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Chapter 5
The Employer Role in Financing Health Care for Retirees

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The growing pressure on employers who finance health benefits for retirees is evidence of an emerging conflict over the responsibility for financing the health care of older Americans. Modifications in the employer commitment for retiree health, in combination with government cuts in Medicare, are gradually shifting the burden of costs to retirees. The long-term solution is not to protect retirees by shoring up the employer role, because that role already has expanded far beyond the dimensions envisioned by most employers when retiree health benefits were first adopted. The trend now is toward a reduction in that role. It is more likely that comprehensive health care reform will set forces in motion to encourage and enable employers to restructure and reduce the role they now play.

In many ways, the crisis that has emerged, particularly the conflicts now being played out in the courts between retirees and former employers, results from a clash of management and worker expectations. What workers want and need in the way of health benefits in retirement is most likely not what management intended or what is realistic over the long term. By the same token, the benefits that employers could provide easily would not be adequate for the long-term needs of retirees.

For decades, these differences in expectations went largely unnoticed. Then, in the late 1970s and early 1980s, a series of recessions forced widespread corporate downsizing, aggressive early retirement incentives, and, in some industries, a dramatic increase in the number of retirees per active worker. These things all placed a tremendous burden on the remaining productive capacity. At the same time, a continuous 5-to-6-percent real annual growth in health care costs, lengthening lifespans for retirees, and Medicare reductions that shifted costs to employer plans helped make rising retiree health costs noticeable for employers. On top of this trend, an increase in corporate merger and acquisition activity and bankruptcies of large corporations highlighted the high costs, lack of funding, and benefit insecurity of retiree health.

The final straw has been the financial accounting standard on post-retirement benefits (FAS 106), effective January 1993. FAS 106 requires employers to account on the corporate balance sheet for projected health liabilities for retired and active workers, offset by any assets reserved for their use. Their resulting awareness of the immensity of these long-term obligations has moved many employers to reduce or eliminate the promise to active workers and to limit the benefit for retirees. Although most employers remain committed to these benefits in some form, an opportunity to contain or reduce the long-run obligation in the context of overall reform inevitably will precipitate widespread changes.

The gap between the expectations of retirees who have employer health benefits and the employer's limited capacity to meet these expectations raises important questions about the wisdom of attaching retiree health benefits to employment. Success by employers in limiting their share of the future retirement health burden, however, will not reduce the overall burden itself. The residual costs will have to be met in the future, either from the limited retirement incomes of future retirees or from government funding. These large redistributional questions are the crux of the retiree health financing issue to be tackled in the health care reform debate.

Role of Retiree Health in Financing Care

Employer-provided benefits are an important part of the financing of health care for retirees overall, but they play a more significant role for pre-Medicare-aged retirees than for those persons enrolled in Medicare. For substantial subgroups of retirees, employer-provided benefits are the major source of health care financing. The importance of retiree health benefits to various groups of retirees is a function of the extent of coverage and the level of financing.

Retiree Health Coverage

Roughly half of all retirees in the United States have some employer-provided retiree health coverage, according to data from the 1987 National Medical Expenditure Survey (NMES). Employer-provided coverage is the second leading source of health insurance coverage for retirees, after Medicare. In 1987, of the 22 million retirees aged 55 and older, 38 percent had coverage from a former employer, another 10 percent had coverage through a spouse's employment-related plan, and 32 percent purchased individual coverage, whereas 19 percent had no private coverage (see Table 5.1) (Monheit and Schur 1989).

Early retirees rely most on employer-based coverage. According to NMES, employment-related health benefits were the dominant source of coverage of the 5.5 million retirees aged 55-64 in 1987: 51 percent were covered as policyholders and 17 percent as dependents under an employer plan; only 16 percent had individual coverage; whereas another 16 percent were without private coverage (Monheit and Schur 1989).

TABLE 5.1 Health Insurance Coverage of Retirees Aged 55 and Older: 1987[a]

		Sources of Private Health Insurance Coverage (Percent of Total Retirees)			
Age	*Number of Retirees (millions)*	*Employment-Related (Policyholder)*	*Employment-Related (Dependent)*	*Other Private Coverage*	*No Private Coverage*
55-59	1.7	50.1	20.6	11.2	18.1
60-64	3.8	51.9	15.0	17.5	15.6
65-69	5.2	40.3	11.1	29.7	19.0
70-74	4.8	37.1	7.6	38.7	16.6
75+	6.4	28.1	4.9	43.5	23.6
55-64	5.5	51.3	16.7	15.6	16.4
65+	16.5	34.6	7.7	37.7	20.1
Total	22.0	38.8	9.9	32.1	19.1

[a]*Source:* Monheit A, Schur C. *Health Insurance Coverage of Retired Persons,* National Medical Expenditure Survey Research Findings 2. National Center for Health Services Research and Health Care Technology Assessment. (DHHS Publication No. (PHS) 89-3444.) Rockville, MD: U.S. Public Health Service. September 1989; see Table 2.

More recent data analyzed by the Employee Benefits Research Institute (EBRI) from the Census Bureau's 1992 Current Population Survey (CPS) show some decline in employer-provided coverage for early retirees aged 55-64. Of the 3 million retirees that EBRI counts in this age group, 42 percent have direct employer-provided insurance, 17 percent have coverage through a spouse's employer, and 18 percent have purchased private coverage (see Table 5.2) (Foley 1993).

Retirees aged 65 and older were more likely to purchase an individual Medigap policy than to be covered under an employer plan. Of the 24 million Medicare beneficiaries who no longer were working in 1987, 41 percent had private policies that were not employment related, 25 percent had no insurance, and only 21 percent had their own employment-related coverage, whereas 12 percent had employment-related coverage through a spouse, and 2.4 percent had coverage as an active worker (see Table 5.3) (Monheit and Schur 1989).

The EBRI estimates from the 1992 CPS survey show a similar pattern for the 65 and older population but indicate some erosion in employer

TABLE 5.2 Health Insurance Coverage of the Population Aged 55-64 in 1991[a]

Age 55-64 by Work Status	*Total (millions)*	*Sources of Private Health Insurance Coverage (Percent of Total in Age Group)*					
		Employer Coverage (Self)	*Employer Coverage (Spouse)*	*Other Private*	*Total Public*	*Medicaid*	*No Health Insurance*
Working	13.0	61.2	13.5	12.1	7.6	1.3	10.8
Retired	3.0	41.7	17.1	17.7	24.8	4.3	11.8
Other Activity/ Could not find work	5.1	8.1	33.5	15.2	38.7	18.5	16.0
Total	21.1	45.7	18.6	13.6	17.4	5.8	12.4

[a]*Source:* Foley J. *Sources of Health Insurance and Characteristics of the Uninsured.* Analysis of the March 1992 Current Population Survey. Special Report SR-16 and Issue Brief Number 133. Washington, DC: Employee Benefit Research Institute. January 1993; see Table 24.

