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RETIREE HEALTH BENEFITS: ISSUES OF STRUCTURE, FINANCING, AND COVERAGE

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SUMMARY STATEMENT

- In 1988, 43 percent of those aged 40 and over had retiree health coverage through their own or their spouse's current or former employer.

- Among men aged 40 and over, 23 percent have this coverage through their current employer compared with 10 percent of women, while 5 percent of men aged 40 and over receive coverage through a spouse's plan compared with 17 percent of women.

- In a survey conducted by Gallup for EBRI, 59 percent of respondents who had not yet retired expected to receive health insurance coverage through their former employer. Only 36 percent would retire before they were eligible for Medicare if their employer did not provide health benefits for retirees.

- Companies can design retiree health benefit plans as either defined contribution plans, defined dollar benefit plans, or defined benefit plans. In this latter type, employers assume the full risk of medical inflation; in the first type, the employees bear this risk.

- A recent statement from the Financial Accounting Standards Board (FAS 106) requires that employers providing these benefits place a liability on their balance sheet to reflect this plan as well as an accrued expense on the income statement. Surveys indicate that this may decrease pretax earnings and annual net income.

- Company changes to retiree health benefits occur largely in response to FAS 106, medical inflation, changing demographics, and/or company finances. Some companies have kept their traditional plans but are capping (or limiting) employer-provided benefits in order to reduce costs. Other companies may change to a defined contribution plan.

- There are several vehicles that companies can use to fund retiree health liabilities, each with some tax advantages and significant limitations. These include 501(c)(9) trusts, 401(h) accounts, 401(k) plans, and corporate-owned life insurance.

- Employees and/or retiree whose benefits were changed (due to FAS 106 or other factors) may feel that these changes were illegal and want to pursue the issue in court. In general, the courts have have ruled that an employer has a right to terminate or amend retiree welfare benefits, although the employer must prove that such a right has been reserved (or stated) in specific language and on a widely known basis.

- Changes in Medicare can have quite significant effects on employer retiree health plans depending on how the plan is integrated with Medicare.

- Both private and public financing of retiree health benefits are likely to be limited in the future as health care inflation continues to increase. The combination could leave retirees paying more.

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Introduction

In 1960, 9 percent of the population was aged 65 and over. By 1990, this proportion had increased to 12 percent, and it is expected to increase to nearly 24 percent in the next 40 years as the baby boom ages. Currently, the elderly account for a disproportionate share of all health care expenditures (U.S. Congress, 1989). To help cover these costs, some level of health insurance is currently provided to all elderly persons through a combination of benefits from employers and the government—employer-provided retiree health benefits and Medicare benefits. Both government and employer-based programs face growing financial strains.

Retiree health benefits were originally offered by many companies in the late 1940s and 1950s when business was booming as a result of economic expansion and there were very few retirees in relation to the number of active workers. The resulting liabilities were not substantial, and the financing of these benefits was not of concern. However, with the above mentioned factors, utilization patterns, and rising health care costs, many employers now have higher retiree-to-active-worker ratios and growing retiree health liabilities.

Many companies currently use pay-as-you-go financing (paying for retiree health care benefits out of current earnings). This method of financing involves no prefunding (that is, setting funds aside to pay for retiree health benefits in the future). Prefunding may increase, though, with the long-anticipated and recently approved Statement No. 106 (FAS 106) from the Financial Accounting Standards Board (FASB), which requires companies to recognize benefit costs and liabilities as they are incurred.

Retiree health benefits are also provided to the majority of those aged 65 and over through the Medicare program. It has been one of the fastest growing programs in the federal budget. Financing Medicare benefits has caused increasing strain on public funds throughout the 1980s and can be expected to continue doing so in the decades ahead.

This testimony begins with an overview of retiree health benefit coverage. Then it discusses a wide variety of issues concerning retiree health benefits from employers and from the government.

• Retiree Health Care Coverage

In 1988, 43 percent of those aged 40 and over had retiree health coverage through their own

Table 1
Employer-Provided Retiree Health Coverage of Persons Aged 40 and Over, by Sex, August 1988

Coverage	Total	Men	Women
Total	89,964,438	41,273,463	48,690,975
No Retiree Health Coverage	57.2%	53.1%	60.6%
Workers			
Covered by employer's plan	16.3	23.4	10.4
Covered by spouse's employer plan	11.7	5.0	17.3
Retirees			
Covered by employer's plan	11.5	17.3	6.6
Covered by spouse's employer plan	3.3	1.2	5.0

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.

