

Providing Health Care Benefits in Retirement

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Chapter 1

Overview

Anna M. Rappaport and Sylvester J. Schieber

During the national political campaigns in 1992, deep concerns emerged about many aspects of the health delivery and financing systems in the United States. President Clinton was elected, at least in part, because he promised to reform the health care system in this country. As the debate has unfolded, however, very little of the public discussion has centered on the special plight of retirees and how health care reforms might affect them.

The elderly are much less able than younger people to adjust to evolving health insurance patterns. In addition, dissatisfaction from providers and consumers alike about the costs of the current health care delivery system has introduced the prospect of limitations (or "caps") on resources devoted to health care. As the largest consumers of health care, the elderly will be profoundly affected by any such restrictions.

The purpose of this book is to first identify and then explore the challenges faced by private and public sector policymakers in providing retiree health care insurance in the current economic environment and under probable national health care reform. The chapters and commentaries were first presented as papers and discussions at a Wharton School Impact Conference in May, 1993, that was hosted by the Pension Research Council at the University of Pennsylvania, with additional sponsorship from the Leonard Davis Institute of Health Economics (University of Pennsylvania). Participants in the symposium represented the diverse constituencies involved in direct provision, funding, and evaluation of health care delivery to older Americans. The group included policy-making and academic economists, actuaries, statisticians, physicians, employee-benefit-plan sponsors, representatives of labor, attorneys, and health care policy specialists. The combination of practical, research, and policy expertise brought together a rich diversity of perspectives and resulted in this book, which addresses the ongoing debate over health

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care funding and delivery issues, particularly as these things apply to retiree health care needs.

Several common themes emerge in the chapters and commentaries that follow and are highlighted here to provide readers with an overview of salient issues related to the funding and delivery of retiree health services.

The Challenges

Judith Mazo, Senior Vice President of The Segal Company, takes up the general question of how to provide health benefits to elderly Americans in Chapter Two, where a distinction is made between two diverse groups of retirees: those early retirees who are not yet Medicare eligible, and those retirees over age 65 or disabled who are Medicare eligible.

Before Medicare, most retirees who received Social Security benefits did not have health insurance coverage and could not afford to purchase health care coverage directly. Today, most Social Security beneficiaries aged 65 and older, as well as many disabled persons, enjoy coverage from Medicare, a program that cost American taxpayers \$82 billion in 1992 (for Medicare Part A). Despite this massive growth in health care protection, the elderly's out-of-pocket health care spending as a share of their income is as high today as it was before Medicare was introduced,¹ and the federal Medicare program faces a difficult economic future. Recently, payroll taxes financing Medicare Part A grew at a rate of 6.9 percent, whereas expenditures rose at an annual rate of 11.1 percent.² This scenario leads Dr. Mark Pauly, Chairman and Professor of Health Care Systems, The Wharton School, and Director of the Center for Research at the Leonard Davis Institute, to remark that "the fundamental conclusion is that Medicare has to change" (see Chapter Six).

In addition to Medicare, some retirees are eligible for health benefits provided through their former employers' health benefit programs. These benefits often are provided to people who retire before age 65, typically with a reduction in benefits and coverage once the Medicare eligibility age is attained. Employers who provide health insurance protection for retirees have found that recent private health insurance coverage premiums rose far more rapidly than the other costs of doing business. This cost pressure was exacerbated in 1990 when a new financial accounting standard (FAS 106) required employers to recognize the financial obligations incurred by promising such benefits.

Problems with the current employer-sponsored group retiree health benefit system may be summarized as follows:

- When employers offer early retiree health care coverage, the costs often are high and variable. Early retirees cost about two-and-one-

half times as much to insure on average as younger active workers. Companies face substantial uncertainty regarding future company-sponsored plan costs, as well as costs of related government programs (e.g., Medicare). In addition, frequently changing rules and legal uncertainties regarding national reform make it difficult to manage the benefits.

- Employer-provided health insurance coverage often is costly to retirees; benefit caps and cost-sharing make coverage unaffordable for some people.
- Because employers usually reserve the right to alter and amend benefit offerings, active and retired workers sense some insecurity with regard to benefits. Also, employer plans are typically not prefunded, nor is there plan termination insurance. Long-term care generally is not covered, and many plans do not cover prescription drugs.
- Many companies offer no retiree coverage, and early retirees' income often is inadequate to cover the full cost of health coverage, particularly before Medicare eligibility sets in.

As a consequence of these uncertainties, firms that provide health benefits to current workers not only expend more in current operating costs but also reduce their reported financial values because they need to forecast future retiree health care cost liabilities. The net result has been that many employers have curtailed the health benefits offered to retirees. As Mazo concludes in Chapter Two, "overall, the outlook is for less employer-paid retiree health coverage."