TABLE 5.3 Private Health Insurance Coverage of the Population Aged 65 and Older Who Have Medicare in 1987[a]

		Sources of Private Health Insurance Coverage (Percent of Total in Age Group)					
		Employment-Related Coverage					
Age	*Number of Persons with Medicare (millions)*	*Retiree*	*Dependent of Retiree*	*Active Worker*	*Dependent of Active Public*	*Other Private Medicaid*	*No Private Insurance*
65-69	8.9	23.2	12.6	5.8	2.6	33.0	22.7
70-74	7.4	23.8	11.9	1.1	0.8	41.3	21.1
75+	10.8	16.3	7.8	0.5	0.6	46.3	28.5
Total	27.1	20.6	10.5	2.4	1.3	40.6	24.6

[a]*Source:* Monheit A, Schur C. *Health Insurance Coverage of Retired Persons.* National Medical Expenditure Survey Research Findings 2. National Center for Health Services Research and Health Care Technology Assessment. (DHHS Publication No. (PHS) 89-3444.) Rockville, MD: U.S. Public Health Service. September 1989; see Table 5.

TABLE 5.4 Private Health Insurance Coverage of the Population aged 65+ 1991[a,b]

		Sources of Health Insurance Coverage (Percent of Total in Age Group – Duplicated Counts)					
	Total (millions)	*Employer Coverage*	*Other Private*	*Medicare*	*Medicaid*	*Champus/ VA*	*No Health Insurance*
Age 65+	30.6	33.1	34.7	96.0	9.5	3.8	0.9

[a]*Source:* Foley J. *Sources of Health Insurance and Characteristics of the Uninsured.* Analysis of the March 1992 Current Population Survey. Special Report SR-16 and Issue Brief Number 133. Washington, DC: Employee Benefit Research Institute. January 1993; see Table 1.

		Sources of Health Insurance Coverage[b] (Percent of Total in Age Group – Author's Unduplicated Estimates)						
	Total (millions)	*Medicare Only*	*Medicare plus Employer*	*Medicare plus Other Private*	*Medicare plus Medicaid /Champus*	*Private Insurance Only*	*Medicaid/ Champus /VA Only*	*No Health Insurance*
Age 65+	30.6	22.5	29.2	32.1	12.2	2.7	0.4	0.9

[b]*Source:* Author's estimates from J. Foley, EBRI Issue Brief Number 133; Tables 1 and 5.

coverage for this age group as well. Of the 30 million persons aged 65 and older in 1992, 29 percent had group health insurance in addition to Medicare (compared to 34 percent in the 1987 survey), 32 percent had private individual insurance in addition to Medicare, and 35 percent had Medicare only or Medicare and Medicaid (see Table 5.4: Foley 1993 and author's estimates).

Retiree Health Financing

Employer plans provide a varying proportion of total financing for health care to early retirees and Medicare-eligible retirees. Because payments from employer plans for health care services are broken out by age group but not by employment status, it is difficult to distinguish employer plan payments for services to early retirees from those to active workers. Employer plans are the most significant source of health care payment for the older population (aged 55-64), because over half (55 percent) of this population is still in the labor force, and the majority of those retired have employer-provided health benefits as the primary payer and no Medicare coverage. Among this age group, the primary source of payment for 66 percent of the hospital discharges in 1987 and 48 percent of the physician office visits in 1985 was private insurance (Blue Cross, prepaid plans, or other commercial insurance), most of it, presumably, employer-provided. By contrast, among those aged 65 and older, private insurance was the primary source of payment for only four percent of hospital discharges and 31 percent of physician office visits (see Tables 5.5 and 5.6) (Van Nostrand et al. 1993). For this age group, private insurance in total accounts for less than 10 percent of personal health expenditures in 1987. Most private spending by those aged 65 and over is not from insurance but, rather, through out-of-pocket payments, largely for long-term care. Nearly 60 percent of private spending for the elderly is for nursing homes and other care, almost all uninsured (Senate Committee on Aging 1991).

Although employer plans are a significant source of acute care financing for early retirees, they play a minor role for Medicare enrollees. As a group, retirees rely much less heavily on employer-provided benefits than other groups because, at best, only half of retirees are covered, and Medicare dominates hospital and physician payments for those 65 aged and older. Individuals and families already bear a substantial out-of-pocket burden for retiree health care, and, with shrinking coverage from employer-based plans, this self-financing of care by the elderly is likely to increase.

TABLE 5.5 Hospital Discharges for Persons Aged 55 and Older by Principal Source of Payment, 1987[a]

Age	Total Discharges (millions)	Expected Principal Source of Payment (Percent of Total Discharges)						
		Medicare	Medicaid	Blue Cross/ Blue Shield	Other Commercial Insurance	Workers Compensation	Self-Pay	Other or No Charge
55-64	4.0	16.1	6.5	25.4	40.5	1.5	5.2	4.8
65+	10.4	93.4	0.9	1.1	3.0	0.7	0.5	0.4

[a]*Source:* Van Nostrand JF, Furmer SE, Suzman R, eds. *Health Data on Older Americans: United States, 1992.* Washington, DC: U.S. Public Health Service, National Center for Health Statistics. 1993. *Vital Statistics* 3(27):219; see Table 6.

TABLE 5.6 Physician Office Visits by Persons Aged 55 and Older by Principal Source of Payment, 1987[a]

Age	Total Visits (millions)	Expected Principal Source of Payment (Percent of Total Visits)					
		Medicare	Medicaid	Blue Cross/ Blue Shield	Other Commercial Insurance	Prepaid Plan	Self-Pay
55-64	75.0	9.2	5.4	17.3	22.8	7.5	48.1
65+	130.5	71.4	8.2	15.4	10.2	4.9	32.7

[a]*Source:* Van Nostrand JF, Furmer SE, Suzman R, eds. *Health Data on Older Americans: United States, 1992.* Washington, DC: U.S. Public Health Service, National Center for Health Statistics. 1993 *Vital Statistics* 3(27):220; see Table 7.