Table 2

Employer-Provided Retiree Health Status of Persons Aged 40 and Over, by Age and Family Income, August 1988

Age and Income	Total	No Retiree Health Coverage	Workers		Retirees	
			Covered by Employer's Plan	Covered by Spouse's Employer Plan	Covered by Employer's Plan	Covered by Spouse's Employer Plan
	(thousands)		(percentage)			
Total						
40 and over	84,180[a]	57.1%	16.5%	11.8%	11.4%	3.2%
65 and over	26,524	71.5	1.6	1.8	20.5	4.5
Under $5,000						
40 and over	5,563	90.7	1.8	1.0	5.2	1.2
65 and over	2,811	93.1	b	b	5.7	0.8
$5,000–$7,499						
40 and over	5,640	86.2	1.5	1.1	8.3	2.9
65 and over	3,449	87.3	b	b	9.4	2.9
$7,500–$9,999						
40 and over	5,092	78.0	2.8	2.2	12.8	4.3
65 and over	2,864	78.5	b	0.6	16.1	4.5
$10,000–$14,999						
40 and over	11,205	69.7	4.8	4.0	16.8	4.7
65 and over	5,509	69.5	0.5	0.8	23.2	6.1
$15,000–$19,999						
40 and over	15,310	57.7	13.1	9.1	16.2	3.8
65 and over	5,396	62.9	1.4	2.4	27.9	5.4
$20,000–$29,999						
40 and over	13,095	48.1	21.1	15.2	12.7	3.0
65 and over	2,914	61.3	3.0	2.9	28.0	4.8
$30,000–$49,999						
40 and over	18,081	40.9	28.5	19.6	8.7	2.5
65 and over	2,435	59.1	4.9	4.5	26.9	4.6
$50,000 and over						
40 and over	10,194	37.6	30.8	22.7	6.0	2.9
65 and over	1,145	55.6	9.3	8.0	21.4	5.6

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.

[a]Total is less than in table 3 because it excludes those who did not know their family income or did not answer the question.

[b]Less than 0.5 percent of age group total.

or their spouse's current or former employer (table 1).[1] This includes both private and public employers. Among all employees of medium-sized and large private employers who are covered by group health insurance, 41 percent have employer-sponsored retiree health coverage before age 65 and 36 percent have such coverage at age 65 and over (U.S. Department of Labor, 1990).

Among the 50 state employee plans, 22 offer full retiree health benefits to those aged 65 and over (Meckin, 1990). This is an increase from 16 state plans in 1988. In 1987, 48 percent of full-time participants in medical plans of state and local governments had health care coverage after retirement at least partially paid for by their employer (U.S. Department of Labor, 1988).

Employer-provided retiree health coverage differs by gender (table 1). While 16 percent of all those aged 40 and over work and receive coverage through their current employer, 23 percent of men aged 40 and over fall into this category, compared with 10 percent of women aged 40 and over. Similarly, while 12 percent of all those aged 40 and over work and receive coverage through a spouse's plan, only 5 percent of men aged 40 and over are in this category, compared with 17 percent of women. Similar patterns are evident among those who receive coverage from a past employer.

Retiree health coverage differs by age group and family income. Among those aged 40 and over, 16.5 percent are active workers with direct coverage, compared with 1.6 percent of those aged 65 and over (table 2). Also, 15 percent of those aged 40 and over receive retiree health benefits through their spouse's plan, compared with 6 percent of those aged 65 and over.

Workers and retirees with higher family incomes are more likely to have retiree health coverage (table 2). At family incomes over $20,000, those aged 40 and over are more likely to have retiree health coverage through a current employer than through a past employer. With family incomes of $15,000 to $19,999, 13 percent of those aged 40 and over had retiree health coverage through a current employer and 16 percent had this coverage from a past employer.

