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 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 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 retired individuals 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 currently 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 will most likely increase for those beneficiaries who enroll in and use the new Medicare Part D prescription drug program. However, even for retirees covered by Medicare, there are services that Medicare does not cover, such as most routine check-ups. 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). Medicare could be enhanced to expand coverage or to offer a catastrophic limit. However, as Medicare has just begun to offer its new costly prescription drug benefit, it is unlikely that other expansions will take place in the near future that might serve to replace or reduce some of the costs of retiree health insurance.

Employer Mandates

Employer-sponsored health insurance is offered voluntarily by employers and in general,³⁸ 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. 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. Although rather unlikely, in the most extreme case, employers could drop coverage for workers, while still providing coverage for retirees. 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

³⁸ 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.

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-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.

Most recently, a new program was created for some colleges and universities, Emeriti Retirement Health Solutions. Institutions that chose to participate in this program make contributions to a tax-exempt trust, a VEBA, for retirement health insurance. Employees may also contribute, on an after-tax basis to a separate VEBA. The contributions and investment income earn tax-free interest. At retirement, employees eligible for Medicare, can use these funds, tax-free, to pay for certain uncovered health care expenses, such as Medicare premiums or enrollment in a qualified health care plan. Employees who met their institution's retirement eligibility requirements but retire before they are Medicare-eligible can also withdraw funds, tax-free, for certain health care-related expenses. While current tax laws limit the ability of many private employers to use VEBA on a tax effective basis, changing those laws might expand opportunities for creating programs like that offered through the Emeriti Retirement Health Solutions program.

Legislative Proposals

The 110th Congress has not yet introduced bills relating to retiree health insurance. However, given the continued reduction in employer-sponsored retiree health insurance, it is likely that this issue will be as active in the 110th Congress as it was in the 109th Congress. Therefore, listed below is a summary of some of the bills introduced in the 109th Congress, to provide a sense of the types of legislative solutions that were proposed to address retirees' health insurance coverage. The 109th bills cover a wide variety of options for making retiree coverage more available and affordable such as, options for expanding Medicare or FEHBP coverage to certain retirees, prohibiting group plans from reducing benefits for retirees, or providing 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. This list does not include bills that would amend Medicare prescription drug coverage or associated employer subsidies. The list will be updated in response to congressional activity in the 110th Congress, as information becomes available.

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 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% deduction for the health insurance costs of individuals.
- **H.R. 2089, H.R. 765, S. 4 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.
- **S. 1573** would amend the Internal Revenue Code to encourage funding of collectively bargained retiree health care benefits.
- **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.

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