Rationale for an Employer Role

Origins of Retiree Health

In its early years, the rationale for employer-based retiree health benefits was that it was a simple benefit to provide with few reasons not to provide it. It was a benefit that emerged, largely without design or intent, through the collective bargaining over benefits in the 1950s and 1960s. In the context of providing early retirement pensions, the extension of the active workers' health insurance into retirement was viewed as an important benefit for retirees, and one that cost the employer little or nothing. Medical benefits were often viewed by employers as a "throwaway" in collective bargaining, because the cost was such a small portion of total compensation (Kelly 1985). With relatively few retirees, comparatively small health benefit costs, and a philosophy that American manufacturing would dominate world markets forever, the idea of financing retiree health from future income seemed reasonable. The employer obligation became even less significant with the enactment of Medicare in 1965. Until the early 1980s, employers rarely even measured or cared about the separate cost of the medical benefits provided for retirees.

For workers, the implied promise of lifetime health benefits, particularly until Medicare eligibility, became an increasingly important aspect of retirement security. Highly skilled workers who were in demand and had become most sophisticated about benefits were aware of health benefits in their retirement package, and large companies in established industries were willing to provide such benefits to attract and retain talented workers (Abrahams 1993). With the growing use of age-rated and experience-rated insurance premiums, the opportunity for a worker to continue in the employers' group indefinitely became increasingly important. The idea of lifetime coverage under an affordable policy without regard to the worker's or spouse's current or future health conditions provided peace of mind for workers who were near retirement. For early retirees, health benefits could be worth more than the pension, and, for many, the availability of retiree health benefits was a significant or even deciding factor in the decision to take early retirement (McIntyre 1993).

Employers adopted retiree health benefits because they needed them to make their retirement packages work, because they helped in collective bargaining, because they were attractive to labor in competitive labor markets, and because the costs were rarely significant—a few retirees were simply continued in their health plan. The benefit was viewed as an extension of the health benefit in a world of relatively low-cost health benefits. Had it been viewed properly and valued as a retirement benefit, it might never have been adopted, particularly with its original design.

General Rationale for Retirement Benefits

The logic for connecting retiree health benefits with employment is related to the logic for financing any retirement benefits through work. Because the phenomenon of retirement is viewed in industrial society as a consequence of work, it is appropriate to connect the income for retirement to the productive output of work.

That retirement benefits are employment-based means several things. First, they are "earnings related" to protect workers against the loss of their earning capacity. With widespread industrialization in the early twentieth century and the separation of workers from control over the means of production, workers could be involuntarily severed from their jobs, lose all capacity to generate income, and become public wards. Taking a small portion of the returns from production to guarantee income security was viewed as a reasonable way to reduce the public burden and to improve the worker's security and productivity on the job.

Second, retirement benefits are employment based in that they are financed through labor productivity. The justification for tapping returns on labor to pay for retirement traditionally takes one of two forms. Under the "human depreciation" concept that was advanced by the labor movement, the cost of maintaining the worker during *and* after the active working life was viewed as a cost of production. Human capital that was depleted through use should be depreciated by putting aside small amounts of money (in the form of health and retirement benefits) toward its maintenance and eventual replacement. In effect, the worker was owed a secure retirement in exchange for having been worn out. Under the "deferred wage theory," workers who otherwise would be unable to save for their own retirements could collectively forego cash wages during their active working life to finance retirement (McGill 1984).

Third, retirement benefits are employment based in that they can serve as tools for employers in meeting objectives for labor supply and productivity. Pensions often have been designed to attract and retain skilled labor in competitive labor markets, to reduce turnover, and to reward loyal employees. Because turnover is costly to employers, the benefits of a more productive and more stable workforce offset the added costs and then some of the pensions (Lazear 1982; Blinder 1982).

Pension and retiree health benefits also have been used to encourage and enable older workers to retire, to create openings for younger workers, and to increase overall productivity. Many established pension programs, including Social Security and the Federal Civil Service Retirement System, had their origins in efforts to reduce the number of "superannuated" workers. Recently, pension and health benefits have been offered to younger populations of older workers to induce early retirement, par-

ticularly during downsizing. The use of attractive benefits to encourage early retirement has grown as various overt forms of forced retirement, such as mandatory retirement ages, have been blocked through amendments to the Age Discrimination in Employment Act.

Weaknesses in the Rationale for Retirement Benefits

The rationale for any employer-based retirement benefit is based on conflicting objectives that reduce the capacity of the system to finance retirement and raise questions about the wisdom of an employment-based system. Linking benefits to specific employers and periods of employment furthers the labor supply goals of employers at the expense of the retirement income goals of workers and society. At the one extreme, labor supply goals would be best served by a benefit that vested only at retirement and was related purely to length of service with the last employer. At the other extreme, retirement income is best provided through a program like Social Security that relates benefits solely to lifetime earnings and is unaffected by anomalies in employment history.

This conflict has been increasingly resolved, especially since the enactment of the Employee Retirement Income Security Act of 1974 (ERISA), through legislation to strengthen the delivery of retirement income benefits. Employers have been forced to accrue pensions more evenly over a working career, to minimize disparities in pension benefits between low- and high-paid workers, to vest benefits earlier in the working career, to fund vested benefits fully, and to provide some degree of portability of benefits for workers who leave and go to another job. Employers have found that their flexibility to construct retirement income packages that favor loyal employees or highly compensated employees has become increasingly constrained, and, as a consequence, they have tended to reduce their commitment to traditional forms of retirement benefits.

The linkage of retirement benefits with specific employers causes a poor distribution in both benefits and costs. Retiree benefits are distributed on the basis of employment history rather than on lifetime earnings or needs. The employment relationship produces deficiencies in coverage, vesting, benefit delivery, and equity in outcome not found in a public program such as Social Security, which bases benefits on lifetime earnings without regard to employer and distributes costs equitably among employers as a function of total compensation.

Without prefunding, the retiree who no longer makes a productive contribution to the employer must be financed from the productive output of active workers, and that financing must continue over the retiree's remaining life, regardless of the employer's profitability during that time. Costs of financing old age are distributed as a function of each employer's

workforce demographics rather than as a function of labor productivity. Where an employer's retirees outnumber active workers, where an employer's output is insufficient to finance the benefits, or where an employer ceases to operate, it may become impossible to finance the benefits.

Weaknesses of Retiree Health as an Employer Benefit

The rationale for retiree health as a retirement benefit is even weaker. Essentially, retiree health is an unreformed pre-ERISA benefit that meets neither the employee's retirement income goals nor the employer's labor supply goals. It was not conceived as a stand-alone retirement benefit but evolved, instead, from an indefinite extension of an active worker's health benefit into retirement. It many ways, it resembles a severance benefit more than a retirement benefit.