However, among those aged 40 and over with family incomes of $20,000 to $29,999, 21 percent had this coverage through a current employer, compared with 13 percent from a past employer. There are several possible reasons for the differences in income. Workers have higher incomes compared with retired persons (assuming generally that those with benefits from a past employer are retired) largely due to the loss of wage and salary income. This would make retiree health benefits coincide with lower family incomes for those with coverage from a past employer. Another possibility is that those with high income are more likely to continue working past age 65.

Coverage also varies by firm size and industry. Among those receiving health coverage from a past employer, 62 percent had worked in firms with more than 1,000 employees, and 76 percent had worked in firms with 100 or more employees (table 3). By comparison, 63 percent of all nonfarm wage and salary workers are employed in firms with 100 or more employees (Piacentini, 1989). Fifty-four percent of persons receiving health coverage from their employer work in private industry, while 36 percent work for public employers. By comparison, 75 percent of all nonfarm wage and salary workers are in private industry, and 15 percent work for public employers (Piacentini, 1989), implying that public employers are more likely to provide this benefit.

• Public Attitudes Towards Retiree Health

In a survey conducted by Gallup for EBRI, 59 percent of respondents who had not yet retired said they expect to receive health insurance coverage through their former employer (Employee Benefit Research Institute/The Gallup Organization, Inc., 1991). Sixty-five percent of those who plan to retire before age 65 expect to receive coverage compared with 50 percent of those aged 66 or older. The provision of retiree health benefits was a major consideration in the decision of when to retire. Among nonretired persons, only 36 percent would retire before they were eligible for Medicare if their employer did not provide health benefits for retirees. This percentage jumps to 43 percent for those with an income of $75,000 or more and drops to 26 percent for those with an income of less than $20,000.

Seventy-three percent of respondents said employers should be required to provide health benefits to their retirees. Notably, those between the ages of 18 and 34 were more likely to support this type of proposal as were minorities. Even if providing such health benefits would mean a reduction in pension benefits, 67 percent of respondents still supported this proposal.

• Plan Design

Companies can design their retiree health benefit plans as either defined contribution plans, defined dollar benefit plans, or defined benefit plans. Defined contribution plans for retiree health are similar to defined contribution plans for pensions—the employer allocates a specified amount to each employee's account and usually relinquishes the investment decisions to the employees through various investment options. This money is then used by the employee to purchase health insurance after retirement. By definition (as in defined contribution plans for pensions), the employer has no liability beyond the contributions, even though the money may not fully cover health insurance costs in retirement.

A second plan design is a defined dollar benefit. In this plan, an employer promises a maximum annual dollar amount after retirement, to be used toward the cost of medical

Table 3
Retirees Receiving Health Coverage from Their Employer, by Firm Size and Industry, August 1988

Firm Size and Industry	Covered by Own Employer Plan
Total (thousands)	10,358
Firm Size	
Fewer than 20	3.7%
20–99	5.8
100–249	5.1
250–499	4.3
500–999	4.8
1,000 or more	61.8
Don't know/no response	14.5
Industry	
Private	54.1
Government	
federal	16.4
state and local	19.4
Self-employed	1.3
Unemployed	a
Don't know/no response	8.7

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.
[a]Less than 0.5 percent of the total.

coverage. Under this scheme, the employee is responsible for any remaining cost of coverage and thus carries the full burden of the cost of medical inflation if the employer does not provide increases in the amount contributed.

Third, companies can retain the promise to pay the full cost of medical coverage throughout retirement and, therefore, assume the full risk of medical inflation associated with retiree health care liabilities. These companies may, however, introduce increased cost sharing with retirees through copayments, deductibles, etc. The company also retains the investment risk if there is prefunding. This type of plan design, also called a medical service benefit, was most common when many of the retiree health plans were started in the 1950s and 1960s. These plans present the company with perhaps the largest obstacles for calculating liabilities and funding due in large part to the substantial size of the liabilities and the uncertainties of medical inflation.

Any change in plan design alters an employer's obligation to employees. While reduced or changed benefits may be beneficial from a bottom line standpoint, this action may lower employee morale and reduce a firm's ability to attract and retain employees. Explaining the changes to employees may also be costly for the employer. However, companies may be re-evaluating their plans in view of FAS 106.

