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Chapter 4
Adequacy of Employer-Sponsored Retiree Health Benefit Programs

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Employer-sponsored retiree health benefits have undergone significant changes in the past ten years and have become a leading source of concern for employers. In fact, the future of health care coverage for retired employees has been threatened by many financial, demographic, medical, and legislative developments. These include the astronomical rise in the cost of medical services, recognition of the costs and liability for retiree health care, as required by Financial Accounting Standard 106 (FAS 106), increasing frequency of early retirements, and retirees who are living longer than before.

As a group, retirees usually have a greater number of health problems and, consequently, typically use more medical, hospital, and prescription drug benefits than active employees. Hence, it is far more expensive to provide health benefits for retirees than to provide health benefits for active employees. Furthermore, during the last decade, employers have seen a decline in Medicare and Medicaid reimbursement of hospital, medical, and surgical providers, a burgeoning of Medicare Secondary Payer provisions, the enactment of the Consolidated Omnibus Budget Reconciliation Act (COBRA), continuation coverage requirement and the repeal of the Medicare Catastrophic Care Act, all of which contribute to an increase in the health care costs borne by employer-sponsored plans.

This chapter examines employer-sponsored retiree health benefits in terms of the scope of coverage and the level of benefits provided, the continual growth in the cost of coverage, how employers are dealing with the health care cost dilemma, and the prospect of continued retiree health coverage in the future. In attempting to measure whether employer-sponsored retiree health benefit programs are adequate, it is important to recognize that no absolute or numerical standard exists for evaluation

purposes. Instead, adequacy should be considered in terms of the employee's total retirement benefit package, in addition to the coverage provided, the design of the plan, and the level of contribution from the employer.

The chapter also examines the levels of affordability of retiree health benefits according to varying amounts of retiree contributions. The cost of retiree health benefits for employers, the recognition of these costs, and their effects on the employers' decision-making process in offering benefits also are discussed. Finally, employer retiree health plan design changes and trends are reviewed throughout the chapter.

Environment for Retiree Health

People in the United States generally obtain health care coverage through employers, a government-sponsored program, or a plan purchased directly from a health insurance company. Employer-sponsored health care coverage for active employees became a standard fringe benefit in the United States during the early 1950s, when the economy was bouncing back after World War II. Health care benefits for retirees evolved, however, as more of an afterthought to pension benefits and were considered, for the most part, as a goodwill gesture and an inexpensive addition to the total retirement package. In 1974, when the Employee Retirement Income Security Act (ERISA) was enacted, significant restrictions were placed on an employer's ability to take away previously promised pension benefits; however, no similar restrictions were imposed on health benefit promises. Recently, however, the astronomical rise in health care costs and the lack of access to and affordability of nonemployer-sponsored, individual health care coverage for employees younger than age 65 have made the continuation of health benefits for retirees as essential as pension benefits.

Employers originally provided health plans to retirees to ease the transition from employment to retirement. Eligibility for a majority of the plans established during the 1950s and 1960s generally was based on pension plan eligibility, regardless of the retiree's age or years of service. The benefit levels of most plans usually were continuations of the active employee plans. Upon Medicare eligibility, employers, for the most part, continued to cover whatever Medicare did not. Many employers paid the full cost of retiree health coverage because of the reasonable cost of benefits at the time and the difficulty in collecting premiums from retirees. In addition, many of these plans had first-dollar coverage for hospital and surgical services with little or no retiree/dependent cost-sharing requirements. Changes in workplace demographics, rising health care costs, government-sponsored health programs, and new financial accounting

standards for retiree health liabilities have permanently changed the nature of employer-sponsored retiree health care coverage for retirees of the future.

Demographic and Labor Force Context

The population in the United States is getting older; the near-elderly, that is those persons aged 55 to 64, represented approximately 9 percent of the total population in 1990. By 2020, this group is projected to expand to 14 percent of the total population. Those persons over the age of 65 represented 9.2 percent of the American population in 1990 and are expected to account for almost 24 percent of the population by 2030, as the baby boomers age (U.S. Dept. of Commerce,1992).

According to recent data from the U.S. Department of Labor (DOL), the labor force participation rate for males aged 55 to 64 has decreased from 89.5 percent in 1948 to 66.9 percent in 1991 (DOL 1992). Data for the past eight years indicate that the participation rates for this group have leveled off at approximately 67 percent. In addition, the Bureau of the Census estimates that by the year 2000 nearly 35 million people in the United States will be 65 years of age or older, an increase of 12 percent from 31.2 million in 1980 (U.S. Dept. of Commerce 1989). The ratio of elderly to working age persons (aged 18-64) will increase from 1 to 5 in 1985 to 1 to 3 in 2025, hence fewer workers will be supporting a larger number of retirees (EBRI 1992). Both non-Medicare- and Medicare-eligible retiree populations are increasing in numbers and as a percentage of those age groups.

In addition to these projected increases in the total numbers of retired persons over the next decade, retirees also are living longer today and will require some form of basic or supplemental health benefits (before and after Medicare eligibility) for an even longer time than two or more decades ago. For example, in 1960, male life expectancy in the United States at age 60 was 15.8 years, whereas, in 1990, it was 18.6 years. Female life expectancy at age 60 in 1960 was 19.5 years, whereas, in 1990, it was 22.7 years (OECD 1992). Data also indicate that older persons are living longer and are sicker in these later years (Crimmins 1991). Hence, the demand for and use of health services are rising in direct proportion to the decreased mortality rates for the elderly.

Furthermore, the ratio of active to retired employees in 1965 was 15 to 1, whereas the ratio today for many companies/industries is approximately 3 to 4 employees for each eligible retiree. In fact, the current ratio for some older industrialized companies is closer to three retirees for every active employee. Several factors contribute to the changing balance in

many companies in the numbers of active to retired employees. These include

- Demographic shifts;
- Growth of retirement plans—making retirement affordable;
- Downsizing of older, well-established companies—with retirees being;
- survivors of workforces that once were much larger;
- Growing popularity of early retirement windows—these provide incentives for certain employees to retire earlier rather than later.

Because demographic trends, downsizing, and early retirement windows are likely to continue throughout the 1990s and beyond, the active-to-retired employee ratio is not likely to improve. As the so-called "baby boomers" age, demographics will become an increasingly more important factor.

Scope of Coverage Provided

Large, mature employers, such as utilities, the mining industry, construction, manufacturing, the energy/petroleum industry, banks, and insurance companies, tend to sponsor retiree health coverage. The relatively young age of other employers, such as retailers, colleges, and universities, seems to determine whether retiree health coverage is provided. Employers with unionized workforces are also more likely to provide retiree health coverage than nonunionized companies. In addition, health coverage for retirees is common among public employers. Coverage is much less common, however, in the health care industry and among middle-sized employers, and it is rare among small employers.

Although only an estimated 4 percent of all companies in the United States provide retiree health coverage, about one third of all private sector employees work for companies that cover retirees in their health plans, according to recent estimates from the U.S. General Accounting Office (GAO 1991). Among retirees who receive health benefits from a past employer, 62 percent had worked in companies with more than 1000 employees, and 76 percent had worked in companies with more than 100 employees (see Table 4.1) (EBRI 1991).

According to GAO estimates, approximately 32 million people are currently enrolled in employer-sponsored plans that provide health benefits for retirees. The most recent data indicate that in 1989, of the 23.7 million retirees, more than 9 million had retiree medical coverage through an employer-sponsored plan (GAO 1991). Within this group, an estimated 3 million retirees were under age 65. Health benefits are espe-

cially important to the early retiree because most of them are not yet eligible for Medicare benefits.

TABLE 4.1 Retirees Receiving Health Coverage from Employers, by Firm Size and Industry: August 1988[a]

Firm Size and Industry	*Covered by Own Employer Plan*
Total (thousands)	10,358
Firm Size	
< 20	3.7%
20 - 99	5.8
100 - 249	5.1
250 - 499	4.3
500 - 999	4.8
1000 or more	61.8
Do not know/no response	14.5
Industry	
Private	54.1
Government	
Federal	16.4
State and local	19.4
Self-employed	1.3
Unemployed	*
Do not know/no response	8.7

*Less than 0.5% of total

[a]*Source:* Employee Benefit Research Institute tabulations of the August 1988 Current Population Survey. This universe consists of all persons aged 40 and over in the U.S. civilian noninstitutionalized population living in households.

Early Retirees

Early retirees (aged 55 to 64) who receive private pension and/or Social Security income are more likely to have employer-sponsored health insurance (52.9 percent) than those who do not (36.8 percent) (U.S. Dept. of Commerce 1986). Among early retirees, there is a decrease in health coverage provided by former employers, from 70.2 percent before retirement to 54.2 percent after retirement (Rogowski and Karoly 1992). This drop tends to be larger for retirees aged 62 to 64 than for those aged 55 to 61, perhaps because of the increasing number of early retirement packages offered today that usually include a promise of continued health coverage and the reluctance of those employees without coverage to retire at early ages.