In the past, its weakness as a retirement benefit has been that it often accrued entirely upon eligibility for a pension, and indiscriminately provided full benefits to short-service workers who reach retirement, sometimes depriving long-service workers of benefits if they left the job before retirement. Because retirement was the only test, the responsibility and cost of a retiree's health care were borne fully by the last employer. At the same time, the benefit had the same value for all employees unrelated to compensation or length of service, thus long- and short-service retiring employees received equal benefits, weakening the benefit's value as a tool to encourage worker loyalty.

Recently, some employers have modified their retiree health benefits to relate them more directly to their labor supply goals. A survey released in 1992 by A. Foster Higgins indicated that 11 percent of the 2409 employers surveyed had tightened their eligibility for retiree health benefits in the previous two years (e.g., by relating benefits to years of service), and another 10 percent were planning to do so by 1994 (Foster Higgins 1992). Another survey by the Wyatt Company found that 20 of the top 50 industrial companies in the United States restrict coverage based on age, length of service, date of hire, date of retirement, or some other factor (The Wyatt Company 1992).

Poor Distribution of the Financial Burden

Retirement income benefits can be rationalized for the employment relationship by accruing and funding them over the worker's active life and, thus, relating their cost to the active worker's productivity. Retiree health expenses, however, are realized only after the worker retires. Although the FAS 106 accounting rules require that liability be accounted

for on an accrual basis over the worker's active life, the actual cash outlay for retiree health is rarely prefunded. In this way, the cash outlay remains a post-retirement expense. As a consequence, companies' costs in relation to active worker compensation are entirely a function of the ratio of retirees to active workers. Those companies that have young workers and few retirees, either temporarily as start-up companies or permanently because of the nature of their employment, devote only a small portion of compensation to retiree health costs. Those companies that have high ratios of retirees to active workers, either because of the natural aging of their workforce or a reduction in force combined with aggressive early retirement programs, devote substantial portions of compensation to retiree health costs.

Retiree health therefore is something that makes the least sense as an employee benefit. Companies that have the greatest responsibility for providing the benefit often are least able to. It is easy for companies to promise substantial retiree health benefits when they have few retirees. At the time when retirees begin to receive benefits, however, some companies may become unable to deliver them. Financially troubled companies often are left with huge retiree health costs as a result of downsizing and end up bearing these costs on a reduced productive base. Companies with large numbers of retirees may be driven to bankruptcy by the burden of unfunded pension and severance benefits combined with retiree health benefits. In the end, the companies either reduce or eliminate these benefits in the process of restructuring.

No particular social purpose can be served in distributing these costs unevenly across companies. If the intent is to finance retirement on the productive output of the economy, then to clump retiree health costs in the segment of the economy that has the oldest or most financially insecure companies is counterproductive. In effect, the present system finances retirement disproportionately through the manufacturing base, particularly through the core-industry manufacturing base that recently has been forced to downsize so substantially, with little impact on retail and service industries that now provide few or no retiree health benefits.

To the extent that the uneven distribution of total health costs across industries and types of employers impairs the international competitiveness of some American manufacturing industries, retiree health costs can be considered a compounding factor. Whether high health benefit costs have contributed to a lack of competitiveness or whether the lack of competitiveness has contributed to high health benefit costs is controversial. At least one school of thought holds that large manufacturing companies that matured in earlier decades in a protected domestic market showed little resistance at that time to providing elaborate and expensive health benefits for workers, because the costs could be passed on easily to con-

sumers in markets where an oligopoly of suppliers controlled prices. The introduction of these companies into highly competitive world markets in the late 1970s and 1980s highlighted these health obligations—particularly retiree health—as a substantial irreducible factor in the cost of production. Other industries that always were in competitive world markets, and those that were in highly competitive domestic markets, never acquired these benefit obligations to begin with (Brailer et al. 1991). In any case, the net effect has been to place a tremendous burden on American manufacturers that must find ways to become more competitive in current markets.

Unpredictability of Costs

Funding health benefits over the worker's active life would be nearly impossible for most employers today because the value and costs of the benefits are constantly changing and are largely unpredictable. Although FAS 106 has established conventions to set values on liabilities (for accounting purposes only), these conventions may no longer relate to the factors that now drive actual expenses.

To begin with, the precise scope of benefits is influenced by a conflict between retirees' and employers' perceptions of the benefit. Retirees see the benefit in terms of coverage of medical treatment, whereas employers view it in terms of the costs of care. A static benefit for retirees is one that continues to cover a specified set of conditions and treatments at the current nominal level of copayments and deductibles. Contrary to this, employers view this definition of benefits as dynamic—as a package that increases in real value over time not only as the cost of treatment increases but also as the nature and quality of treatment grow. New and more elaborate medical procedures are added or substituted for earlier forms of treatment and, as more effective and less risky procedures are developed, a greater proportion of patients can be treated. All this expansion in treatment eventually is encompassed within the existing definitions of coverage.

Employers would prefer a commitment that provides a set amount of real value over time. As the real value and cost of the package increase, employers feel justified in raising the costsharing in the plan to offset some of the growing value. In fact, most employers—even those who adopt substantial cost sharing features—continue to finance most of the cost and value increases in the plan. Most employers will adjust deductibles and copayments for inflation in an effort to maintain the real value of the existing costsharing. Even when they undertake more aggressive efforts to add new premiums or increase other costsharing for more than inflation, employers still are unlikely to allocate an equal share of the cost increases to retirees.

Even without this conflict over the scope of the benefits, other aspects of retiree health make it difficult to prefund the benefit accurately. Like any cash benefit, health care costs in the distant future are difficult to predict. In addition to this normal uncertainty, there is the added one of trying to predict changes in health conditions and treatments. Where benefits are coordinated with Medicare, the potential for substantial unpredictable changes in that program add another dimension of uncertainty. For individuals who split their working careers among a number of employers, it is impossible to subdivide the health benefit to enable portions of it to accrue through separate employers without first converting it to a cash equivalent. Finally, because the benefit is never vested by statute, it can, in certain circumstances, be reduced or eliminated legally, making it difficult to predict the liabilities and, therefore, making it inefficient to prefund.

