Statement

Before the Subcommittee on Health

Ways and Means Committee

U.S. House of Representatives

Hearing on

Retiree Health Care

by

Dallas L. Salisbury
President
Employee Benefit Research Institute

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SUMMARY OF STATEMENT
OF DALLAS SALISBURY
EMPLOYEE BENEFIT RESEARCH INSTITUTE

- 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. These changing demographics are likely to have serious implications for the financing and delivery of health care services because, overall, the elderly use more health care services than others in the population.

- To help cover these costs, some level of health insurance is currently provided to nearly 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.

- Most companies currently use pay-as-you-go financing (paying for retiree health care benefits out of current earnings).

- 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.

- In response to this newly adopted standard and health care cost inflation, many companies are considering whether to continue to provide a full retiree health benefit or to make a limited contribution to this benefit. Several companies have already begun to make changes to current plan design.

- EBRI estimates that the present value of private employers' liabilities for current retiree health insurance obligations was approximately $241 billion in 1988.

- Considering the magnitude of the retiree health liabilities, putting them on financial statements is unappealing to many companies. Even among companies that advance fund retiree health obligations, very few have fully funded the obligations. Moreover, expectations may significantly understate actual obligations. Announcements of company disclosures to date have consistently exceeded "rule-of-thumb" estimates.

- In reaction to FAS 106 and increases in health care costs, some firms have dropped the provision of retiree health benefits for future retirees entirely, while others have no plans to change their existing plans.

- Companies can design their retiree health benefit plans as either defined contribution plans, defined dollar benefit plans, or defined benefit plans.

- Any change in plan design alters an employer's obligation to employees.

- EBRI's 1991 fall policy forum examined the types of plan design and funding changes employers are making in response to FAS 106. Some companies have kept their traditional plans but are capping (or limiting) employer-provided benefits in order to reduce the present value of the company's future health benefit obligation. 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.

- Some companies have elected to take a one-time charge against their earnings to comply with FAS 106. General Electric Company announced September 16 that it would take a one-time pretax charge of $2.7 billion against 1991 first-quarter earnings. Financial analysts have said the company's strong balance sheet allowed it take the hit at one time, as did IBM, which took a charge of $2.3 billion earlier this year. In addition, ALCOA announced a one-time pretax charge of $1 billion, Lockheed announced $1 billion, and USX announced $2–3 billion.

- 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, according to EBRI tabulations of the August 1988 Current Population Survey.

- In a recent EBRI survey conducted by The Gallup Organization, 59 percent of respondents who had not yet retired said they expect to receive retiree health insurance coverage through their former employer. Sixty-five percent of those who plan to retire before age 65 expect to receive coverage compared with 50 percent of those who plan to retire at age 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.

- EBRI has analyzed both H.R. 3205 and H.R. 1444 to estimate the effects of each proposal on health care coverage for early retirees.

- H.R. 3205 would reduce the Medicare eligibility age to 60. EBRI analysis found that if H.R. 3205 were completely implemented in 1989, total Medicare enrollment would have increased by as much as 5.0 million individuals. The new enrollees would include two-thirds of the 1.2 million individuals aged
60–64 who were previously uninsured.

- EBRI estimates that 2.6 million individuals receiving early retirement benefits under Social Security would become eligible to purchase Medicare under H.R. 1444. Nearly one million dependents of early retirement beneficiaries and disability beneficiaries would also be eligible to buy into Medicare. EBRI estimates that 13 percent of the 4.1 million individuals aged 62 to 64 in families with a Social Security beneficiary, or 554 thousand individuals, are disability recipients who would become eligible for Medicare under H.R. 1444.

- Medicare provides a wide range of health benefits to the elderly. However, this program is facing a difficult financial situation. According to the Health Care Financing Administration, the program could have negative cash flow by 1997 and be insolvent by 2003.