• FASB Statement No. 106 on Postretirement Benefits Other Than Pensions

FASB Statement No. 106, "Employers' Accounting for Postretirement Benefits Other Than Pensions" (FAS 106)—approved in December 1990—requires liabilities for retiree health benefits to be recognized explicitly on companies' balance sheets. FAS 106 applies many of the same principles that were used in accounting for pensions (FAS 87 and FAS 88) to other postretirement benefits (for example, health coverage, life insurance, long-term care insurance, and housing). It applies to current and future retirees, their beneficiaries, and qualified dependents. The statement generally does not cover post*employment* benefits such as severance pay or wage continuation for disabled or terminated employees.[2]

FAS 106 requires that a liability based on the projected unit credit actuarial cost method (which considers future benefits expected to be earned by the employee) be accrued over the period from the first date that the plan grants credits toward these benefits (generally date of hire) to the date that the employee is fully eligible. Under FAS 106, the amount of a company's actuarial present value of benefits attributed to employee service rendered to a particular date (accumulated postretirement benefit obligation) that exceeds plan assets will be recorded as a liability on the company's balance sheet.[3] For some companies, the retiree health care liabilities required to be listed on the balance sheet in accordance with FAS 106 will far exceed the costs that currently appear in financial statement footnotes.

Even within these guidelines, there are several assumptions that employers must use to estimate postretirement benefit liabilities. Most important is the assumption about health care cost trends that implicitly considers expected health care inflation, changes in health care utilization and delivery, technological advances, and changes in the health status of plan participants. The rates at which the benefits' expected future cost is discounted (to their present value) must also be assumed.[4]

Several cost components make up the expense recorded in companies' income statements. Overall, this will require that, as with other forms of deferred compensation, the cost of providing postretirement benefits according to the terms of the plan will attribute to the employee during each period of service.

The effective date for adoption of this statement is the fiscal year beginning after December 15, 1992, for most employers. However, for certain small, nonpublic employers and non-U.S. plans, the statement is effective for fiscal years beginning after December 15, 1994.

• The Costs of FAS 106 to Employers

The projected impact of FAS 106 has been widely studied. There will be higher expenses for sponsoring companies under the new standard than under the current pay-as-you-go system,

due to the need to amortize the past obligations and to expense benefits as earned rather than as paid. Analysts expect employers with these benefits to record significant liabilities on their balance sheets, thereby increasing the amount of debt on the balance sheet compared to equity, a commonly watched ratio (Coopers and Lybrand, 1989).[5]

Other studies provide insight into the effects of FAS 106 through limited surveys. It is expected that the median annual medical cost for retirees will increase six times after adoption of FAS 106 (Hewitt Associates, 1990); pretax earnings will decline on average by 10 percent (Towers, Perrin, Forster & Crosby Inc.); annual net income of some companies may decrease between 30 percent and 60 percent, by one estimate (Integrated Administrative Services, 1990).

• Company Changes to Retiree Health Benefits

Company changes to retiree health benefits occur largely in response to FAS 106, medical inflation, changing demographics, and/or company finances. Some companies have kept their traditional plans but are capping (or limiting) employer-provided benefits in order to reduce costs. This is often done by limiting dollar contributions toward these costs in retirement, capping the increase in the amount contributed, or requiring a long service period before employees become eligible to receive these benefits.

A recent survey of 1,100 companies that offer retiree health benefits showed that nearly one-half had changed or planned to change their plans as a result of FAS 106. Twenty-eight percent of surveyed companies had increased employee premium contributions within the past two years or expected to do so in 1991, 18 percent began to require deductibles, and 14 percent decreased benefits. The survey also found that, while none of the companies had changed to a defined contribution type of plan in the past two years, 5 percent expected to make such a change by 1991 (A. Foster Higgins, 1990).

For the remaining liability, some plans are funded under certain tax codes that are specifically for this purpose, such as 401(h) or 501(c)(9). (These are described in the following section.) A survey by the Wyatt Company of 312 employers providing retiree health benefits showed that 57 percent of these employers used a pay-as-you-go system in 1986, and 63 percent used this system in 1988. Of companies with a liability for retiree health benefits, the use of insurance contracts decreased from 20 percent to 15 percent during this period. However, the use of 501(c)(9) trusts increased from 15 percent to 18 percent, and the use of 401(h) plans increased slightly, from 1 percent to 2 percent.