The consequence of not accruing and not prefunding the benefit over a workers' active career is that all actual expense is borne once workers retire and continues to be borne as long as the retiree remains alive, even though the liabilities may have been accounted for previously under FAS 106. This structure provides neither the predictability that the employer needs nor the security that employees and retirees need. Employers already have begun to resolve this problem by limiting their liability. Retirees are likely to respond with greater pressure to guarantee coverage. It is only a matter of time before this growing conflict forces a radical change in the employer-provided retiree health benefit.

Options for Restructuring the Employer Role

Employers are wrestling with the uncertain future costs of retiree health benefits, the need to manage liabilities, and, to the extent that it is still necessary, the need to deal with FAS 106. Those who have significant liabilities have a strong incentive to limit them either by redistribution to other employers or by transfer to retirees. Employees and retirees are looking for some assurance that the benefit (or something of equal value) will be there in the future, no matter what their health status, so that their health care bills can be paid. The health care reform process now under way offers the best hope for restructuring responsibilities and costs.

For most employers, the problem with retiree health costs is not the annual expense but the size of the future liability and the resultant impact on corporate balance sheets. Although health care is the most rapidly growing input cost, it still is not a significant one for most employers, compared to other compensation costs. Chamber of Commerce data show that, on an expense basis in 1990, active workers' medical benefits were only a little over seven percent of payroll on average in 1990 (a little

over eight percent for manufacturers), or $2358 per worker, and retiree medical benefits were only one percent of payroll (almost one-and-one-half percent for manufacturers), or $323 per worker (Piacentini and Foley 1992). Unlike expenses, however, liabilities may be significant compared to company assets or equity. Retiree medical liabilities, according to a Hay-Huggins survey of FAS 106 liabilities of 300 companies, may average almost seven times the company's annual pay-as-you-go expense (Hay Group 1992). In fact, for three percent of the companies surveyed, FAS 106 liabilities were reported to be at least 20 times their annual costs.

Redistributing the Retiree Burden

The poor distribution for payment of the retiree health benefit is the most significant issue for some employers. The redistribution of this burden, however, is a zero sum game for employers as a group. Employers with large retiree health liabilities will benefit from any opportunity to shift toward broad-based financing. Employers with few or no retiree health liabilities could be at a substantial disadvantage with such a shift. Although various approaches to refinancing retiree health benefits would have different distributional results, all refinancing schemes, whether based on new or higher taxes or on community-rated insurance premiums, inherently tax those people who do not provide the benefits now so that others who do provide benefits can be relieved of the burden.

The problem is that although a large number of employers have significant FAS 106 retiree health liabilities in relation to their net worth, the majority of employers either have more manageable liabilities or have no liabilities at all. In fact, most employers now provide no financing for retiree health. An estimated 57 percent of medium and large private firms, 42 percent of state and local governments, and 83 percent of small private establishments provide no retirement health benefits or require that retirees pay the entire cost (Piacentini and Foley 1992). For this reason, redistribution will be difficult politically.

In the end, only a limited number of ways can effectively redistribute the burden: payroll tax financing that spreads the cost in relation to overall compensation rather than linking it to the demographics of an individual employer's workforce; or community-based ratings that spread the cost equitably among all premium payers rather than associating costs with the health risk of the individual.

Payroll Tax Options

Payroll tax proposals focus on expanding Medicare, either by lowering the age of eligibility to cover early retirees or by expanding the scope

of benefits for those age 65 and older, to eliminate Medigap coverage. One proposal to lower Medicare eligibility to age 60 (H.R.3205) was introduced in the 102nd Congress by House Ways and Means Chairman Dan Rostenkowski. Under this proposal, everyone aged 60 to 64, whether retired or employed, would become eligible for Medicare benefits, with the expansion in eligibility financed by an increase of 0.2 percent (from 1.45 percent to 1.65 percent) in the HI payroll tax rate for employers and employees.

The proposal would have several advantages for employers, with significant early retiree health costs. It would shift a portion of the retiree health costs to the Medicare tax and, by spreading this portion across all employers, would reduce the competitive disadvantage for employers with benefits. By converting a portion of the retiree health obligation to a tax, it also would reduce the amount of liability that had to be offset by assets or that had to be booked under FAS 106. Employers would receive support for the pre-65 health plan participants—working and retired. The extent of support for workers would be substantially lower than that for retirees, because Medicare would probably act only as a secondary payer for workers.

To the extent that the proposal provided federal subsidies for health benefits for early retirees, it could encourage employers to offer early retirement incentives. It also would skew *the subsidies* to companies that had pledged expensive health benefits to gain the productivity improvements associated with downsizing and would skew *the costs* to companies that had avoided taking on the burden in the first place. In this way, the federal government might reward inefficient labor practices and other industrial inefficiencies and penalize the very companies that have operated the most efficiently.

Another approach to expanding Medicare is to improve the benefit for those who already are eligible. This proposal would resemble the Medicare Catastrophic Coverage Act provisions enacted in 1988 and repealed in 1989. Specifically, it would expand the scope of benefits for those who are aged 65 and older, with the intention of providing full coverage under Medicare and eliminating the employer's obligation for retirees once they reach age 65. The Medicare Catastrophic Coverage Act provided employers with a windfall by financing the new benefits entirely through Medicare premium and tax increases for the elderly. An alternative would be to use an increase in the Medicare payroll tax to finance all or part of the expansion and then redistribute retiree health costs among employers, regardless of their share of retirees.

Eliminating company obligations for post-65 health benefits would enable employers to focus exclusively on early retirement benefits, which usually are more directly under the employer's control and are related to

the employer's own workforce needs and decisionmaking. The fact that the benefits would be time limited (granted only to age 65) would make the total cost of the benefit more predictable in that the unknown factors—life expectancy and the uncertainty of future Medicare benefits—would be removed from the equation and the time horizon for estimates could be shortened. In addition, the affordability of the benefits could be tied more directly to the employer's larger decisions about early retirement packages.

Proposals for Pooling and Community Rating

Proposals to restructure the insurance market—to pool health risk better or to have community-rated premiums—offer opportunities to redistribute the burden of retiree health costs. Proposals considered by President Clinton's Health Care Task Force for health insurance purchasing cooperatives (or health alliances) suggest community rating to pool health risk and to reduce adverse selection incentives. These prospects, however, raise a number of questions about the financing of health care for pre- and post-65 retirees.