Post-65 Retirees

For retirees over the age of 65, insurance patterns differ considerably from the under 65 age group, because Medicare eligibility begins at age 65. Most retirees over the age of 65 have Medicare coverage, although only 15 percent of retirees have coverage solely through Medicare, and the remainder (84 percent) have a plan that supplements Medicare (Rogowski and Karoly 1992). Of the 84 percent of Medicare-eligible people with more than one source of coverage, approximately 41.4 percent have purchased private coverage; 33.6 percent have coverage through an employer; 5 percent have coverage through a spouse's employer; and 3.8 percent are entitled to Medicaid (Rogowski and Karoly 1992). A small number of post-65 retirees (0.8 percent) who are not eligible for Medicare only have employment-related coverage (Rogowski and Karoly 1992). In the United States, fewer than 1 percent of retirees over the age of 65 have no health coverage at all.

Uninsured Retirees

The probability of becoming uninsured after retirement is generally related to the type of insurance coverage a person has before retirement. Approximately 5.4 percent of retirees become uninsured shortly after they retire (Rogowski and Karoly 1992). Early retirees who have private insurance (not employer-sponsored) before they retire are the most likely to become uninsured. Even with COBRA continuation coverage availability, some early retirees do not continue their employer-based coverage when they retire. This may be related to the high cost of purchasing health insurance coverage, whether private or employer-sponsored, on a retirement income. Those persons who have insurance coverage through their spouse before they retire are the least likely to become uninsured.

Coverage Trends

Although millions of workers and retirees today have or are eligible for employer-sponsored retiree health benefits, the employer's role in providing these benefits is changing. As a result of the FAS 106 liability, the increasing numbers of retirees, and the escalating cost of retiree health care, many employers either are reducing or terminating retiree health benefits. The Employee Benefit Research Institute (EBRI) reported in August 1992 that the percentage of employees under age 65 eligible for wholly employer-financed retiree coverage fell from 53 percent in 1988 to 45 percent in 1989 (EBRI #128 1992). Furthermore, the number of companies that provide retiree health benefits continues to slip, falling below half to 49 percent in 1992 from 54 percent in 1990. The GAO

found that wholly employer-financed coverage for those aged 65 and over fell from 55 percent to 47 percent between 1990 and 1992 (GAO 1991).

Although the most severe employer reaction to the high cost of covering retirees, as well as the FAS 106 liability, is simply to terminate health benefits for future retirees, a 1992 survey of 2000 employers by William M. Mercer, Incorporated showed that only 2 percent of both large and small employers actually plan to cancel retiree health care benefits altogether (William M. Mercer Companies, Inc. 1992). The Mercer study also found that only 7 percent of the large employers and 5 percent of the small employers surveyed plan to cancel these benefits for future retirees.

Workers who already have retired are far better able in most cases to maintain benefits than soon-to-retire or younger workers. Most employers are hesitant to alter the benefits given current retirees but ask active employees to shoulder more of the rising cost of health care for both active and retired persons. Concerns about litigation are a key factor in the reluctance to change coverage for existing retirees. Legal developments during 1992 and 1993 have indicated more willingness on the part of employers and employees to take aggressive positions in this regard. (Specific examples are discussed later in this chapter.) In general, however, the analysis shows significant gaps in coverage. The current system seems to be failing in its efforts to serve substantial segments of the retired population.

Levels of Benefits Provided

A retiree medical plan can be viewed as having two components—the structure and design of the medical benefits payable and the eligibility pattern and method of costsharing. The structure and design of the medical benefits often follow the employer's health plan for active employees, at least for those retirees not yet eligible for Medicare. The eligibility pattern and method of costsharing usually follow the structure of the pension plan. In contemplating issues that relate to retiree health, the former is viewed primarily as "health-benefit-related" and the second as "retirement-benefit-related". The section that follows discusses the structure of retiree health benefits and their costs relative to levels of pension benefits.

Before Medicare Eligibility

Benefits for pre-Medicare eligibles typically follow the same plan as the active employee medical plan, but they have retiree contributions that are considerably higher than the employee contributions required of ac-

tive employees. The U.S. Department of Labor's survey, "Employee Benefits in Medium and Large Firms, 1989" indicates that 79 percent of retirees under age 65 have no change in coverage at retirement and before age 65, and 72 percent have no change after age 65 (DOL 1990). This survey covers employers that have over 100 employees.

Retiree medical plans often differ from the medical plan for active employees in the way that costs are shared between the employer and the employee. Cost sharing includes contributions, deductibles, and copayments. Many companies have increased their cost sharing for retirees in the last few years.

In addition, the DOL survey of benefits in medium and large firms showed the following cost sharing features for retirees enrolled in health plans for 1989 (DOL 1990):

- 97 percent of participants were in plans with coinsurance;
- 83 percent of participants were in plans with an out-of-pocket limit;
- 80 percent of participants were in plans with annual deductibles.

Individual out-of-pocket limits for retirees were as follows:

Under $500	13 percent
$500 - $749	12 percent
$750 - $999	12 percent
$1000 - $1249	25 percent
$1250 and up	22 percent
No limit	16 percent

A typical indemnity plan today may pay 70 to 75 percent of eligible charges for an average claimant.

After Medicare Eligibility

Several different employer-sponsored benefit plans are available that coordinate with Medicare, and there are three common methods of Medicare "integration." These methods include a carve-out, an exclusion, and a traditional coordination plan. Under a carve-out plan, the retiree gets the same benefit from the plan and Medicare (in total) as would have been paid before Medicare eligibility. Under an exclusion plan, the benefits paid by Medicare are excluded, and the plan formula is applied to the balance of the charges. Under a traditional coordination of benefits provision, the benefits are determined as if there is no Medicare, but the total payments from the plan and Medicare generally are limited to 100 percent of the total charges.

TABLE 4.2 Retiree Health Insurance Costs Compared to Pension Benefits: Benefit if 1.25% of Final Average Earnings per Year of Service[a]

	Period of Service				
Pay Level	*10*	*15*	*20*	*30*	*35*
	Annual Benefit at Age 65 Based on Formula				
$ 20,000	$ 2500	$ 3750	$ 5000	$ 7500	$ 8750
40,000	5000	7500	10,000	15,000	17,500
60,000	7500	11,250	15,000	22,500	26,250
80,000	10,000	15,000	20,000	30,000	35,000
100,000	12,500	18,750	25,000	37,500	43,750
	Annual Benefit at Age 55 Assuming 50% Reduction				
$ 20,000	$ 1250	$ 1875	$ 2500	$ 3750	$ 4375
40,000	2500	3750	5000	7500	8750
60,000	3750	5625	7500	11,250	13,125
80,000	5000	7500	10,000	15,000	17,500
100,000	6250	9375	12,500	18,750	21,875

[a]*Source:* Authors' calculation.

TABLE 4.3 Value of Retiree Health Insurance: Assume Couple Covered[a]

Pre-65 in 1992	$8000
Post-65	$2000
Rate of Annual Increase	10%

	Health Benefit as a Percentage of Pension				
	Period of Service				
Pay Level	*10*	*15*	*20*	*30*	*35*
	Benefit at Age 65 in 1992				
$ 20,000	80%	53%	40%	27%	23%
40,000	40	27	20	13	11
60,000	27	18	13	9	8
80,000	20	13	10	7	6
100,000	16	11	8	5	5
	Benefit at Age 55 in 1992				
$ 20,000	640%	427%	320%	213%	183%
40,000	320	213	160	107	91
60,000	213	142	107	71	61
80,000	160	107	80	53	46
100,000	128	85	64	43	37

[a]*Source:* Authors' calculation.

TABLE 4.4 Value of Retiree Health Insurance: Assume Retiree Pays for 50% of Health Benefit Contribution as Percentage of Pension[a]

	Period of Service				
Pay Level	*10*	*15*	*20*	*30*	*35*
	Benefit at Age 65 in 1992				
$ 20,000	40%	27%	20%	13%	11%
40,000	20	13	10	7	6
60,000	13	9	7	4	4
80,000	10	7	5	3	3
100,000	8	5	4	3	2
	Benefit at Age 55 in 1992				
$ 20,000	320%	213%	160%	107%	91%
40,000	160	107	80	53	46
60,000	107	71	53	36	30
80,000	80	53	40	27	23
100,000	64	43	32	21	18

[a] *Source:* Authors' calculation.

TABLE 4.5 Value of Retiree Health Insurance Benefit as a Percentage of Pension Benefit[a]

	Period of Service				
Pay Level	*10*	*15*	*20*	*30*	*35*
	Benefit at Age 65 in 1997				
$ 20,000	129%	86%	64%	43%	37%
40,000	64	43	32	21	18
60,000	43	29	21	14	12
80,000	32	21	16	11	9
100,000	26	17	13	9	7
	Benefit at Age 55 in 1997				
$ 20,000	1031%	687%	515%	344%	294%
40,000	515	344	258	172	147
60,000	344	229	172	115	98
80,000	258	172	129	86	74
100,000	206	137	103	69	59

[a] *Source:* Authors' calculation.