• Funding Options

Companies maintaining retiree health benefits may have a number of concerns, including reducing costs and cost volatility as well as the effects of the funding on corporate and retiree taxes.

There are several vehicles for funding retiree health, each with some tax advantages and limitations. Funds must be segregated and restricted (usually in a trust) to be used as an asset against the FAS 106 liability. These vehicles include 501(c)(9) trusts, or voluntary employee beneficiary associations (VEBAs), and 401(h) plans. Alternatively, some plans are used to help employers and employees set aside monies to help plan for the purchase of retiree health insurance, although these funds are not specifically reserved for this purpose. Such plans are 401(k) plans and corporate-owned life insurance (COLI). Not all are tax-deductible means of funding or setting money aside, and each has specific limits. The following summary and table 5 outline these differences.

501(c)(9) Trusts or VEBAs

Voluntary employee beneficiary associations (VEBAs) must be based on voluntary membership, and qualifications for membership eligibility must be defined by objective standards of an employment-related "common bond." The employer can make tax-deductible contributions; however, these are limited to essentially only the cost necessary to pay current welfare benefits plus a contribution to a qualified asset account.[6] While the contribution to the asset

account is intended to fund the liability over the employees' working life, neither health inflation nor increased utilization can be taken into account when figuring that contribution. Investment income is not exempt from tax for most plans (it is taxable as unrelated business income unless invested in tax-exempt instruments), although for 501(c)(9) plans established under a collectively bargained agreement, the contributions are unlimited and earnings accumulate tax free. Expenses for disability, medical benefits, and group-term life insurance purchases are also tax-free to the recipient, although other benefits are taxable upon receipt.[7], [8] A reversion of assets from a VEBA to the employer is strictly prohibited (there is a 100 percent excise tax).

401(h) Plans

Another vehicle is a 401(h) plan, in which contributions are put into a separate account within a defined benefit pension plan. Medical benefits must be subordinate to retirement benefits. This means that the contributions made to cover medical benefits cannot exceed 25 percent of aggregate employer contributions for both medical and retirement contributions after the plan first provides medical benefits.[9] Therefore, some plans may not be able to make such a contribution if the pension plan has been restricted by the full-funding limits. Investment earnings of a 401(h) plan are not taxable to the employer. If the pension plan or the medical benefit plan is discriminatory, neither plan will be tax qualified.[10] The plan must allow the employer to take a reversion of any excess amount remaining in the separate medical benefit accounts after all liabilities have been satisfied.

In the Omnibus Budget Reconciliation Act of 1990 (OBRA '90), Congress increased the options for using a 401(h) account to fund retiree medical benefits by allowing a transfer of assets from a defined benefit pension plan (other than a multiemployer plan) to a 401(h) plan once a year for five years.[11] These transfers are limited to only the amount the employer would pay during the year for current retiree health expenses[12] and therefore cannot be used to prefund any future benefits. Additionally, the pension plan must maintain assets equal to a minimum of 125 percent of current liability for accrued benefits, so only amounts over that minimum can be transferred.[13]

There has been mixed reaction to this transfer option. Plan sponsors that are more likely to take advantage of this option have older work forces (and, therefore, large and immediate liabilities), largely overfunded pension plans (and, therefore, the assets to transfer), and positive net income (and, therefore, a positive tax bill).

There is some debate about the extent to which such transfers affect pension plans' financial soundness. If one feels that the full-funding limits are higher than necessary, such a transfer to a 401(h) account may not reduce the pension plan participants' level of security. However, if the full-funding limit is not seen as providing a sufficient cushion for the pension benefits, such a transfer could reduce the pension plan participants' security.

401(k) Plans

A third method for setting aside funds for retiree health benefits is through a 401(k) plan. However, this method depends on an employer's ability to communicate to employees that they should use the money received from this plan to pay for retiree health benefits. Since the money is not directly earmarked for retiree health benefits, the assets in 401(k) plans cannot be used to count against the FAS 106 liability for balance sheet purposes.