To implement health alliances like those designed by the Jackson Hole Group that merely provide affordable individual and small group coverage could easily prompt a wholesale abandonment of employer-provided retiree health benefits for today's active workers. Because the health alliance would guarantee insurance at an affordable community-rated premium to individuals with no regard for health risk, retirees then could be assured of obtaining adequate health benefits through the health alliance and no longer would have to depend solely on the coverage available through the employer's group. Employers could substitute a supplemental pension benefit calculated to pay health alliance premiums, assuming that pension benefits could be increased sufficiently under the tax code limits on contributions and benefits. Although employers might be reluctant to terminate current retirees' health coverage for legal reasons, there would be little reason to continue promising retiree health coverage to active workers. It is most likely that retirees would lose value in the conversion from health to pension benefits, because pensions would be unlikely to match or keep pace with health alliance premiums. Employers would benefit from the ability to prefund this pension obligation and to manage its liabilities.

Although the Health Alliance would be attractive to employers as a way to manage their retiree costs better, it would not necessarily reduce those costs. For the health alliance to actually reduce an employer's retiree costs it would have to do three things: use community-rated or modified community-rated premiums to redistribute the retiree burden

to employers with younger workers and to others in the community; offer a standard benefit below the level of current retiree benefits to share a greater portion of the cost with retirees themselves; and slow the rate of growth in future health care costs.

Community rating is a highly controversial aspect in the health alliance proposal. Community rating that included older workers and retirees in the rating pool could be expected to raise premiums substantially for low-risk individuals and groups that have benefited for many years from experience-rated premiums. Small employers currently insured and anticipating lower premiums from the development of health alliances could find that community-rated premiums actually were higher. Employers forced to sponsor health benefits for the first time could find these premiums to be well beyond their economic reach. Federal subsidies for small employers that financed premiums in excess of a specified threshold ultimately would transfer some portion of the added cost of retirees to the federal budget.

To the extent that employers continued to make contributions, retirees or employers themselves could be required to pay a portion of the cost differential through modified community ratings that based premiums on age or other demographic or risk factors. Employers that chose to "buy" their retirees into the health alliance might be required to pay an age-adjusted premium. This also would have to apply to older individuals not in groups, to prevent employers from terminating retiree health coverage and letting their retirees purchase coverage as individuals. Employers that chose to pay modified community-based rates would still realize savings from recharacterizing the benefit as a cash benefit with prefunding, from the greater costsharing in the health alliance standard benefit, and from any of the health alliance's administrative savings or cost-containment successes. They would not realize as much benefit, however, from a redistribution of the health care costs attributed to their active worker/retiree ratio.

The main impediment to redistribution of the retiree health burden is the reluctance of lower risk groups, younger individuals, and employers without substantial retiree health costs to pay higher premiums to offset costs of early retirement programs adopted voluntarily by employers with larger retiree health burdens.

Managing Liabilities Without Redistribution

Even if no significant redistribution of costs occurs, many questions remain for employers who will need to cope with this liability in the future—particularly for those who continue to provide benefits for currently active workers. First, the liability will need to become more predictable

and manageable. Employers are now attempting to tame their retiree health liabilities (1) by converting the current open-ended health benefit to a predictable and measurable cash benefit; (2) by accruing the benefit over a working life or at least relating the benefit to the employee's length of service; and/or (3) by increasing retirees' costsharing. Second, employers will need some way to offset retiree health liabilities with tax-favored assets. Again, by converting the liabilities to cash obligations, it becomes easier to prefund the benefit through a pension program, given that contributions for employees will not exceed the IRS section 415 limits on tax-favored contributions and benefits.

Trade-Offs for Retirees

To convert retiree health obligations to cash results in many trade-offs for retirees. Retirees are at a disadvantage in that cash benefits, which tend to be static and maintain a nominal value over time, are rarely adequate enough to replace health benefits, which are dynamic and grow in both nominal and real terms. For retirees to avoid a substantial loss from this exchange, they need to have increased or indexed cash payments. Cash benefits need to be increased more to compensate for the loss of tax credits as the tax-free health benefit is converted to taxable cash. Retirees can gain some advantage from the conversion to cash benefits, however. To the extent that cash benefits can be accrued over the working life, can be vested and prefunded, and can be more portable than health benefits, retirees may find that, on balance, they receive more security and fungibility of the benefit, even if the cash value is not equivalent to the health benefit value.

Who Should Pay for Retirees?

The question of who should pay for retiree health care was answered partially in 1965 when Medicare was enacted to spread the hospital and physician expenses for the elderly equitably (as a percentage of compensation) across the productive output of the country. The Medicare act acknowledged the difficulties that the elderly encountered in financing this cost through private insurance or other private retirement vehicles—but it went only part way. Medicare left almost half of the expenses for the post-65 and over population uncovered, the most significant being prescription drugs and long-term care, and it never addressed the costs of health care for younger retirees. The holes in Medicare are plugged by the elderly and by their families, by employer-provided and individual early retirement, by Medigap insurance policies, and by Medicaid, a federally funded program for those people who have no resources. This

patchwork of coverage and costsharing places burdens on employers and individuals, however, and seems temporary at best.

Recently, soaring projections of future health care costs have made it even more difficult to resolve the question of who should pay for retirees. Long-term care costs have moved beyond the economic reach of most families, impoverishing large numbers of the elderly and placing an increasing strain on the ailing Medicaid program that already finances more than 40 percent of nursing home expenses. Prescription drug costs are consuming growing portions of the budgets of the chronically ill elderly, and employer-provided retiree health programs have come under increasing scrutiny from their sponsors as rising costs and projections of liabilities have begun to affect the financial health of many large corporations. Although Medicare expansion may seem the most equitable way to finance these costs, within a decade Medicare will be unable to finance its current package of benefits on its prevailing tax rate, and any congressional enthusiasm for Medicare expansion has been dampened severely by the painful repeal of the Medicare catastrophic benefit soon after its enactment. In short, no sector of the economy seems prepared to step forward to cover the growing gap in health care financing for retirees. In this context, what is the proper role for employers?

Early Retirement

The strongest case for employers to finance health benefits is to make them available in early retirement packages. In the absence of accessible and affordable individual insurance for older persons, the ability to continue in the employer's group can be worth more to an early retiree than the pension benefit. The health benefit is a necessary element in a package that makes early retirement attractive to an older worker. It also enables employers to reduce capacity in a humane way.

More significantly, from a national policy perspective, early retirement is viewed as a convenience to the employer that runs counter to the public good. It is inappropriate to finance early retirement through public funds, because able-bodied workers are removed prematurely from the workforce, the tax base is reduced, and the demand for public benefits is consequently increased. As a device used to lower the cost of production for a specific firm, the entire cost of early retirement should be financed through the productivity of that firm and not by its competitors.