- Both private and public financing of retiree health benefits are likely to be limited in the future as health care inflation continues to increase. 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. The combination could leave retirees paying more. This increases the need for individuals to find ways to finance retiree health care in the future. This prospect is likely to force continued reevaluation of how this care is financed and who should pay.

STATEMENT OF DALLAS SALISBURY
PRESIDENT
EMPLOYEE BENEFIT RESEARCH INSTITUTE
BEFORE THE SUBCOMMITTEE ON HEALTH
COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES
NOVEMBER 5, 1991

I am pleased to appear before you this afternoon to discuss retiree health benefits. My testimony will examine the newly adopted accounting standard for postretirement benefits and its potential impact on employer-sponsored retiree health care plans. I will also review current retiree health benefit coverage statistics. Finally, I will consider the impact of current congressional proposals to expand Medicare eligibility to cover early retirees.

EBRI has long been committed to the accurate statistical analysis of public policy benefits issues. Through our research, we strive to contribute to the formulation of effective and responsible health, welfare, and retirement policies. Consistent with our charter, we do not lobby or advocate specific policy solutions.

◆ 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. These changing demographics are likely to have serious implications for the financing and delivery of health care services because, overall, the elderly use more health care services than others in the population. In 1988, the elderly accounted for 33 percent of all health care expenditures (U.S. Congress, 1989). The combination of an aging population and continued rapid health care cost inflation means that current and future retirees face growing health care expenses.

To help cover these costs, some level of health insurance is currently provided to nearly 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 1950s and 1960s 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, due to changing demographics, utilization patterns, and rising health care costs, many employers now have higher retiree-to-active-worker ratios and growing retiree health liabilities.

Most 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). FAS 106 requires companies to recognize benefit costs and liabilities as they are accrued.

In response to this newly adopted standard and health care cost inflation, many companies are considering whether to continue to provide a full retiree health benefit or to make a limited contribution to this benefit. Several companies have already begun to make changes to current plan design.

◆ 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.

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.[1] 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.[2]

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.[3]

EBRI estimates that the present value of private employers' liabilities for current retiree health insurance obligations was approximately $241 billion in 1988. It is this amount that employers will be required to recognize in their financial statements with the adoption of FAS 106. The General Accounting Office (GAO) estimated these earned liabilities at $217 billion, and the liabilities expected to be incurred in the future by current employees at $175 billion, for a total of $402 billion in 1988.[4] More recently, GAO estimates that as of 1991, private employers had accrued retiree health liabilities of $296 billion, with $93 billion owed for current retirees and $203 billion accrued by current employees.

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).

Some analysts believe the market has already taken these liabilities into account, and their disclosure on the financial statements will not significantly affect stock market prices. Nevertheless, considering the magnitude of the retiree health liabilities, putting them on financial statements is unappealing to many companies. Even among companies that advance fund retiree health obligations, very few have fully funded the obligations.

Moreover, expectations may significantly understate actual obligations. Announcements of company disclosures to date have consistently exceeded "rule-of-thumb" estimates. For example, the market estimate of General Electric's liability was $1.8 billion; the company announced a $2.7 billion pretax charge this fall (Elliott, 1991). And this charge is likely to be less than some employers because GE was already accruing part of its future obligation for retirees.

◆ **Plan Design**

In reaction to FAS 106 and increases in health care costs, some firms have dropped the provision of retiree health benefits for future retirees entirely, while others have no plans to change their existing plans. In between some employers may place limits on their postretirement medical benefit promises, tie the promise to length of employment, or comprehensively restructure the plan design. Overall, most companies are or will be evaluating their retiree health liabilities and deciding whether or not changes to the current plan design are necessary.

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 coverage. Under this scheme, the employee is responsible for any remaining cost of coverage and thus carries the full burden of the effects of health care cost 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 reduce retiree health liabilities, 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.

♦ Company Changes to Retiree Health 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).

EBRI's 1991 fall policy forum examined the types of plan design and funding changes employers are making in response to FAS 106. Some companies have kept their traditional plans but are capping (or limiting) employer-provided benefits in order to reduce the present value of the company's future health benefit obligation. 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.