These plans can include both elective and nonelective contributions. While they can be financed wholly through elective deferral, employers may use nonelective deferrals in order to ensure money is set aside for retiree medical payments for all their employees. Total contributions are limited by law. These plans follow the same laws as all 401(k) plans while being communicated to employees as a plan for retiree health, and not a pension plan. In retirement, distributions to the retiree are taxable and can then be used to pay premiums for medical care.

Corporate-Owned Life Insurance

A company could use corporate-owned life insurance (COLI) to set aside money for retiree

health liabilities. In this method, the employer purchases life insurance on the active work force (and sometimes on retirees). Later, the company can collect the life insurance proceeds tax free and/or borrow the maximum cash surrender value to derive positive cash flow in later years. COLI does not fund postretirement benefits in either a traditional sense or in accordance with FAS 106, but it does create a cash flow stream to meet all or part of the benefit costs. However, it is estimated that some plans will need seven years to have sufficient cash inflows from loans and death proceeds (reduced by loans) to cover all expenses and meet retiree health benefit expenses. COLI can be nonleveraged; that is, no loans are taken out on a policy or its cash value, or leverage, each incurring different tax implications.

A company must be able to prove the existence of an insurable interest in order to purchase tax-advantaged insurance on the employees with the company as the beneficiary. According to the U.S. Supreme Court, this means proving that the beneficiary of the policy (the employer, in this case) must "expect some benefit or advantage from the continuance of the life of the assured" (Integrated Administrative Services, 1990). However, each state can stipulate what constitutes an insurable interest; some states limit this to only key employees, some to all employees, and others do not specify whether or which employer-employee relationships are insurable.

• Court Cases

Employees and/or retirees whose benefits were changed (due to FAS 106 or other factors) may feel that these changes were illegal and want to pursue the issue in court. The courts must determine the extent of retiree health benefits that employers are obligated to pay on a case-by-case basis. The Employee Retirement Income Security Act of 1974 (ERISA) provided reporting, disclosure, and investment fiduciary requirements for pension and welfare plans. It included funding and vesting requirements for pensions but not for welfare plans. As a result, employers have generally not advance funded and have not viewed retiree medical benefits as a vested right.

Litigation on the rights of employees to receive retiree health benefits has been decided to date largely through the adoption of generally applicable contract principles. In general, the courts have ruled that an employer has a right to terminate or amend retiree welfare benefits, although the employer must prove that such a right has been reserved (or stated) in specific language and on a widely known basis.

The issues of which documents legally describe the benefits and if they indicate whether these benefits were to continue throughout retirement were addressed in a landmark 1984

Table 5
Funding Vehicles for Postretirement Medical Benefits
(Those Specifically in Tax Law and Examples of Other Arrangements)

	Deductible Contributions	Limited Contributions	Tax-Exempt Earnings for Company	Benefits Excludable from Retiree Tax	Benefit Security for Retirees	Applies as Financial Accounting Standards Board Asset
401(h)	●	●	●	●	●	●
501(c)(9) (Voluntary Employee Benefit Associations)	●	●	◑	●	●	●
401(k)	●	●	●	○	○	○
Corporate-Owned Life Insurance	◑	○	●	○	●	○
Employee Stock Ownership Plan	●	●	●	○	○	○

● Applies ◑ Partially Applies ○ Does Not Apply

Source: Employee Benefit Research Institute.

case.[14] There, in terms of the benefit promise, the circuit court held that certain "extrinsic evidence" (such as memos, pamphlets, and oral statements) could be considered as part of the agreement (or contract) between workers and employers where a collective bargaining agreement did not explicitly state such items. However, in another case, in which the benefits were not bargained, the court ruled that, since the company had reserved the right to change the benefits in its plan documents, other information from the company that seemed to promise lifetime benefits was not binding.[15]

An additional factor to be considered in determining the parties' intent in the framework of contract law is what the courts interpreted as a lifetime benefit "inference."[16] The court stated that, if employees forgo wages in return for retiree benefits, there may be an inference that the benefits will continue as long as the retirement status is maintained, thus a "status benefit inference." Some courts[17] have upheld this type of reasoning; other courts have disagreed.[18]

• Medicare

The most important source of retiree health insurance is Medicare. Medicare is another important source of health coverage for the elderly. While the elderly represented about 12 percent of the population in the late 1980s, they accounted for nearly 36 percent of every personal health care dollar spent in the United States. Medicare is by far the largest public health care financing program for the elderly. In 1988, Medicare financed an estimated $78 billion of the elderly's health care, representing 44 percent of their total health care costs of $176 billion.