The problem with early retirement health benefits is that they have been overvalued by retirees and undervalued by employers. Retirees who act on the offer of health benefits assume that these benefits will continue throughout retirement. The fact that employers do not vest or fund the benefits and reserve the right to modify or terminate them in the

future adds an element of risk that retirees often discount in their calculations. At the same time, when firms calculate the cost of a reduction in force or a plant shutdown, they rarely account for the true cost of the future stream of health benefits that they pledge in early retirement packages. This undervaluation has contributed to shutdowns, downsizing, and early retirement offerings that have cost companies far more than they have saved.

If employers are to continue to finance early retirement health benefits, these valuation issues need to be addressed. On the one hand, promised benefits should be vested at the time that the promise is conveyed. On the other hand, if the benefits are promised as part of a package of deferred compensation, then they should accrue and vest over the working life and become portable with the worker. If they are part of a severance package and accrue fully at the moment when a worker becomes eligible for retirement, then they should vest fully at that point as well.

With vesting comes funding. Without funding, vesting becomes hollow, to be met through creditors' claims in bankruptcy. Without vesting, prefunding has no purpose, because the benefits may never become payable. This combination of events can be made manageable if the early retirement health benefit is treated as severance and is earned, vested, and fully funded at the employee's retirement. In the context of health alliances that could provide affordable insurance for early retirees, the alternative is to convert the promise of health benefits to a cash commitment and then allow it to accrue and fund it over the working life. As a cash benefit, early retirement would be earned, regardless of whether a worker retired early, and could be used to purchase health insurance or could be deferred for other retirement uses.

Medicare Supplementation

The case for employer financing for normal retirement health benefits is not as strong as that for early retirement benefits. From a public policy perspective, normal retirement is a societal phenomenon and not unique to specific employers. A stronger case, therefore, exists for spreading the health costs associated with normal retirement equitably across society's total productive base. To the extent that the public sector draws a limit on its commitment and chooses to split the cost of health care with retirees (through limitations in Medicare coverage or copayments) to meet their other retirement goals, employers may find it necessary to ensure that future retirees have sufficient incomes to pay these out-of-pocket health costs. More appropriately, this begins to resemble a retirement income obligation, not a promise of health benefits. Nonetheless, two significant problems arise when retirement income approaches are used

to prefund out-of-pocket health expenses: it is difficult to anticipate the scope of out-of-pocket expenses that the Medicare policy will leave to retirees in the distant future, and, it is difficult to provide a cash benefit that can be indexed adequately to pay rising health care premiums over a retired lifetime. As of early 1993, most conversions of retiree health benefits to cash obligations have left the retirees responsible for any increases above current health care costs.

Controlling costs in private plans or Medicare by shifting growing portions of the costs to retirees and their families is not a viable way to finance retiree health over the long run. This long-term reduction in health coverage will leave future retirement incomes more vulnerable and less valuable, reducing the incentives that employers can offer to make retirement attractive, and increasing popular pressure for an expanded public role in financing health care for retirees.

Given the limited number of retirees aged 65 and older who are covered under employer plans, and given the uncertainties about the adequacy of future employer coverage, an expansion of Medicare coverage along the lines of the repealed Medicare catastrophic package may be appropriate. The failure of this legislation lay in its reliance on the elderly to "self-finance" the expanded coverage, because the catastrophic coverage was not sufficiently valuable on an individual basis to justify the high premiums that some individuals were required to pay. In addition, for retirees who already had employer coverage, the catastrophic act transferred the employer cost to them and gave employers a windfall without giving retirees the added retirement income needed to meet this cost. A more successful expansion of Medicare would be financed in part through a payroll tax or some other method that would capture a portion of the employer's retiree health contributions. Any payroll-tax-financed expansion of Medicare will have to be conditioned, however, on successful efforts to control rising health care costs.

Long-Term Care Financing

The financing of long-term care is a unique and complex problem that has, to date, defied all rational solutions. Although some employers have chosen to organize private group insurance for long-term care that employees may purchase, as yet, no widespread employer interest has been seen in financing long-term care for retirees. For one thing, long-term care expenses are too far removed from the retirement age for the offer of long-term care coverage to operate as a strong inducement for retirement. The costs of long-term care also are high and uncertain and, in the past, have been immune to efforts to control costs, particularly through traditional coverage limitation approaches.

The case against long-term care as an employer-financed benefit is also based on the complexity of the long-term care benefit. Long-term care is one part health services, one part housing, one part custodial services, one part protection of assets for spouses left in the community, and one part estate preservation for heirs. A persuasive rationale for the accumulation of assets over a working life is to prepare for the possibility of substantial long-term care costs late in life. The availability of Medicaid for those who consume their assets on long-term care insures against errors in estimating the amount of assets needed. In this context, long-term care insurance functions to protect those accumulated assets, to support a spouse who still lives in the community, to support the return of the patient to community living after a nursing home stay, or to provide for surviving children. In addition, long-term care insurance can help to finance home-based health care, because there is little such coverage now in Medicaid or Medicare, where home care is preferred over institutionalization. The difficulty in prefunding long-term care needs is that the nature of these needs varies so much for individuals, depending on circumstances that cannot be predicted. It may be more efficient to meet these needs through specific forms of insurance (e.g., for estate preservation) or through general retirement savings (e.g., for supported housing) than to try to meet them all in one package. At least some of these needs (e.g., nursing home or home health care) may be so prevalent at advanced ages and so expensive to meet that some form of social insurance, along with universal coverage and broad financing, would be a better solution.

Conclusion

No simple answer is available to the questions of who should pay for retirees or what the employer's role should be in financing retiree health. In general it makes sense to apply employer financing to where it relates best to the employer's labor force needs. Because employers are somewhat responsible for early retirement and because some employers need to preserve flexibility in managing their workforce, early retirement health benefits should remain their responsibility. Employers should remain free to decide whether or not to provide early retirement benefits; however, those employers choosing to offer early retirment benefits should be obligated to fund or otherwise commit to providing the promised package. With the emergence of health alliances or other forms of market reform, employers should be able to convert the benefit to a cash payment sufficient for the individual retiree to purchase health coverage through the health alliance. To make this commitment manageable, the benefit promise should be time limited until the retiree becomes eligible for Medicare.