For example, AT&T has maintained the entire retiree health benefit cost for 102,200 retirees, which totaled $319 million in 1989. For employees retiring after March 1, 1990, AT&T pays for retiree premiums up to a maximum fixed amount, based on the retiree's age and coverage type (single or joint). Retirees will be responsible for the remainder.

Quaker Oats redesigned its retiree medical plan, effective 1989, to relate benefits more equitably to service, to provide broader, more flexible service, and incorporate cost containment and liability controls. Its Retiree Health Incentive Plan, which will be updated annually to reflect inflationary changes, is composed of two parts: comprehensive medical coverage and the health expense account. The defined contribution expense account replaces open-ended first-dollar benefits. It is available to reimburse dental, vision, hearing, and wellness care, or contributions to the plan. Quaker pays a majority of plan costs, while retirees contribute a percentage of costs based on their service. The longer an employee has worked for the firm, the lower the retiree contribution, and the higher the health expense account.

American Airlines redesigned its plan effective January 1, 1990, to include employee contributions as a new eligibility requirement for retiree coverage. Active employees are required to make monthly contributions ($10 for 1990) for at least ten years prior to retirement to help prefund their retiree medical coverage. To retire with medical benefits, there is a minimum employment period of 10 years and an age minimum of 55 years. All employees are automatically enrolled to prefund their retiree medical benefits unless they sign a program waiver. Among the employees, 99 percent chose to participate.

Some companies have decided to use a defined contribution approach in which a specific amount of money is set aside that may or may not be sufficient to cover all retiree health costs. Although these plans are described by the companies as providing savings for retiree health expenses, the money is not legally earmarked for these expenses. These plans include ESOPs and 401(k) plans, with contributions coming from either the employer or employee, or both, depending on the plan's provisions.

The Ball Corporation of Muncie, Indiana, discontinued its employer-paid retiree medical plan for persons hired after January 1, 1990, and has instituted an employee-pay-all program to fund retiree medical costs for new employees. Ball hopes to encourage its employees to save for future medical care costs by allowing them the opportunity to contribute after-tax dollars into a fund. The fund will be invested in group annuity contracts that yield a fixed rate of interest, similar to guaranteed investment contracts. Employees must contribute at least 2 percent of pay in order to participate, and investment earnings may accrue tax free. There is a debate among

tax attorneys, however, about whether or not the Ball approach is permissible under tax law.

Some companies are setting up hybrid plans that combine aspects of several different types of plans. Procter and Gamble has used an ESOP and 401(h) plan (HSOP) to fund its future retiree benefit costs, beginning in fiscal year 1991–1992. This plan allows for assets to grow tax free, and funds are immediately available to offset the accounting liability (since the funds are in 401(h) accounts). The IRS has subsequently sent out a field directive suspending future determination letters for HSOP arrangements, pending notice from the national office.

Some companies have elected to take a one-time charge against their earnings to comply with FAS 106. General Electric Company announced September 16 that it would take a one-time charge of $2.7 billion against 1991 first-quarter earnings. Financial analysts have said the company's strong balance sheet allowed it take the hit at one time, as did IBM, which took a charge of $2.26 billion earlier this year. In addition, ALCOA announced a one-time pretax charge of $1 billion, Lockheed announced $1 billion, and USX announced $2–3 billion (Elliott, 1991).

◆ Retiree Health Care Coverage

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, according to EBRI tabulations of the August 1988 Current Population Survey (table 1).[5] This includes both private and public employers. A recent Bureau of Labor Statistics survey found that 41 percent of full-time employees of medium-sized and large private employers who are covered by group health insurance are eligible to receive employer-sponsored retiree health coverage before age 65 and 36 percent can receive 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 (Mackin, 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).

Retiree health coverage differs by work status, gender, age group, and family income. Among those workers aged 40 and over, 38.7 percent were covered by employer health plans that continue into retirement, and 10.1 percent were covered through a past employer (table 1). Among retirees aged 40 and over, 35.7 percent received health benefits from a former employer. Men were more likely than women to receive retiree health benefits, and much more likely to have a retiree health plan in their own name.