Reviewing the Current Situation

Anna Rappaport, Managing Director of William M. Mercer, Inc., and Carol Malone, also from William M. Mercer, Inc., examine aspects of the retiree health insurance market in Chapter Four of this book. They focus on plan coverage, benefit levels (including cost sharing), and the types of services provided. Their chapter notes that retiree health insurance coverage depends on the employer's size and other characteristics. Coverage levels are relatively high for large employers in established industries such as heavy manufacturing and financial services and are also high in unionized industries and in the public sector. In contrast, there is virtually no coverage for retirees given by employers who have fewer than 100 employees or by companies that have been in operation for only a few years. A serious concern is that privately provided benefits may be cut even more in the future in response to the cost concerns just discussed.

Two specialists comment on Chapter Four. William Custer, Director of Research at the Employee Benefit Research Institute, observes that a

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degree of subjectivity is required when evaluating the adequacy of employer-provided health benefits, but he concludes that current benefits are "clearly inadequate" because only about one third of current retirees receive them. He predicts that health care reform packages will allow retirees to join community-rated risk pools, in which case employers may offer reduced retiree health benefits in exchange for meeting retiree income needs through cash-income retirement plans. This is likely because current retiree health insurance plans cannot be prefunded on a tax-preferred basis. This approach clearly places the responsibility of purchasing private retiree health insurance on the individual.

In contrast, Paul Grant, Associate Professor of Human Resources and Industrial Relations at Loyola University, expresses concern over asking individuals to pay for their own care, because health insurance markets are thin for early retirees. In part, this is because the lack of good data on this population and also because greater needs for new types of coverage such as long-term care are thwarted by changing social patterns, making the benefits less available.

The trade-off between retiree health insurance and cash benefits is taken up by Deborah Chollet, Associate Director at the Alpha Center in Washington, D.C. In Chapter Three, she asks whether the high and rapidly growing cost of retiree health benefits is putting pressure on other benefits, particularly pensions, while recognizing that pension savings have a tax-preferred status in contrast to the less tax-favored retiree health insurance coverage. Chollet's analysis suggests that reductions in retiree health benefits are more likely than reductions in pension benefits, and she concludes that retiree health obligations will not jeopardize pension benefits in the near future. She also contends that the future of employer-sponsored retiree health plans is highly uncertain, in light of the financial disclosure requirements recently imposed on retiree health care plans and the dire straights in which Medicare finds itself.

Diana Murray, Senior Manager of Group Insurance Plans for the Sara Lee Corporation, offers the corporate perspective on Chollet's chapter, concluding that many firms "do not want to have to tell employees when, where, and how to buy care." If retiree health insurance benefits do decline, then this might have a serious and perhaps unpredictable effect on older workers' willingness and ability to retire, warns Olivia Mitchell, Executive Director of the Pension Research Council and International Foundation of Employee Benefit Plans and Professor of Insurance and Risk Management at The Wharton School. In her commentary to Chollet's chapter, Mitchell notes that reluctant retirees will present human resource specialists with yet a new and potentially unexpected spillover effect in the health insurance problem. This point is shared by Rappaport and Malone in Chapter Four, where they state that both employers and em-

ployees tend to be dissatisfied in situations in which early retirement must be delayed.

Looking Forward

One theme that runs through the chapters and their related commentaries is the view expressed by Joseph Antos, Director of the Office of Research and Demonstrations in the Health Care Financing Administration. In his commentary to Chapter Five, Antos states that the nation is "nearing a practical limit to health care expenditures." Somewhat optimistically, Mark Pauly suggests in Chapter Six that policymakers may have another six years to resolve the Medicare funding problem. Antos counters that governmental budgets are straining now under the burden of medical plans at federal and state levels alike. The Medicare trust fund deficit over the next 25 years is projected to be \$1.4 trillion in present value terms (Board of Trustees, 1993). In addition, employer-provided retiree health benefits always have been limited, and now even those employers who traditionally offered benefits are driven to curtail their commitments. At some point, the problems simply become too pressing to postpone.

What should be the proper role for employers in this retiree health care puzzle? G. Lawrence Atkins, Director of Health Legislative Affairs in the law firm of Winthrop, Stimson, Putnam & Roberts, suggests in Chapter Five that many companies that currently provide these benefits in fact stumbled into offering them, having thought of them in the past as merely an extension of active-worker benefits. Supporting his point is the evidence that these benefits were relatively inexpensive, at least at the outset. Now that retirees are more numerous, and because the benefit cannot be prefunded in a tax-favored vehicle, the benefit payments have become a burden on current workers and shareholders alike. Atkins notes that the extent of the burden depends on the employer's current and retired workforce, as well as on the extent of benefits promised. No matter what else applies, as Atkins points out, redistribution of these obligations will be controversial. Still, he feels that employee obligations for retiree health benefits should be limited to coverage for early retirement benefits, because this allows companies to induce early retirement if necessary. Atkins also argues that employer responsibility for health benefits for retirees aged 65 and over should be phased out, and, over time, more responsibility for the benefit should be shifted to elderly consumers of health services.