TABLE 4.6 Value of Retiree Health Insurance: Assume Retiree Pays for 50% of Health Benefit Contribution as Percentage of Pension[a]

	Period of Service				
Pay Level	*10*	*15*	*20*	*30*	*35*
	Benefit at Age 65 in 1992				
$ 20,000	64%	43%	32%	21%	18%
40,000	32	21	16	11	9
60,000	21	14	11	7	6
80,000	16	11	8	5	5
100,000	13	9	6	4	4
	Benefit at Age 55 in 1992				
$ 20,000	515%	344%	258%	172%	147%
40,000	258	172	129	86	74
60,000	172	115	86	57	49
80,000	129	86	64	43	37
100,000	103	69	52	34	29

[a]*Source:* Authors' calculation.

Another plan is the Medicare supplement. Under this design, the benefits are scheduled and designated to fill in for expenses not covered by Medicare. Federal law regulates Medicare supplemental (also called *Medigap*) insurance plans sold on an individual and group basis (plans not sponsored by employers). Medigap insurance plans must fit one of ten defined benefit plans established by federal law.

Relationship to Pension Benefit Levels

Pension benefits are calculated and compared to retiree health benefit values in Tables 4.2 - 4.6, which help determine whether retiree health benefits, if heavily paid for by the retiree, are affordable. For this analysis, a final average pay plan with a benefit equal to 1.25 percent of final average earnings has been assumed. This is a fairly generous plan, but not the most generous offered. The DOL study of employee benefits in medium and large firms shows replacement ratios from the private plan only as follows:

Years	*Sample Plan: Percent of Final Average Earnings*	*Average Replacement Ratios 1989 DOL Study, Percent of Final Pay*
10	12.50%	9.8%- 12.1%
15	18.75%	14.8%- 17.6%
20	25.00%	19.8%- 23.4%
30	37.50%	33.3%- 39.5%

Source: U.S. Department of Labor (1990), Table 85.

The DOL results vary by pay level. The range is shown for the data for all participants. The results also vary by type of employee. These replacement ratios are comparable to that for the sample plan shown in Tables 4.2 - 4.6. The sample plan results should be reduced by about 6 percent to be percentages of final pay. For example, 12.5 percent of final average earnings is equal to about 11.8 percent of final earnings. For purposes of this analysis, the 1.25 percent plan is a good representation of the average for employees in medium and large firms, as reflected in the 1989 survey.

For the sample plan, benefits are shown at age 65 and at age 55, assuming that at age 55, a 50 percent reduction in the pension occurs to reflect the fact that benefits will be paid for ten years longer than they would have been had they started at age 65. Benefits are shown for five different pay levels and several service periods and do not include Social Security. At age 55, under this plan, an employee with 30 years service would have income replacement of under 20 percent of final average earnings, so that the cash income does not support retirement even with a drastic reduction in living standard. People who retire at age 55 must have other income sources and assets or accept a drastic reduction in living standard.

Retiree health was assumed to be worth $8000 in 1992 for a couple both under age 65, and $2000 in 1992 for a couple both over age 65. Medicare reflects the difference. Costs are assumed to increase 10 percent per year, considerably more than recent Consumer Price Index (CPI) increases and considerably less than medical costs increases under many current medical plans. Pensions are assumed to be level dollar amounts, but some employers will offer ad-hoc increases.

The value of retiree health is compared to the pension in 1992 and 1997 in Table 4.6, and contributions are calculated as a percentage of the pension benefit if the retiree is required to pay 50 percent of the value of the retiree health benefit (considerably more than the contributions required in most plans today). At the 50-percent contribution level, the benefit is clearly not affordable at age 55, except for longer service and higher pay levels. Retirement would be feasible only if other substantial assets existed, or if the retiree or some other family member has current earnings and/or employment that provides benefits. Retirement may still require a major change in lifestyle.

Significant contributions to retiree health will make retirement at earlier ages considerably more difficult for most retirees. Pension benefit levels for hourly employees generally are lower and the situation will be considerably worse. The impact of significant retiree health contributions for early retiree medical is likely to be postponement of retirement to age 65 in many cases, and to at least age 60-62 in other cases.

Employers Without Plans

Considering all the costs and liabilities associated with retiree health, it might seem that companies not offering such plans would be happy. The situation, however, is more complex. In fact, many such companies are wondering what to do, because the absence of plans is a major barrier to early retirement. Some companies are finding that employees cannot afford to retire without access to coverage (particularly those aged under 65 years), and although they would prefer not to provide coverage, they are concerned about the impact on their business of having employees unable to retire. It is unclear at this point what strategies might be adopted on a widespread basis.

Trends in Plan Design

A retiree health plan can be thought of as a medical plan and a retirement benefit. Until the last five years, virtually all the attention paid to these benefits was on the medical benefit itself, but more recently an equal, if not greater, focus has been on the retirement-related issues of cost sharing, how benefits are earned over time, and who gets them.

TABLE 4.7 Results of Mercer Survey: Popularity of Approaches to Manage Retiree Health Benefit Costs[a]

Action	*For Existing Retirees*	*For Future Retirees*	*For Both Groups*	*Total*
Raised retiree contributions	5%	18%	25%	48%
Increased deductible or copay	5	12	27	44
Used managed care techniques	3	6	29	38
Tightened eligibility	1	19	9	29
Capped employer contributions	2	11	10	23
Changed Medicare integration	2	4	13	19
Used a defined dollar approach	-	8	5	13
Canceled benefits	-	9	3	12
Reduced lifetime benefit cap	1	2	4	7

[a]Survey findings demonstrate that the most popular way of managing retiree medical liabilities is to increase the portion of costs borne by retirees. Almost half (48%) the 780 respondents have raised retiree contributions and about the same number (44%) have implemented a higher deductible or copayment in their plans. The least popular cost-management approach was to reduce the lifetime limit on benefits payable under the plan —only 7% said they had done so. Although only 12% said they had canceled benefits for either existing or future retirees, the prevalence of this approach increased from 1991, when only 1% of 902 respondents said they had stopped providing retiree medical benefits.

Various surveys have shown that employers have reduced coverage for retiree benefit plans. A 1992 Mercer survey indicates the nature of some of these reductions (see Table 4.7). In general, the survey found that

- Until 1992, reductions in benefits were most often for future retirees;
- A few employers have dropped coverage entirely;
- Many employers have adopted programs that might be called "holding actions." Adoption of a "cap," or maximum, on what the plan will pay for a retiree's coverage is common.

Cost and Cost Recognition of Employer-Provided Retiree Health Benefits

Basis for Cost Recognition

Costs are accounted for in profit and loss statements according to accounting rules published by the Financial Accounting Standards Board (FASB). FAS 106, effective for most employers' 1993 fiscal year, requires that a change in accounting be made for other post-retirement employee benefits (OPEB) from the pay-as-you-go (cash basis) method to the accrual method, to reflect the liability of the benefit earned. As a result, employers now are required to accrue post-retirement benefit obligations as an expense from the time an employee is hired until benefit eligibility. Post-retirement benefits are typically health care plans, life insurance, and, sometimes, long-term care benefits. Furthermore, FASB permitted employers to adopt one of two transition methods to recognize their FAS 106 obligation. Employers either could recognize their accumulated liabilities immediately on a one-time basis in 1993, or they could amortize the cost attributed to past periods over a maximum 20-year period.

Effects of FAS 106 on Employer Profits

Although FAS 106 does not increase an employer's long-term cost of providing post-retirement benefits or require that funds be set aside to pay for future benefits, it does require employers to account for the cost much earlier. This change will reduce reported net operating income and earnings per share for employers. Some forecasters suggest that the new accounting method could reduce the pre-tax profits and net worth of large American employers by about 10 percent.

Much larger estimates of the effect of FAS 106 on employer earnings and net worth have been reported. For example, Wein (1992) reports that FAS 106 will have an earnings impact in 1993 of about $1.00 per share for the Standard & Poors 500 companies. That report also identifies a number of other companies for which an even greater impact is predicted.

A major accounting firm surveyed annual report disclosures of 64 public

companies that adopted FAS 106 early (before 1993) (Ernst and Young 1992). For these companies, FAS 106 (or OPEB) costs varied from less than 1 percent to nearly 5 percent of revenues. For companies that recognize the obligation immediately, the effect on pre-tax income and net worth was, on average, reduced by 28 percent and 8 percent, respectively.

Present Value of Liability

According to estimates by the GAO, the present value of private employers' liabilities for current post-retirement benefits, as of 1991, was approximately $296 billion (GAO 1991). It is this amount that employers will be required to recognize in their financial statements with the adoption of FAS 106. About $93 billion of this amount is owed for current retirees and covered dependents, and an estimated $203 billion is the accrued liability for current employees and covered dependents, according to the GAO. To begin prefunding this accrued liability, companies would have had to contribute an estimated $42 billion in 1991—about four times their pay-as-you-go costs. Estimates of the total employer accrued liability for retired workers' health benefits vary from $300 to $400 billion (EBRI 1991).