Individuals under 65 and those with higher family incomes were more likely to have retiree health coverage (table 2). While 43 percent of all individuals over age 40 reported that they had health coverage that continues into retirement, only 28.5 percent of those over 65 had such coverage. The probability an individual over the age of 40 has retiree health benefits increases with income. Over 60 percent of those individuals over 40 years of age who live in families with incomes greater than $50,000 annually have retiree health benefits, compared with about 15 percent of those who live in families with incomes less than $10,000.

Coverage also varies by firm size and industry. Among those retirees 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

Table 1
Retiree Health Coverage

Number and Percentage of Individuals Aged 40 and Over with Employer Sponsored Retiree Health Coverage by Work Status and Sex, August 1988

Work Status and Sex	Total	Retiree Health Coverage				No Retiree Health Coverage
		Current Employer[a]		Former Employer		
		Direct	Indirect	Direct	Indirect	
		(in millions)				
Total	90.0	11.8	10.5	13.2	2.9	51.5
Work Status						
Working[b]	42.9	11.8	4.8	3.5	0.8	22.0
Retired	23.8	na	1.2	7.8	0.7	14.1
Other[c]	23.3	na	4.5	1.9	1.4	15.4
Sex						
Male	41.3	8.2	2.1	7.1	0.5	21.9
Female	48.7	3.7	8.4	3.2	2.5	29.5
		(percentage within work status and gender categories)				
Total	100.0%	13.1%	11.7%	14.7%	3.3%	57.2%
Work Status						
Working[b]	100.0	27.5	11.2	8.2	1.9	51.3
Retired	100.0	na	4.9	32.8	2.9	59.3
Other[c]	100.0	na	19.5	8.3	6.2	66.0
Sex						
Male	100.0	19.8	5.0	17.3	1.2	53.1
Female	100.0	7.5	17.3	6.6	5.0	60.6

Source: EBRI tabulations of the August 1988 Current Population Survey.

[a] Respondents currently receive health coverage from an employer which continues in retirement.

[b] Includes current workers as well as those who reported that they were looking for work and those who had a job but were not working during the week prior to the survey.

[c] Includes students, individuals who were unable to work, and homemakers.

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	Present Employer		Past Employer	
			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%	13.3%	11.8%	14.6%	3.2%
65 and over	26,524	71.5	1.0	1.8	21.1	4.5
Under $5,000						
40 and over	5,563	90.7	1.4	1.0	5.6	1.2
65 and over	2,811	93.1	b	b	5.8	0.8
$5,000–$7,499						
40 and over	5,640	86.2	1.4	1.0	8.5	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	2.0	2.2	13.6	4.3
65 and over	2,864	78.5	b	0.6	16.2	4.5
$10,000–$14,999						
40 and over	11,205	69.7	3.7	4.0	17.9	4.7
65 and over	5,509	69.5	b	0.8	23.4	6.1
$15,000–$19,999						
40 and over	15,310	57.7	11.0	9.1	18.3	3.8
65 and over	5,396	62.9	1.0	2.4	28.4	5.4
$20,000–$29,999						
40 and over	13,095	48.1	17.4	15.2	16.3	3.0
65 and over	2,914	61.3	1.8	3.0	29.1	4.8
$30,000–$49,999						
40 and over	18,081	40.9	22.8	19.6	14.3	2.5
65 and over	2,435	59.1	2.8	4.5	29.0	4.6
$50,000 and over						
40 and over	10,194	37.6	24.0	22.7	12.7	2.9
65 and over	1,145	55.6	6.6	8.0	24.2	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.

Table 3
Retirees Receiving Health Coverage from Past 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.

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 recent EBRI survey conducted by The Gallup Organization, 59 percent of respondents who had not yet retired said they expect to receive retiree 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 who plan to retire at age 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.