Although public spending for the elderly's health care has grown during the past decade, it has decreased as a proportion of the total costs. Between 1984 and 1988, Medicare financing decreased from 46 percent of the elderly's total health care costs to 44 percent (Chollet, 1991). Since private insured spending for health care remained stable at about 12 percent of the elderly's total health care costs between 1977 and 1988, virtually all of the relative increase in private spending for health care by the elderly has been borne by the beneficiaries as an increase in out-of-pocket spending. The elderly's costs for health care have risen much faster than their incomes (Chollet, 1991). Estimated out-of-pocket spending as a percentage of personal income rose from 9 percent in 1977 to nearly 13 percent in 1988.

A poll conducted in January 1990 found that 64 percent of those aged 18 and over who are not eligible for Medicare benefits do not anticipate receiving the same level of benefits the Medicare program offers today when they become eligible in the future (Employee Benefit Research Institute/The Gallup Organization, 1990). Respondents were divided on whether they would be willing to pay an increased payroll tax during working years to insure receiving the current level of these benefits (47 percent against, 48 percent for, and 5 percent unsure). Notably, those earning less than $20,000 were the most likely to be willing to pay such an increased payroll tax (55 percent).

The ways in which employer plans are integrated with the Medicare program have important implications for the costs to employers and to retirees. Some forms of integration involve more cost sharing by the beneficiary than others. For all methods, however, Medicare is treated as the primary payer and the employer plan is the secondary payer.[19] .

- Medigap coverage essentially is coverage that pays the deductibles and coinsurance rates for Medicare; in this plan there is no cost sharing by the beneficiary.
- The coordination-of-benefits plan pays the lesser of (1) the plan benefit calculation without regard to the Medicare reimbursement amount or (2) the cost of covered services minus the Medicare reimbursement amount. In essence, the plan treats all money from any other plan as coming from the beneficiary. Therefore, payments from Medicare or other sources of insurance can be used to meet the deductibles or coinsurance rates for the employer retiree health plan and the beneficiary often pays nothing. Employers are moving away from these types of plans largely because of high costs (A. Foster Higgins, 1990).
- Under Medicare exclusion, Medicare payment is first subtracted from the bill, deductibles and coinsurance of the employer plan are then applied, and the employer plan pays the

remainder of the bill. Therefore, the beneficiary has some cost sharing under this type of plan, although not the Medicare cost sharing.

- For a Medicare Part B plan, the employer pays the retiree's share of the Part B premium, and the beneficiary continues to pay the deductibles and other cost sharing in Medicare Part B and Part A.
- Carve-out plans are becoming more common (A. Foster Higgins, 1990). In these plans, the employer determines the retiree health plan benefits and reduces them by Medicare payments. This leaves intact any cost sharing on the part of the beneficiary that the Medicare plan requires, such as deductibles and coinsurance.
- A Medicare supplement plan is one in which the employer offers only those benefits that are not covered by Medicare, such as vision and drug benefits; the beneficiary continues to pay the Medicare plan cost sharing features but gains the coverage of the employer plan.

Curbing the soaring cost of the elderly's health care defines perhaps the chief agenda for all "third parties" that pay: Medicare, Medicaid, and private insurers—including employer plans that provide health insurance coverage to retirees. Both demographic trends and the history of health care costs in the United States suggest that continuing, if slower, growth in spending for the elderly's health care is inevitable. This prospect is likely to force continued reevaluation of how this care is financed and who should pay.

• Conclusions

Retiree health insurance benefits are a common provision of large employers' benefit packages, both private and public. FAS 106 has brought the full financial impact of these benefits to the forefront, causing many private employers to reevaluate their plans and to consider limiting or eliminating them. For those employers who do continue providing benefits at some level, there are few funding vehicles available, all of which have significant limitations.

Medicare provides a wide range of health benefits to the elderly. However, this program is facing a difficult financial situation and according to the Advisory Council on Social Security, the program will be bankrupt by 2006 (Advisory Council on Social Security, 1991).