The total toll on American corporate profits is expected to be a record for any accounting rule, with the liability as high as $1 trillion (Berton and Brennan 1992). Hardest hit will be businesses that are unionized, labor-intensive, low in employee turnover, and high in the ratio of retirees to active employees. For example, the Big 3 American automobile makers spent on average $1086 per vehicle in 1990 for health care coverage compared to $475 for Japanese automobile manufacturers who build cars in the United States. American car makers have complained for many years that their high health care costs have affected their ability to compete on an international basis. Ford, General Motors (GM), and Chrysler also cite the fact that their foreign competitors all have some form of national health coverage.

In February 1993, GM announced that it was taking a one-time $21 billion charge for FAS 106 and an annual charge of $1.4 billion a year on an indefinite basis to account for future unfunded post-retirement medical liabilities. Other companies with older workers and generous health plans, like Ford Motors, AT&T, and IBM, have also announced liabilities for post-retirement medical benefits in the billions of dollars.

Financial Impact

Many studies have attempted to measure the financial impact of implementing FAS106 on employer plans. A William M. Mercer, Incorporated

survey (1992) of recent retiree health valuations shows that employer costs will increase by the following multiples when FAS 106 is adopted:

- For highly mature companies (those with fewer than two active employees per retiree), 3.5 times;
- For mature companies (those with two to six active employees per retiree), 7.0 times;
- For less mature companies (those with more than six active employees per retiree), 13.5 times.

This study also showed the average cost per active employee in 179 actuarial valuations performed by William M. Mercer consultants:

Pay-as-you-go cost	$528
EPBO	$24,785
APBO	$11,927
Expense	$2097

The pay-as-you-go cost is the amount needed to pay benefits to current retirees, or, if the plan is insured, the premium costs needed to cover current retirees for one year. The EPBO (expected post-retirement benefit obligation) is the present value (including discount for interest, terminations in employment, and so forth) of lifetime retiree health benefits per employee determined at the time of the valuation. Hence, if an employer had exactly average results and wants to set aside enough money today to cover these benefits for the existing workforce, approximately $25,000 would be needed for each employee. The APBO (accumulated post-retirement benefit obligation) is the portion of the EPBO attributable to past periods by the cost-spreading method prescribed in the accounting rules set forth in FAS 106.

Finally, the expense is the amount that will be booked on average, assuming that employers spread out (or amortize) the amounts charged to past periods. Many employers have chosen not to amortize this amount because future earnings will be greater if the amount is recognized in a single year. In that situation, the annual average expense is reduced to $1495 per active employee. For an employer with a $30,000 average pay amount, the expense is 7 percent of pay if there is amortization of APBO, and 5 percent of pay if the APBO is recognized immediately rather than amortized.

Cost Information

Most current post-retirement cost data are based on estimates from surveys conducted by employee benefit, accounting, and actuarial consult-

ing firms and the GAO. Most employers have focused their attention on their health benefit plan expenses because they represent the largest post-retirement expense. In particular, employers are reviewing the actuarial assumptions regarding health care cost projections, levels of participation in the retiree plan, health service utilization rates, age at retirement, mortality rates, employee turnover rates, and rates of marriage.

Much of the more recent retiree health plan data are incomplete due to a number of employer health plan reporting inconsistencies. Some of these inconsistencies include a failure to differentiate retiree health plan cost data from active plan data and a widespread lack of separate pre-65 retiree versus post-65 retiree information. In some cases, it has been difficult determining the actual numbers of retirees and covered dependents in the plan and their related claims cost and utilization information.

For example, a 1992 study of 226 Fortune 500 companies found that only 99 of the surveyed firms reported cost information on post-retirement benefits, and this data combined health care benefits with life insurance benefits (Tang and Langsam 1992). The total 1990 post-retirement benefit cost for these firms was $4.23 billion. The top eight employers with the largest post-retirement costs in 1990, according to the study, were

General Motors	$1200 million
Ford	$ 582 million
Chrysler	$ 266 million
Textron	$ 236 million
DuPont	$ 216 million
Honeywell	$ 158 million
Rockwell International	$ 142 million
Navistar	$ 123 million

When attempting to determine the cost per retiree receiving health benefits, this study found that data on the specific numbers of retirees, for the most part, have not been available in annual financial reports. Instead, the study calculated the 1990 cost of post-retirement benefits per active employee and found that the costs vary widely by employer. Navistar had the highest post-retirement cost per active employee at $8742. Navistar, which had more than 40,000 retirees as of 1990, reduced its active employee population from 96,000 in the 1980s to 14,000 workers by 1992. In July 1992, the Chicago-based truckmaker asked a federal district court for permission to cut health benefits by $90 million for current retirees, including those represented by the United Auto Workers (UAW).

The UAW challenged Navistar's right to adopt certain retiree health benefits outside the collective bargaining process. Navistar and the UAW

announced an agreement in late December 1992 that included an increase in retiree contributions, deductibles, and copayments. In addition, Navistar reportedly agreed to issue at least 255 million new shares of common stock to be held in a newly formed trust for future retiree health benefits. In April 1993, a federal judge gave preliminary approval to their proposed settlement to modify Navistar retiree's health benefits. Final approval of the plan is expected to be granted after further court hearings.

Employer Payments for Retiree Health Coverage

The GAO estimates that private employers paid $9 billion for health care benefits for retirees and their dependents in 1988 and that costs have increased an average of more than 20 percent a year since then. The GAO also reports that, in general, employers that offer coverage to their retirees have higher total health care costs. A survey of medium- and large-sized employers found that the provision of retiree health benefits represented 14 percent of total employer health benefit plan costs (GAO 1992). In the communications and utilities industries (employers that traditionally tend to have rich benefit plans), retiree health expenses represent over 20 percent of total health costs each year. In contrast, health services or technical/professional service firms (employers that have less generous benefit plans) report that retiree health costs consume 6 percent of overall health care costs.

In terms of employers' total payroll costs, one benefits consulting firm estimates that after FAS 106 is fully implemented, the median annual health expense for retirees, as reported on profit and loss statements, will increase from the current 1.1 percent of payroll to approximately 6.25 percent (Hewitt Associates 1990).

Employer Cost Variation

Not surprisingly, many surveys have indicated that retiree health care costs vary by employer. For example, 11 percent of employers surveyed in 1990 reported that health care costs per retiree were under $1000 whereas 16 percent noted costs in excess of $3000 per retiree (Foster Higgins 1991).

Variation among employers for retiree health care costs occurs for many reasons: the benefit plan design; the number of employees expected to reach retirement age; the age of retirees and their dependents; the number of retirees under the age of 65; and the size and geographic location of the employer.

As expected, employers that offer a generous health benefit plan to

retirees tend to have the largest retiree health costs. This is certainly the case among the medium- to large-sized employers with collectively bargained workers. Historically, they have been known to offer very generous health benefits to salaried and hourly employees alike. Many of these plans have similar deductibles and coinsurance levels for early retirees and for active employees. Employers that do not implement an increase in required costsharing or a reduction in benefits, especially for the under age-65 group, are likely to experience substantial health care cost increases yearly for their covered retiree population.

In addition, the number of employees expected to reach retirement age greatly affects the level of an employer's retiree health costs. For example, manufacturing firms have twice as many retired plan participants as wholesale/retail firms (GAO 1991). In general, retailers experience higher rates of employee turnover than other employers and, as a result, have much lower retiree health costs.

The age spread of participants in the retiree health plan also has a direct effect on an employer's retiree health costs. The greater the number of early retirees not yet eligible for Medicare, the greater the level of retiree health costs, especially for employers whose pre-65 retiree plan is similar to the active employee plan, because Medicare pays for the majority of acute health care benefits for retirees 65 years of age and older.

Available evidence suggests that it costs employers 35 to 60 percent more to provide health benefits for retirees not yet eligible for Medicare, as compared to active employees of the same age, because employees under the age of 65 often retire because they or a dependent covered under an employer plan are ill (Hay Group 1993). Other consultants believe that as much as 40 percent of the cost of retiree health comes from early retirement; however, this varies according to the employee's reason for retirement. Recent insurance industry estimates indicate that the median annual cost for insured plans that cover retirees under age 65 was $2246 per retiree/dependent, compared with $1033-$1372 per retiree/dependent older than 65 and eligible for Medicare benefits in 1990. Costs also tend to increase for both the under and over age-65 retiree groups (according to the size of the employer, by geographic location, and by cost-sharing provisions).

Dealing with Cost Increases

Trends in Employer-Sponsored Plans

Even with skyrocketing medical cost inflation, an increasing number of retirees, and the FAS 106 requirements, only a handful of large employers actually have terminated or plan to terminate retiree health benefits.

Many, however, have changed their retiree medical plans in some way. United Dominion Industries and First City Bancorporation are examples of two employers that have terminated retiree medical plans: United Dominion discontinued benefits in 1988 at the end of a bargaining agreement, and First City canceled benefits effective January 1991.