◆ **Pending Medicare Expansion Proposals**

I was asked to discuss current legislative proposals to expand Medicare eligibility to cover early retirees. EBRI has analyzed both H.R. 3205 and H.R. 1444 to estimate the effects of each proposal on health care coverage for early retirees.

Under House Ways and Means Chairman Rostenkowski's comprehensive health care reform proposal (H.R. 3205), the Medicare eligibility age would be gradually reduced to age 60 by 1997. In addition, employers would be required to provide basic health insurance coverage to all employees or pay an excise tax to help finance a newly created public plan. Individuals not covered under an employer plan or another public plan such as Medicare or Medicaid would be insured under the new public plan.

EBRI analysis found that if all the provisions of H.R. 3205 were fully implemented in 1989, total Medicare enrollment would have increased by as much as 5.0 million individuals (table 4). The new enrollees would include two-thirds of the 1.2 million individuals aged 60–64 who were previously uninsured. Individuals whose primary source of coverage before enactment was individually purchased private health insurance (0.9 million), Medicaid (0.3 million), or CHAMPUS/CHAMPVA[6] (0.4 million) would also gain Medicare coverage. Generally, Medicare would become the primary source of coverage for all nonworkers not covered by the group health plan of a working family member.

The remaining 0.4 million working uninsured could gain coverage through either an employment based plan or the new public plan.[7] Other workers who relied on individually purchased private coverage (0.5 million), CHAMPUS/CHAMPVA (0.1 million), Medicaid (0.03 million), and Medicare (0.04 million) as their primary source of coverage before enactment would also switch to either employment based coverage or the new public plan. Individuals currently covered by a group health plan as a dependent would keep employment based coverage as long as either the individual or the head of household are currently employed.[8]

Some individuals whose primary source of coverage under existing law is employment based may use Medicare as their primary source of coverage after enactment. This would include retired and other nonworking individuals whose direct employer sponsored coverage was through a former employer. In addition, some workers may choose to retire because they could now receive health coverage under Medicare.

A proposal (H.R. 1444) offered by Subcommittee on Health Chairman Stark would permit Social Security recipients aged 62 years or older, spouses (who are aged 62 or older) of Medicare beneficiaries, and children of Medicare beneficiaries to buy coverage under the Medicare program. In addition, the bill would provide Medicare

Table 4

Health Insurance Coverage under Current Law and Estimated Coverage After Enactment of H.R. 3205 for Individuals Aged 60–64

Source of Primary Coverage[a]	Before Enactment	After Enactment	Change
		(in thousands)	
Total Aged 60–64	10,683	10,683	0
Employment Based	6,587	4,896	-1,690[b]
Other Private Coverage	1,404	0	-1,404
Medicare	715	5,786	5,072
CHAMPUS/CHAMPVA	413	0	-413
Medicaid	330	0	-330
Uninsured	1,235	0	-1,235
Total Working Aged 60–64[c]	4,282	4,282	0
Employment Based	3,163	4,282	1,119
Other Private Coverage	522	0	-522
Medicare	36	0	-36
CHAMPUS/CHAMPVA	126	0	-126
Medicaid	28	0	-28
Uninsured	407	0	-407
Total Retired Aged 60–64[d]	2,445	2,445	0
Employment Based	1,508	109	-1,399
Other Private Coverage	264	0	-264
Medicare	244	2,336	2,091
CHAMPUS/CHAMPVA	116	0	-116
Medicaid	57	0	-57
Uninsured	255	0	-255
Total Other Aged 60–64[e]	3,956	3,956	0
Employment Based	1,915	505	-1,410
Other Private Coverage	617	0	-617
Medicare	434	3,451	3,016
CHAMPUS/CHAMPVA	171	0	-171
Medicaid	245	0	-245
Uninsured	573	0	-573

Source: EBRI tabulations using the March 1990 Current Population Survey.