Over time, the employer's responsibility for health benefits for retirees aged 65 and older should be phased out and Medicare's package of acute benefits should be expanded to eliminate the need for Medigap plans. To the extent that this expansion is financed through payroll taxes, it simply will replace employer and retiree financing that now comes through retiree health plans. It is inevitable, however, that costsharing with retirees will grow over time as the population ages in the next century. Today's workers should have greater opportunities for employer-financed and self-financed retirement income savings, to prepare for the higher out-of-pocket health costs they will face in the future.

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Commentary: Donald C. Snyder

In Chapter Five, G. Lawrence Atkins looks at the rationale for employers to provide retiree health benefits as an employment-based benefit. As an add-on to pensions (to facilitate early retirement programs), these benefits

- Protect workers at retirement;
- Attract and retain workers;
- Act as early retirement incentives.

Atkins concludes that the cost of the current system is not a reasonable burden for a company to bear. He correctly points out that one major problem with the current financing of these benefits is that today's retirees receive benefits from today's workers. These are not prefunded (vested) benefits. A second problem is that a single benefit is given to all workers. It is not based on pay or service at retirement. A third problem is that companies pay uneven amounts and many retirees are uncovered. As companies age and fail, these benefits are being reduced. As a result, retiree health coverage is no longer a secure benefit, neither legally nor morally. A fourth problem is that costs are growing and are unpredictable. The liabilities for these benefits have been highlighted by the Financial Accounting Standards Board's new accounting standard, FAS 106. In light of these conditions, Atkins then proposes some broad policy approaches to restructure the employer's role in providing retiree health benefits.

Background

Historically, many large employers offered retirees health benefits in the 1950s (most plans also provided spouse benefits). In total, these companies probably provided health benefits to the bulk of the 38 percent of

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Opinions and conclusions expressed are solely those of the author.

retirees who had health insurance in 1965, as cited by Greer and Hillman in Chapter Seven. It is important to note that when Medicare was passed in 1965, these companies received a large windfall savings; their retiree health benefit plans became "Medigap" (second-payer) programs. So, proposals to lower the Medicare eligibility age, and the accompanying savings, are not unprecedented. Early retiree costs were unaffected by the passage of Medicare in 1965.

As Atkins points out, costs for providing retiree health benefits are low because companies sponsor group policies. These group plans have a much higher value to retirees, however, because individual policy costs are so high. In addition, retirees value this benefit so highly because many individuals who have pre-existing medical conditions could not purchase health insurance.

Retiree health benefits are valuable not only because of the absolute savings to retirees but also because health care is a high-cost expenditure relative to the modest pensions and Social Security income that most retirees receive. Prescription drugs, a high and ongoing expense for many people, can be a significant drain on disposable income. In addition, Medicare benefits have been cut periodically, shifting costs to company sponsors and to retirees. This past history of cuts in Medicare raises the question of just how secure these benefits really are.

Company Costs and Liabilities

Pay-as-you-go costs, accrued liability, and prefunding costs are large for American companies. As of 1993, it is estimated that pay-as-you-go costs for companies already are near $14 billion and 63 percent is for early retirees (author's estimate). The liability for the future stream of benefit payments is $412 billion, and prefunding costs would be around $46 billion (author's estimate).

Recent health care proposals would lower the Medicare eligibility age from 65 to 60. If the Medicare age were lowered, then the pay-as-you-go amount would fall by $5 billion (35 percent), funding costs would fall by $6 billion (17 percent), and liabilities would fall by $123 billion (30 percent). Of this, the liability for current retirees of $155 billion would fall to $119 billion (23 percent) and the liability for active workers of $257 billion would fall to $170 billion (34 percent) (author's estimates). Although these numbers are large, in the aggregate they are modest, compared to corporate profits and assets.

Atkins posits that employers got into this cost and liability situation blindly, found the costs to be unacceptably high, and, consequently, have taken actions to reduce or eliminate these benefits. In this way, companies can reduce their cost/liability exposure. They are free to reduce or

eliminate these benefits if they have reserved the right to do so. As the U.S. Government Accounting Office (GAO 1991) has reported, many companies appear to be reducing retiree health benefits, using FAS 106 as an excuse.

It should be noted that FAS 106 does not impact cash flows; it only involves a bookkeeping entry. Many companies making changes to their plans do not have extraordinary numbers of retirees but are reducing health coverage or expenses for active worker plans, which recently has included retirees as well. Current data (see Chapter Four, Table 4.7 in this book) show that retiree plans are now targeted specifically for reductions in benefit coverage or for increases in the costs borne by retirees. These benefits therefore are not secure and have become less so in recent years.

In one sense, this is a puzzling situation because corporations have enjoyed a "pension-funding holiday" as their pension plans have become fully funded. It would seem that more expensive health benefits would be affordable as pension contributions have fallen.

Proposed Reforms

Atkins has proposed a split in responsibility for early-and normal-aged (65 and over) retirees. He proposes that employers pay for retiree health benefits until the Medicare eligibility age of 65. From that point on, the public plan would be responsible. The proposal fits Atkins' description of retiree health benefits as an employment-related benefit, that is, one that serves to attract and retain workers and to enhance early retirement incentives. As Medicare is constituted today, however, it generally is viewed as an inadequate medical benefit package. If Medicare is enhanced, then provision of an early retiree health benefit would seem to be reasonable for business sponsors. How secure, though, would post-age-65 health coverage be? The Medicare promise is not a secure one, and this approach of having no company benefits over age 65 would remove one layer of protection that current retirees now have against further changes.

Atkins' premise that employers should abandon those persons over age 65 is not feasible under the current health care system. Even though companies are cutting retiree health benefits, some benefits are still needed to supplement Medicare. And if the public benefits are cut rather than enhanced, then down the road company plans could pick up some of the lost benefits, by paying for those benefits that Medicare does not support (e.g., prescription drugs and long-term care).

Atkins' proposal covers one important need. Early retirees are especially burdened if they retire from a company that offers no retiree health benefits. If the Medicare age is not lowered, then one way to cover early

retirees would be through a COBRA-like extension of benefits up to age 65. This approach, to let employees buy into the active worker plan when they retire, has precedent in multiemployer plans. In 1988, 13 percent of plans offered a retiree health benefit plan with 100 percent of costs paid by the retiree. Of the remaining plans, 38 percent paid all costs, and 49 percent shared the cost with retirees. This COBRA-like extension fits in with Atkins' proposal and would appeal to retirees under the age of 65 who are not covered by a company-sponsored group health plan.

Conclusion

Atkins concludes that today's workers should prepare to bear a larger share of medical expenses in their retirement. This is not a pleasant message, but one that is on target and includes a warning that workers certainly should not overlook in their pre-retirement financial planning.

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