Other employers, such as McDonnell Douglas and Unisys, have announced that their company-funded retiree medical plans for all current and future nonunion retirees will change to plans that are fully funded by retirees. Although McDonnell Douglas is providing its retirees with a one-time taxable pension supplement to assist in paying these premiums, the company is guaranteeing group retiree health plan coverage availability only through the end of 1996. Please note, however, that McDonnell Douglas retirees have filed a class action suit in Los Angeles to prevent these changes. In December 1992, the court refused to issue a preliminary injunction that would have prevented McDonnell Douglas from imposing the premium requirements on the retirees; however, the court urged the retirees to pursue their claim. In addition, eight separate groups of Unisys retirees have filed class action suits against Unisys to prevent it from proceeding with its plan.

Bankers Trust terminated benefits for future retirees, except for employees who were over the age of 40 on January 1, 1990. Another employer, Boise Cascade, will provide coverage only for retirees over the age of 65.

Far more common are employers like Green Bay Packaging and Media General that no longer offer or subsidize retiree medical benefits for employees hired after a certain date. El Paso Natural Gas Company, like other employers, recently announced its plan to eliminate retiree medical contributions for employees that retire after a certain date. Please note that the U.S. Court of Appeals for the Fifth Circuit ruled on March 25, 1993 that El Paso's unilateral cut-off did not violate ERISA (Wise v. El Paso Natural Gas Company, 1993).

In general, although most employers want to continue offering retiree medical benefits, most are seeking ways to slow down or limit not only the growth rate of their retiree health costs but also their future liability. Employers are doing this in a number of ways and often are using one or more of the following methods:

- Changing the health benefit plan design;
- Increasing contribution amounts required of employees;
- Switching from a defined benefit to a defined contribution plan;
- Changing eligibility criteria;
- Using managed care and flexible benefit plans;

- Offering a catastrophic plan and/or a long-term care plan instead of a more comprehensive plan.

Although many employers are maintaining traditional retiree medical plans, a growing number are reducing benefit levels and increasing the contribution amounts required of current and future retirees. Many employers now require retirees to pay the entire cost of certain benefits such as prescription drugs, dental, vision, or hearing, and some employers are eliminating such benefits altogether. Sundstrand, for example, eliminated dental benefits for future retirees, effective 1992. Also, UOP, a joint venture between Allied-Signal and Union Carbide, eliminated its prescription drug benefit for retirees and replaced it with an annual $500 medical reimbursement account.

General Motors announced medical plan changes and an increase in cost-sharing for salaried retirees, effective in 1994. General Motors retirees will now have a greater selection of managed care programs but will have to share a greater portion of the cost of both the health plan and prescription drug coverage. In addition, Unilever employees who retired after 1987 can now choose between a low- or a high-option medical plan. Benefits are reduced under both plans for retirees with fewer than 25 years of service. Unilever retirees are not required to contribute to the lower option plan, and cost-sharing for the higher option plan depends on the retiree's years of service.

The method by which the employer's retiree health plan integrates with Medicare for retirees over age 65 also will have a tremendous influence on plan costs. For example, per retiree costs reportedly were 12 percent lower among employers using a nonduplicative carve-out approach when integrating their covered retiree benefits with Medicare benefits. Under the Medicare carve-out method, the employer calculates regular plan benefits, assuming that Medicare does not exist. The Medicare payment is then subtracted from the employers' calculated amount and the employer pays the difference. The Medicare-eligible retiree's combined benefit is then the same as the company-provided benefits for retirees not eligible for Medicare.

Campbell Soup, for example, which previously had paid 80 percent of any covered expense that Medicare did not pay, implemented a carve-out plan for coordinating benefits with Medicare. Under this approach, Medicare's payment plus Campbell Soup's Medicare supplemental plan does not exceed 80 percent of their pre-65 plan approved amount. The utility Central and South West Services Inc. also switched to a Medicare carve-out plan and replaced their indemnity drug plan with a managed prescription drug program.

In addition to benefit plan changes, most employers now require retir-

ees to share more, or, in some cases, all the cost of the retiree health plan. One consulting firm found that about one third of employers that modified their retiree health plans in 1990 and 1991 imposed higher retiree contribution requirements. It is estimated that requiring retirees to pay a higher deductible, share more of the costs, or be limited to a maximum dollar amount of benefit can cut as much as 12.5 percent of post-retirement costs.

One employer, DuPont, is planning to reduce retiree health benefits for current and former employees and their dependents starting in January 1994. DuPont will split with the retirees any health care cost increases that occur after January 1997. Equifax and Sears also require health plan contributions from current retirees. Another employer, Ball Corporation, has announced that it no longer will make retiree health contributions for salaried employees hired after 1989. Yet another employer, Morgan Stanley, subsidizes retiree health coverage for people hired after 1988 at 4 percent of plan costs for each year of service, to a maximum of 25 years.

Many employers are switching from a defined benefit approach to a defined dollar approach by capping their contributions to the cost of retiree health care at some predetermined level. General Electric, Keebler, Maersk, and Westinghouse, for example, all have capped the amount they will pay for the cost of current and/or future coverage for retirees. Some defined dollar benefit plans place a cap on annual health payments based on years of employment. The Bank of Boston, for example, provides a defined dollar plan whereby the retiree receives a $500 credit for each year of service, starting at age 40, up to a maximum of 20 years, or $10,000.

Employer plans that restrict eligibility for retiree health coverage might include those that govern the age of employees and the years of service to be eligible initially, the age at which employees stop being eligible, and whether and for how long spouses and other dependents are covered. Southeast Banking Corporation, for example, set their retiree health contribution at $125 per retiree per month, with no subsidy for spouse coverage. Sundstrand makes no contribution toward health care benefits for retirees once they reach the age of 80.

Many employers also are disengaging pension eligibility from retiree health benefits. Other employers are finding that by changing plan eligibility, they can reduce their accounting liability considerably because they may not have to book a liability for retiree health care for all employees from the date of hire.

A growing number of employers are enhancing the managed care plans offered to retirees. For example, GM plans to expand their Preferred Provider Organization (PPO) and Health Maintenance Organization (HMO) retiree health options. For post-65 people, some HMOs coordi-

nate with or replace Medicare and provide a greater level of benefits than a Medigap plan. Although these Medicare HMOs generally limit enrollment to individuals, both employers and retirees also can save money on Medicare HMO risk plans. In addition, a new PPO type of Medicare supplement—Medicare SELECT—has been implemented. Some employers are even offering a choice of several flexible benefit plan options.

Flexible compensation packages allow workers to choose from among various pension and welfare benefits. The number of flex plan credits that retirees receive will apply toward their coverage options and will be based on their age at retirement and years of service. Offering multiple medical plan options allows retirees to select a plan within their financial limits. Employers can use flexible benefit plan options and pricing strategies to promote lower cost plans. For example, many employers provide a lower subsidy for the higher cost health plan options.

One employer, Pillsbury, implemented a retiree flex plan for employees who retired after 1986. To qualify for the plan, retirees must have at least 10 years of service and be at least 55 years old. Pillsbury retirees receive credits worth $1400 for each year of service (up to a maximum of 30 years, or $42,000). At retirement the employee decides how the lump sum is to be allocated annually. Retirees then can use the credit to purchase medical, dental, or life insurance and/or to establish a reimbursement account.

Finally, providing a relatively inexpensive catastrophic plan is another way that employers can limit their retiree health liabilities. Employers can subsidize coverage based on years of service and provide more coverage to employees with longer service. Many employers give retirees the option of electing an additional level of coverage that requires significant employee contributions. For example, Johnson and Johnson replaced their basic/major medical plan for salaried employees with a $1000 deductible and a $3000 out-of-pocket maximum catastrophic comprehensive plan.

Dealing with Catastrophic Illness

The catastrophic illness issues are different for pre-65 and post-65 coverage. Pre-65, there is no Medicare coverage available (except for certain disabled persons and those with end-stage renal disease), but Medicare is available after age 65. Pre-65, the issues are similar to active employee issues, except that the nature and incidence of various illnesses differ by age.

The typical employer plan has a lifetime maximum benefit of from $250,000 to $1,000,000. A few plans have lower maximums, particularly for retirees. A lower maximum applies to some employer plans, but, for

most employer plans, the overall maximum is generally not a problem.

The major issues in terms of coverage for catastrophic illness are the overall maximum amount, mental illness, prescription drugs, and long-term care.

Long-Term Care

Typically, long-term care is not covered in employer plans, nor is it covered under the Medicare program to any significant extent. Long-term health care is a major issue for an aging population.

Long-term care is financed largely by the individual and Medicaid, with each paying nearly half the cost. In the past, it usually was required that the individual spend down assets to be eligible for Medicaid (leaving the surviving spouse impoverished and without assets). There is a growing trend at the state level to modify such requirements. Development of a financing system for long-term care is, however, a future issue and will need to be addressed in the months and years to come.