These constraints will leave more of the costs of retiree health care to be passed on to employer plans or to the beneficiary. Future beneficiaries apparently are aware of this and expect to receive a lower level of Medicare benefits than current beneficiaries. However, in a recent poll concerned with public attitudes on Medicare, 36 percent of those aged 18 to 65 rated the government's efforts at informing the public about the Medicare program as poor and 58 percent rated these efforts as good to fair (Employee Benefit Research Institute/The Gallup Organization, Inc., 1990). Knowledge of these benefits and of the limitations currently being imposed on employer plans and on Medicare could influence future public policy proposals.

Both private and public financing of retiree health benefits are likely to be limited in the future as health care inflation continues to increase. The combination could leave retirees paying more. This increases the need for individuals to find ways to finance retiree health care in the future. The provision of these benefits and who society feels should finance them will be a growing economic and social issue.

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• Endnotes

[1] All EBRI tabulations of the August 1988 Current Population Survey are for the civilian noninstitutionalized population of the United States living in households.
[2] Employees who become disabled with a certain minimum period of service may be eligible to receive pension benefits and may, therefore, be considered to be employees deemed to be on disability retirement. In this case, the long-term disability health benefits paid to them would fall under the scope of FAS 106.
[3] It is not required that this liability be recognized in its entirety immediately on the balance sheet due to some phase-in and amortization provisions.
[4] This should be based on current rates of return on high-quality, fixed-income investments in amounts and with maturities that match the amount and timing of the expected future benefit payments.
[5] As a result, this change in the debt-equity ratio may affect the covenants on current or future debt, resulting in higher interest rates or lower amounts of debt allowed. This secondary effect is difficult to estimate.
[6] The formula is benefits actually paid during any year (direct costs), plus a reserve for estimated claims incurred in the year but not yet paid (which must be determined as reasonable by the IRS and cannot exceed 35 percent of the qualified direct costs), minus the fund's after-tax income for the year.
[7] Disability and medical expenses are tax free to the extent provided in sections 104 and 105 of the Internal Revenue Code, which list the nonincludable expenses specifically.
[8] Most VEBAs are subject to nondiscrimination rules in both design and operations. A separate account must be held for key employees, with contributions counting against defined benefit section 415 limits. Therefore, contributions to the 501(c)(9) may lower the amount that can be funded through a pension plan for these employees.
[9] However, this does not include contributions made to the pension plan to fund the plan's past service credits.
[10] Within this separate account, individual accounts, known as individual medical benefit accounts (IMBAs), must be kept for each employee who is (or was during the past five years) a 5 percent owner of the company. However, separate accounts are only for recordkeeping purposes, and the money investments can be commingled. IMBA contributions are treated as an annual addition to a defined contribution plan for purposes of section 415(c).
[11] Taxable years of the employer beginning after December 31, 1990, and before January 1, 1996. There are special transitional rules for transfers in 1990. The transfer will not violate the requirement that contributions to 401(h) accounts be "subordinate" to the pension retirement benefits.
[12] The transfer is also reduced by the amount that the employer has previously contributed toward these liabilities.
[13] The transfer is made more stringent through vesting requirements for pension participants and health expenses for four years following the transfer.
[14] *International Union, United Automobile, Aerospace and Agricultural Implement Workers of America v. Yard-Man, Inc.* 716 F.2d. 1476 (6th Cir. 1983) *cert. denied* 465 U.S. 1007 (1984).
[15] *Moore v. Metropolitan Life Insurance Company.* 856 F.2d. 488 (2d Cir. 1988).
[16] See *Yard-Man.*
[17] Such as the Sixth Circuit in *International Union, UAW v., Cadillac Malleable Iron.* 728 F.2d 807 (6th Cir. 1984).
[18] Such as the Eighth Circuit in *Anderson v. Alpha Portland Industries, Inc..* 836 F.2d 1512 (8th Cir. 1988). This court stated that since Congress exempted welfare benefits from ERISA's vesting requirements, the intent to vest these benefits seems "illogical."
[19] While this is true for retirees, for current workers older than age 65, Medicare is the secondary payer.