In his commentary, Donald Snyder, Assistant Director of the U.S. General Accounting Office's Human Resources Division, critiques Atkins' stance by arguing that Medicare benefits are inadequate and insecure. Although Atkins believes that the beneficiaries themselves should be re-

quired to undertake a larger share of the overall burden of financing their own benefits, Snyder does not agree. Others take a different tack. For instance, Mark Pauly suggests that the thrust of Medicare should be redirected, moving away from its current emphasis on inpatient care and "caps" on coverage toward a catastrophic coverage program that does not distinguish between different categories of medical expense. It should be noted that even if Medicare promises were revamped, retirees will probably remain insecure about the value of the health care promise. Funding cuts in both Medicare and Medicaid have been experienced in recent years, and many costs have been shifted to private payers over time.

The financing issues in health benefit reform are taken up by Sylvester Schieber, Vice President of The Wyatt Company and Director of its Research and Information Center. His Chapter Eight suggests that governments and employers have reached their "practical limit" of what they can pay for health care, to borrow Antos' terminology. Several reform options are discussed, and Schieber concludes that there are no "magic bullets." In particular, current proposals to simplify health care delivery and to reform malpractice insurance will not fix major problems in the current system, nor will they generate needed revenues to fund expanded insurance coverage. Schieber concludes that the underlying incentives that face health service providers today must be changed.

One popular policy approach to changing health care system incentives involves "managed competition." This option is reviewed favorably by William Greer, Markey Clinical Scholar at the University of Pennsylvania School of Medicine, and Alan Hillman, Associate Professor of Medicine and Health Care Systems and Director of the Leonard Davis Institute's Center for Health Policy. In Chapter Seven, they state that moving the elderly into a basic benefit package anticipated under health system reform would provide better care and more comprehensive benefits than now available under Medicare. They also caution that creating a cost-conscious system will alter the philosophy of medical delivery decisions drastically. Their warning is that the elderly will be at particular risk of reduced care because they consume most of the public health care budget. Greer and Hillman suggest that any health care reform proposal will need to consider the elderly's special health care needs. Their point illustrates the two sides of this coin: moving retirees into purchasing co-operatives could drive up the cost of coverage to everyone if premiums are not age linked, whereas coverage could become expensive for the elderly if premiums are linked to age.

A commentary on the Greer and Hillman chapter is offered by John Rother, Director of Legislation and Public Policy Division for the American Association of Retired Persons. He concurs that Medicare must be overhauled but does not believe that rationing is required. Instead, Rother

supports the extension of managed competition techniques to the Medicare program, "coupled with vigilant external review of the quality of care provided and rigorous enforcement." A labor union perspective is explored by Peggy Connerton, Chief Economist and Director of Public Policy at the Service Employees International Union, AFL-CIO, and by Peter Nixon, a policy analyst with the same organization. In their commentary to Chapter Seven, they express skepticism about managed competition proposals, particularly as they refer to retirees. The authors note that when the Medicare program moved toward a Health Maintenance Organization (HMO) mode, hospital utilization rates fell but overall costs did not, suggesting that competition and budget-capping may not reduce medical expenditures as much as expected. Also, retirees do have substantially different needs and find it more difficult to obtain private insurance, compared to the younger population.

Some policymakers already advocate the extension of a drug benefit and long-term care to the elderly under Medicare, as Pauly notes. If the national health insurance reform bill that emerges does offer benefits to the entire non-Medicare population, and if they receive significantly more generous benefits than those granted to the Medicare population, then it is likely that the elderly also will seek this extended coverage. Undoubtedly, questions will be raised about the cost of including the elderly under a comprehensive national benefit package and the consequences of doing so.

At issue here are the practical limits that society is willing to place on health care expenditures and the philosophical premise that every American has a "right" to a wide range of health care services. In Chapter Eight, Schieber concludes that the "hope that all Americans are willing to pay for every possible health service or product that the current system might devise and make that service or product available to anyone who might want it is not viable in the current economic situation."

A unique perspective on this theme is offered by John Burns, Vice President for Health Management at Honeywell and a medical doctor as well. In his commentary to Schieber's chapter, Burns indicates that the United States has failed to address "the issue of the necessity and appropriateness of care," and that until unnecessary and unwanted care is eliminated, the "conflict between cultural values and limited resources is a perception, not a reality." In contrast is the assessment of David Asch, Assistant Professor of Medicine, the University of Pennsylvania. In his view, the conflict between individual needs and social goals cannot be resolved. Accepting that practical limits to health care budgets exist at the "global level" ultimately means saying "No" at the micro level, and Asch concludes that "we need to say "No" a bit more often in the provision of medical care. We need to say it to our physicians, and our physi-

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cians need to say it to their patients. If we learn, finally, how to say “No,” then the elderly are going to hear that word more often than other segments of the population.”

Conclusion

An underlying tension marks the chapters and many of the commentaries found here. On the one hand, many authors are deeply concerned about the elderly population's particular risk of health problems and its precarious position as health reform proposals unfold. On the other hand, all participants recognize the vulnerability of the economic and political institutions that must meet the needs of taxpayers, both the young and the elderly. Inevitably, these issues must be confronted in the political arena. The collection of papers and commentaries in this volume highlights many of the special health insurance problems that face the elderly and offers some solutions that the reform process might consider.

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