Cost of Terminal Illness

As technology has opened up new treatment alternatives, the cost of terminal illness has become an increasingly difficult issue, and the application of resources in the event of terminal illness creates a number of questions. Lester Thurow in *Head to Head,* (page 170), summarizes the issue from an economist's point of view:

Consider the conventional "do-no-harm" rule for deciding when medical treatment should be stopped. If every treatment is carried to the point where its negative side effects become worse than the original effects of the disease, doctors prescribe treatments far beyond the rational economic stopping rule (marginal costs should equal marginal benefits) and run up huge costs in situations where few benefits are to be expected—more than one third of all U.S. medical costs are incurred in the last year of life.

In the past, employing every available procedure to the point where it actively began to harm the patient did not cost very much, since there weren't many expensive technologies to be employed in most illnesses. But when such technologies arise and give doctors and their patients a lot of expensive technological options with submarginal payoffs, the old stopping rule can become a very expensive decision rule that can no longer be afforded.

From a social point of view, resources are being allocated to expensive, highly technical treatments when primary care often is not available to people who need it.

A recent article in the Journal of the American Medical Association (JAMA) provides insight into the costs and results of intensive care for terminal cancer patients (Shapiro et al. 1993). The authors concluded that the majority of patients with solid tumors and hematologic cancers admitted to the intensive care unit die before discharge, or, if they survive the hospital admission, they spend a minimal amount of time at home before dying. They found that the potential for survival of these patients was poor once they became critically ill. They recommend that physicians treating patients with these diseases should discuss potential outcomes with the family, including the possibility of withdrawing life-support therapy. The cost per year of life gained for their study group was $189,339. The study also examined the effect of hospice care on hospitalization. The authors note that patients not enrolled in hospice care spent 23 of their last days in the hospital and received only four days of home health care visits. In contrast, those enrolled in hospice care spent only eight of their last 50 days in the hospital. The aggregate effect of these decisions is a material factor in health care costs. The JAMA article indicates that $62 billion of the $809 billion of the estimated 1992 health care spending in the United States were dedicated to the intensive care unit.

It seems clear that this is not a problem of retiree health plans per se, but, rather, a problem of the medical system in general and of the decisions that will be made without treatment. The impact of this issue on retiree health benefit plans, however, is significant.

Future Prospects for Retiree Health

The new accounting rules for retiree health are effective for most employers in 1993, and, as of late 1992, it remained to be seen how this will affect the way in which employers manage their plans. Until late 1992, many major employers had reduced benefits primarily through increased costsharing, but relatively few had eliminated benefits altogether. For the most part, changes affected future retirees only. As indicated earlier, several prominent employers have announced new programs that limit the period during which they will provide retiree health coverage.

As of early 1993, the situation was transitional at best; it may be several years before stabilization occurs and it becomes apparent just which policies will prevail among employers. Other employers have been swapping company payments for retiree health for increased cash retirement benefits, either through defined benefit or defined contribution plans.

Depending on the perspective, the current structure can be viewed either as a success or failure. On the success side, many retirees receive benefits that are generally adequate and important to their personal se-

curity in retirement. On the failure side, many employers have no plans or else the plans have weaknesses, such as

- Lack of coverage for people who leave before early retirement age;
- Future cost sharing that may make plans unaffordable;
- Plans that generally are subject to unilateral changes;
- Plans that usually are not prefunded so that benefits depend on the ability of the employer to pay.

Demographics

The issues that relate to retiree health benefits will only get worse in the next century as the age structure of the population becomes considerably older and periods of retirement lengthen (unless retirement ages change drastically). These changes were discussed in a previous Pension Research Council publication (Bodie and Munnell 1992). What is not discussed here directly is that many forces point to uncertainty with regard to future retirement ages. Given current retirement ages and projected increases in life expectancy, employer costs for retiree health will continue to increase and represent a great burden on companies.

Public Policy/National Health Reform

A key question with regard to retiree health coverage is the future role of the federal government. Presently, the federal government provides health benefits to retirees in the form of Medicare, which covers virtually all Americans after age 65; federal funding also partially supports Medicaid, which provides additional benefits to the medically indigent and funds about 50 percent of long-term care benefits.

Currently in the United States, approximately 38 million Americans have no health insurance. Health benefits for these Americans is a major priority for the Clinton administration, which has announced a blueprint for overhauling the American health care system. Hillary Rodham Clinton and the White House Task Force on Health Care Reform have endorsed a concept of health care delivery called managed competition. Under this system, most people would purchase health insurance from large HMO-like managed care networks that would compete for customers in a given region. In addition, a federally created board would set up nonprofit insurance purchasing organizations to bargain with networks of providers for the most favorable rates.

A major issue in the health reform debate is the ongoing role of employers in providing health benefits for employees. Under two of the three managed competition proposals that have gotten major attention,

the employer continues to play a major role. The employer may well be mandated to offer health coverage. It is unclear, however, how such a policy would affect retirees. If the employer is required to provide coverage to active employees, would the mandate extend to retirement? If the health benefit system is tied to employment, must it also extend to retirement?

Exactly how retiree health benefits, Medicare, or even Medicaid would be changed by the reform legislation remains to be seen. As a result of the current uncertainty in Washington, many employers prefer to consider "holding actions" that limit their retiree health liability as much as possible but, at the same time, preserve their future options. The "cap" and "defined-dollar" benefits provide a way to do this, with the "cap" being more popular at this time.

Legislative Activity

The linkage of employment to health care benefit availability has and will continue to be debated by members of Congress, the White House, and health care policy experts. In March 1993, the U.S. Senate Committee on Labor and Human Resources, Subcommittee on Labor, held hearings on the erosion of employer-sponsored retiree health benefits and the impact on workers and businesses. Many of the employers that testified before the Committee placed the blame squarely on FAS 106, the ever escalating cost of health care, and the lack of national health insurance. In addition, the subcommittee was reminded that employer retiree health plans are covered by ERISA. Unlike pension benefits, ERISA does not mandate that employers provide for the accrual, vesting, and funding of their retiree health liabilities. ERISA does indicate, however, that employers that promise lifetime benefits must provide lifetime benefits. As a result, Subcommittee Chairmen Senators Howard Metzenbaum (D-OH) and Donald Riegle (D-MI) may introduce legislation to protect retiree health benefits.

Continuation Coverage Under COBRA

Under current law, employers are required to continue health benefits coverage for at least 18 months to retirees who lose it at a rate equal to 102 percent of the average cost. This is required under the continuation coverage statute of the Consolidated Omnibus Reconciliation Act (COBRA) of 1985. Proposals have been made to lengthen the period of continuation coverage to Medicare eligibility, although this has not been discussed recently. That is one possible solution to the access problem.

Note, however, that this still would cost employers significant amounts

if COBRA rates are determined as at present. For an average employer group, the COBRA rates, in general, are approximately 40 percent of the average cost for an early retiree group. This is primarily because of differences in age. The ratio can be lower if a large number of early retirees are in poor health.

The future of COBRA is tied to the national health reform debate. Under one proposal, which decouples health coverage from employment, COBRA continuation coverage disappears.

Coverage Sold to Individuals/Groups

Federal and state legislation regulate insurance sold to supplement Medicare. Good policies are available to individuals or through organized programs like that offered by the AARP, but only to those people who are Medicare eligible. Virtually no market exists for individual coverage for retirees not yet eligible for Medicare.

It is likely that many employers will discontinue offering post-65 coverage and encourage employees to buy a Medicare supplemental policy on their own. Some employers may offer a retiree subsidy for the payment (or partial payment) of premiums under this arrangement. The retiree premium plan and increases in cash pension benefits are forms of such a subsidy.

Tie to Medicare-Eligibility Ages

Social Security retirement ages for full benefits have been legislated to increase to age 67 for those born after 1960, but, presently, no plans are on the table to increase the Medicare eligibility age beyond 65. Proposals have been made to reduce the Medicare eligibility age to 60, but this also seems unlikely in light of the federal budget deficit.

If Medicare eligibility were reduced to age 60, it seems likely that many employers would no longer sponsor retiree health benefit coverage and would encourage employees to buy supplemental coverage on their own. This idea may resurface in discussions about national health reform.

Underlying Inflationary Structure

Health care costs have risen much more rapidly than costs in general so that health care represents a constantly escalating percentage of the gross national product (GNP). Employer plan costs have risen even faster than health care costs generally and present employers with increasingly difficult issues. This is also a major issue at the national level.

It seems clear that health care cost increases must be brought under

control, but it is not clear how to accomplish that goal. If costs cannot be brought under control, then employer-sponsored coverage will decline markedly and become less common. The same forces also will serve to put pressure on nonemployer-sponsored plans.

Conclusion

The adequacy of employer-sponsored retiree health coverage, an issue that considers the concerns of people who have coverage and evaluates the levels of coverage available, is the main focus of this chapter. As indicated earlier, adequacy is clearly deteriorating. The number of people who have retiree health coverage is dropping, so that the employer role in retiree coverage is no longer a straightforward one. The level of coverage for those who have it has been adequate historically, but the design changes made recently are calling such adequacy into question for many current and future retirees.

The adequacy of the level of coverage also is a function of the contributions required and the total retirement benefit package. Pension levels for many retirees are not good enough to pay for the fair value of their coverage. Substantial concerns abound about the level of total retirement benefits. If employer support for medical coverage is unavailable, then people generally will not be able to retire until they are eligible either for Medicare or for other subsidized coverage.

A number of challenges and concerns have been presented here. A key question is whether employers will have a continuing role in providing adequate health care coverage. Whereas this chapter sets forth some of the challenges to be addressed if employers are to continue to support retiree health needs, a companion chapter in this book by G. Lawrence Atkins investigates the employer's role more closely.

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Commentary: William S. Custer

Retiree Health Coverage

Retiree health coverage represents two separate benefits for employees. The first is that retiree health benefits are deferred income, and the second is that these benefits offer employees access to a risk pool, that is, to health insurance at group rates. This combination makes the adequacy of retiree health benefits difficult to assess.

The second benefit is especially important. Access to health insurance at group rates gives retirees an implicit subsidy. Older persons are more likely to need health care services and, thus, cost more to insure. If these people were to purchase coverage outside a group, early retirees would face premiums that would reflect their higher use of health care services. In a group, the premiums reflect the average costs of the group. If that group includes active workers, then those younger participants subsidize health insurance coverage for retirees. Essentially, Medicare eligibility provides the same subsidy that group coverage provides retirees under the age of 65, except that younger workers subsidize the health benefits of over-65 retirees through the payroll tax, as do employer-sponsored retiree health benefits.

To determine the adequacy of retiree health benefits requires a point of view. It is obvious from Chapter Four, by Rappaport and Malone, that the adequacy of retiree health benefits depends on the distance that workers are from retirement, the degree of risk aversion, employee self-assessment of future health risks, and the rate at which future income is discounted. From this position, younger workers may not place much value on retiree health benefits and would rather not forego other portions of total compensation to receive such benefits. Conversely, workers nearing retirement may value retiree health benefits highly.

How are the costs of providing retiree health benefits distributed? Simple economic theory suggests that the workers bear the costs of providing any noncash benefit, and that they would agree to accept noncash

rather than cash compensation in situations where employers provide goods or services at a cost lower than what the individual could purchase alone. The tax code obviously affects the relative prices of goods purchased by individuals, compared to goods purchased through an employer, and also affects the provision of noncash benefits. In the case of health benefits, adverse selection makes group purchases less expensive than individual ones. Employees, therefore, are willing to receive some of their compensation in the form of health benefits rather than in cash. The tax code further encourages that choice by excluding the employer's contribution to health benefits from the employee's taxable income. Similarly, the tax code and the employer's greater access to capital markets encourage the allocation of a portion of total compensation as income deferred until retirement.[1]

As discussed earlier, employees are likely to differ in the value that they place on these benefits, but employers are limited in their ability to alter benefits to match individual preferences, because employees would lose the advantages of group purchases.[2] How employers determine the level of health benefits appropriate to their workforce (or desired workforce) is interesting. One possibility is that the level of health benefits is determined by the preferences of the median employee or, in collectively bargained plans, by the median union member, where the median is determined over all employees weighted by their influence within the organization. To the extent that the median employee is likely to be older, the level of health benefits, and especially retiree health benefits, may be greater than younger workers prefer.

From the point of view of the younger worker, if retiree health benefits are too high, then who actually bears the costs? Employment-based retiree health benefits have not generally been prefunded. To the extent that retirees are included in the same risk pool as active workers for purchasing or providing health benefits, younger workers then may face higher costs for health benefits. Seventy-five percent of early retirees who have retiree health coverage participate in the same plan as active workers (KPMG Peat Marwick 1992), who may wish that less of their total compensation went to retiree health benefits.

As previously stated, older workers nearing retirement are likely to view the adequacy of retiree health benefits in a different light than active workers. The access to group purchasing of health insurance benefits is important in evaluating the adequacy of total retirement income. Moreover, the employer contribution to that benefit is excluded from taxable income in retirement, whereas other sources of retirement income are tax deferred.

There may be a systematic sorting of workers related to noncash compensation in general and to retiree health benefits in particular. Larger

employers can exploit economies of scale in administration. They also have more market power and present a larger risk pool for providing health benefits than smaller employers. They thus are able to offer benefits at lower costs than smaller employers, to the extent that retiree health benefits today are almost exclusively provided by larger employers.

Employee Reactions

The responses of employers to health care cost inflation and to FAS 106 are varied, but a common thread has been the desire to separate the two portions of the retiree health benefit. That is, if employers reduce, or "cap," the deferred income portion of the retiree health benefit, then they effectively reduce or limit their liabilities under FAS 106. Employers also can increase retirement income through various vehicles that preserve the tax-deferred status of that income. The difference to retirees is that they must now purchase health benefits with after-tax dollars.

Conclusion

From society's point of view, employment-based retiree health benefits are clearly inadequate: only about one third of retirees receive health benefits from a former employer. Most proposals for health care reform would extend coverage to those early retirees who presently do not have coverage. Many proposals, and particularly managed competition proposals, essentially would provide retirees with access to a risk pool, but they advocate that coverage be paid with after-tax income. Most proposals would provide tax credits or deductions for lower income retirees. In other words, these proposals also separate the provision of health care benefits from retirement income. The adequacy of retiree health benefits then would depend on the composition of the risk pool that retirees can access and the adequacy of their retirement income.

In Chapter Four, Rappaport and Malone expressly state that to determine the adequacy of employment-based retiree health benefits is a subjective exercise. The authors stress, however, that it is important to view health benefits in the context of total retirement income. Employment-based retiree health benefits have contributed to that income in two ways: the employer contribution to the purchase of health benefits that is excluded from taxation, and the access to the risk pool that allows retiree coverage to be subsidized by younger workers. Health care cost inflation and new accounting rules have created a breach in these arenas, however, and health care reform seems likely to exacerbate that trend. Whether employment-based retiree health benefits are sufficient is likely

to hinge almost completely on the adequacy of the individual retiree's income.

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KPMG Peat Marwick. Survey on Retiree Health Benefits. Washington DC: 1992.

Notes

1. The story is not that simple. Employers face a heterogeneous workforce and use benefits as a means of attracting workers with the most productive work characteristics.

2. This is more of a factor in the provision of health benefits than in retirement income, where the combination of a core pension plan and various savings plans gives employees relatively more flexibility in allocating total compensation.

Commentary: Paul B. Grant

Current Status

Based on the rapidly growing number of retirees, increasing life expectancy in the United States, and the need for health care coverage after retirement, it is not out of line to look at employer-provided health care coverage as a growth industry. The population is aging, Americans are retiring earlier, and those persons contemplating retirement are realizing that the ability to pay for their ongoing health care is as important as food and shelter.

Rather than a growth industry, however, retiree health care might now be considered an industry in turmoil and one even in decline. Two major factors contribute to this state: the impacts of continually and rapidly rising costs for health care, and the Financial Accounting Standards Board regulation (FAS 106) that decrees that employers must accrue the liabilities for the benefits promised to retirees.

The result has been that many firms either have made reductions in the coverage they offer retirees and/or employees, or they are seriously considering doing so. One recent study of Fortune 200 firms found that about 85 per cent of companies believe that their plans are targeted for change, with most employers feeling that more of the costs for health care must be shifted to retirees. A majority of employers foresee cutbacks in the benefits being offered (Goeppinger and Dobbelaere 1993).

It is hard to imagine that any firm would establish a new retiree health care program today. Effectively, the field appears to be closed. The evidence, much of it painfully reported in the national media, strongly suggests that firms will seek to reduce of even terminate their obligations. Those who recall the terminations of thousands of defined benefit pension plans after the passage of the Employee Retirement Insurance Security Act (ERISA) will relate to that.

In addition, it is important to remember that this trend strongly suggests that few among the majority of Americans now employed by firms

that do not now offer any retiree health coverage are likely to be offered such coverage in the foreseeable future. The question of how adequate employer-sponsored retiree health plans are may be addressed first by noting that such total coverage is not available in any form to most workers today. Only about one third of American workers are employed by firms that offer sufficient health benefit programs for retired employers and for their dependents (GAO 1991).

Most studies indicate that existing retiree health care programs are offered only by larger firms (see Chapter Four), where it is not unusual for one or more programs to exist. The incidence of retiree health care benefits falls precipitously with smaller firms. The problem is that when no pension or other retirement program is available to older employees of smaller firms, how do they then afford health care coverage in retirement? Must the choice be one of medicine or food?

Medicare

It probably would be unnecessary to discuss the adequacy of employer-sponsored retiree health care programs if Medicare provided comprehensive health care for retirees. Many people believe that this was the intention when Medicare was enacted in 1965. The same cost pressures that have led to this particular discussion of employer-sponsored retiree health care, however, also have bedeviled Medicare. Within a few years after passage, it became necessary to increase participant premiums and to reduce coverages in the Medicare program, a trend that has continued. In fact, one of the annual rites of government has been the announcement that the premium for Medicare B has been increased for the next year, as have the various deductibles for hospitalization.

Even so, Medicare was deficient in its coverage from the start. An attempt to extend its benefits in 1988, with the passage of the Catastrophic Protection Act, failed when angry older people, who would have had to pay for the improved benefits, persuaded Congress to repeal the legislation before it became effective.

Medicare does not provide coverage for out-of-hospital prescription drugs, whose costs are rising faster than any other area of health care (EBRI 1992). Nor does it provide for long-term care, an often bankrupting but rapidly growing health care problem. Hospital and other health care costs that also are not covered by Medicare continue to rise. It could be said, ironically, that Medicare is causing many of the problems that are forcing employers to look more closely at the need to reduce health care coverage.

Early Retirement

For many years, there has been a tendency to retire before age 65, a trend exacerbated by company-inspired early retirement programs designed to encourage older workers to step aside (GAO 1985). Given the fact that, except in a few cases, Medicare is not available until age 65 and that individual health insurance policies for older people are very expensive, workers contemplating retirement are loathe to make the break without assurance of continued health care coverage.

Most employers have provided early retirees with continuation of the same coverage that the individual enjoyed when employed, at least until Medicare eligibility would kick in. Yet, the health care costs of older persons continue to rise rapidly. Such costs for a 60-year-old active employee, for example, may be as much as four times those for a 25-year-old active employee. Many companies are discovering that the health care component of the retirement package offered in early retirement programs is far more expensive than imagined. Similarly, costs of the continuing coverage for dependents of former employers often are surprisingly high.

Current Reactions to Spiraling Costs

For at least a generation, there has been concern over the cost of providing health care to employees. Employers and others have pointed to annual double-digit increases in costs and have said that something had to be done to control the cost spiral. And a large number of "somethings" have been attempted, to relatively little avail. Government-protected oligopolies have continued to act in the same way that they are prone to act: that is, prices continue to rise.

The desire to slow rapidly rising health care costs led to cutbacks in health care provided by employers in the 1980s. That trend has continued and is now being observed in the area of retiree health care. Some firms simply are terminating their retiree health care plans, a cruel fate for those retirees who had expected to receive continued coverage and had built that into their retirement plans. In many cases, angry retirees have reacted by suing, claiming that the former employer had made a lifetime promise. Although kindly, elderly lower court judges may find merit in these claims, recent decisions, at least on the appellate level, have largely favored the companies. (See, for example, Senn v. United Dominion Industries, Inc., C.A. No. 90-3100 [CCA - 7, January 8, 1992]; Boyer v. Douglas Components Corp., No. 91-2098 [CCA - 6, February 18, 1992]; and Wise v. El Paso Natural Gas [CCA - 5, March 25, 1993]).

Several lawsuits are pending, including some that affect Unisys and General Motors. Whether there will be sufficient interest on the U.S. Supreme Court to inspire a definitive statement on the issue is not clear;

but, with the growing numbers of appellate court decisions largely leaning in the same way, the issue already may be settled. In a situation where a firm has clearly reserved for itself the right to terminate or modify benefit plans, the company may well prevail if it chooses to reduce or eliminate coverage.

Although some firms have terminated plans altogether, others are reducing or eliminating coverage for current or future employees. Still other firms are instituting or increasing contributions for retirees and for their dependents, designing other cost-sharing methods, and, in other ways, attempting to shift costs to the employees. One company, AAR, the parent of American Airlines, has instituted employee contributions during employees' active years (Amoroso 1991).

Controversy also is growing over whether the final employer should bear the full burden of providing ongoing retiree health care. With regard to retirement income, firms generally accept no obligation to provide fully a pension or an annuity that a person might need – companies generally accept the obligation only to provide benefits based on the period of time that the employee worked for them. Employers are asking if it would not make more sense to prorate the retirement health obligation in a similar way.

All these modifications to retiree health care plans result in a lessening of the protection afforded retirees, through greater cost to the retiree, reduced overall coverage, or a combination of the two. In effect, they reduce the adequacy of the employer's commitment.

Some firms are turning to cost-control measures recently introduced for active employees with satisfactory results. More emphasis is being given to participation in health maintenance organizations (HMOs), preferred provider organizations (PPOs), and managed care. Flexible benefit plans, with coverage options open to retirees, also may be used. In one area, managed care for prescription drugs, substantial savings appear possible.

In any question of adequacy of benefits, it is clear that reducing them or increasing their costs raises questions. And the chart prepared by Rappaport and Malone for their presentation in Chapter Four demonstrates that retiree health care costs are important to the total retirement income of most people. In fact, for those retiring at lower income and pension levels, retiree health care may constitute a large part of total retirement income. Deprive people of such coverage and they may have to make choices between eating and taking a needed drug.

Uncertainty of Retiree Health Benefits

In any discussion on adequacy of retiree health care benefits, the question of uncertainty should be considered. In the area of retirement, it

long has been advocated that people plan for the event. Popular pre-retirement programs sometimes suggest that planning should begin when workers are in their early 50s. With today's muddled health care world, however, how can anyone plan adequately for the future? In an environment where companies are known for phasing out or terminating their retiree health care programs (or adding new restrictions to them), enough uncertainty exists that few people can feel confident about retirement or feel free to enjoy a company health care program for their lifetime. Retirement is thought of as a time of peace, a time to enjoy the fruits of earlier labors. Now, this image is clouded by increasing financial uncertainty.

Unless an employee contemplating early retirement is convinced that health care coverage will continue at least until Medicare eligibility, how can a rational choice be made? Lacking the safety net of Medicare, such a person is exceedingly vulnerable. Because many workers recently have opted to retire early, in part because of continued health care coverage provisions, will uncertainty now slow this trend?

Additional Considerations

As industry began to prepare for FAS 106, studies were initiated to evaluate the impact that the new accounting rule would have on existing health care plans. In many cases, analysts discovered that they could obtain only incomplete and often inconsistent data. As Rappaport and Malone indicate, many participants' records were not coded in ways that would provide useful data.

Only recently have meaningful data about health care costs been isolated. Before the last 10 to 15 years, it was possible to isolate individual cases and aggregate claim amounts, but little data were available to study health care experience by gender, age, diagnostic classification, or in other ways that might have been useful. This has been changing, but only slowly.

It is now clear that the aggregate data available for so many years tended to obscure some important facts. New information is contributing to an evolving debate over treatments that do not affect life expectancy, do not improve the quality of life, and so forth. When former Chicago Bear football coach Mike Ditka was asked how hard his team had to work, or what he himself was willing to contribute, he would answer, "Whatever it takes." And that appears to have been a guiding principle for health care in the United States for many years, regardless of the cost/benefit analysis that might be used.

The recent Medicare emphasis that about one third of Medicare expenditures for retirees are incurred in the last year of life will add to the debate. Is this really the most efficient use of scarce resources? It is logi-

cal to expect that plans may refuse to pay costs associated solely with prolonging life. To many, it is clear that the national crisis over health care eventually will result in far more quotas and rationing than exist today. What better place to start than with the elderly, on whom large sums are expended solely to prolong life with no demonstration of improving or even maintaining its quality.

Many investigators have been watching the experiment in Oregon, where coverage may not be provided for procedures that do not contribute to a societally approved goal. Perhaps the day will come when the examining physician will determine that the cost/benefit analysis will not support additional treatment and simply makes the patient comfortable. The hospice industry almost certainly will greatly increase in size and scope.

The problems already described are likely to worsen. There is no reason to anticipate a slowing of the inventions, innovations, new drugs, and so on that have contributed to the recent great advances in health care. Even with a national health scheme that may downplay expenditures in the laboratory, however, support for continued research funding in such critical areas as AIDs, cancer, and other major killers must be anticipated. And the private sector may be expected to fund research into diabetes, multiple sclerosis, and many other serious problems. Based on experience, all these improvements surely will lead to longer life but also to sharply higher costs.

Long-Term Care

A cruel irony of life has been the health care industry's ability to assist in prolonging life beyond society's ability to provide long-term care. Societal changes have left no one at home to tend the elderly: changes in attitudes leave people unwilling to do so today. As a result, long-term care facilities have proliferated.

Many people are not aware that Medicare does not provide coverage for long-term care. The Medicaid program that does offer such coverage originally required that a person spend down assets until a spouse often was left destitute. Although some states have changed this regulation recently, the provision of such care still results in poverty for some survivors. Less admirably, it encourages fraud as people attempt to hide assets.

Little insurance protection is available for long-term care, although the field is growing. A few firms have experimented with such programs for employees and their families, usually on an employee-pay-all basis. Experience apparently has been mixed. With possibly one fourth of the

population expected to spend some time in nursing homes, however, there is little question that long-term care needs are not being met.

Conclusion

Federal protection is being reduced, firms are being forced to terminate or reduce the coverage that they offer, and, in both instances, higher costs are being pushed onto retirees. Often, the retirees were never prepared for the possibility that health care protection would be reduced or eliminated. Consideration of the adequacy of available future health care may well impact the decision to retire at all.

Considering that retiree health care is part of the overall retirement package, these reductions in coverage and increases in costs directly affect the overall standard of living that a retiree can anticipate.

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