[a]Individuals are classified according to their source of primary coverage. Those with more than one source of coverage were included in only one category based on the following hierarchy: employment based insurance, Medicare, CHAMPUS/CHAMPVA, individually purchased private insurance, and Medicaid.

[b]Employment based health coverage may be lower after enactment than indicated due to several factors. Some employers may choose to enroll their employees in the public plan rather than Medicare. In addition, some workers may be only part-time and may not be eligible for their employer's plan. Finally, workers aged 60 to 64 may choose to retire earlier because of the availability of Medicare.

[c]Includes individuals whose primary activity during the week prior to the survey was working.

[d]Includes individuals whose primary activity during the week prior to the survey was being retired.

[e]Includes individuals whose primary activity during the week prior to the survey was looking for work, keeping house, or going to school. Also includes those who were unable to work, and those whose primary activity was something not mentioned by the survey.

coverage to Social Security disability recipients aged 62 or older without any waiting period.

EBRI research found that more than 4.1 million individuals aged 62 to 64 were in a family where at least one member received Social Security benefits in 1989 (table 5). This includes disabled workers, early retirees, and their dependents. Fifty-five percent of these individuals were covered by employment based coverage and 11 percent were covered by Medicare (table 5). The remaining 34 percent were covered by individually purchased private health insurance (15 percent), CHAMPUS/CHAMPVA (4 percent), Medicaid (2 percent), or did not have health insurance coverage (12 percent).

Social Security beneficiaries and their dependents would be able to purchase Medicare under H.R. 1444. About 13 percent of all Social Security beneficiaries aged 62 to 64 were disabled, 63 percent were early retirees, and the remaining 24 percent were dependents of these individuals in 1988 (Social Security Administration, 1991). Applying these proportions to the 1989 beneficiaries, EBRI estimates that 2.6 million individuals receiving early retirement benefits under Social Security would become eligible to purchase Medicare under H.R. 1444. Nearly one million dependents of early retirement beneficiaries and disability beneficiaries would also be eligible to buy into Medicare. The proportion of those choosing to purchase coverage will be directly related to the cost of that coverage. Dependents would only be eligible to purchase coverage if the Social Security beneficiary in their household had purchased coverage.

H.R. 1444 would provide Medicare coverage to disabled workers aged 62–64 without the two year waiting period required under current law. EBRI estimates that 13 percent of the 4.1 million individuals aged 62 to 64 in families with a Social Security beneficiary, or 554 thousand individuals, were disability recipients who would become eligible for Medicare under H.R. 1444. Unlike the early retirement beneficiaries and their dependents discussed above, these individuals would not be required to purchase Medicare.

Removing the two year waiting period for disabled beneficiaries aged 62 to 64 may have a small impact on total Medicare enrollment. EBRI estimates that only about 114 thousand disability beneficiaries aged 62 to 64 would gain Medicare coverage under H.R. 1444. Generally, only the disabled and individuals with end stage renal disease are eligible for Medicare before age 65. The latter group generally account for less than two percent of all nonelderly Medicare recipients. Nearly 450 thousand individuals aged 62 to 64 in families where at least one member received Social Security benefits were enrolled in Medicare in 1989. Assuming that 2 percent of these, or 9 thousand individuals, were eligible because of end-stage renal disease, EBRI estimates that 440 thousand disabled beneficiaries received Medicare in 1989. This suggests that only 114 thousand, or 21 percent of all disability beneficiaries in this age group, were not covered by Medicare in 1989.

◆ 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 Health Care Financing Administration, the program could have negative cash flow by 1997 and be insolvent by 2003.

Table 5
Individuals Aged 62–64 in Families Where One or More Members Received Social Security in 1989 by Health Insurance Coverage and Major Activity

Primary Source of Coverage[a]	Total	Major Activity Last Week: Working[b]	Retired[c]	Other[d]
		(thousands)		
Total	4,155	812	1,475	1,867
Employment Based	2,282	516	905	861
Direct	1,487	415	695	377
Indirect	796	101	211	484
Other Private	636	152	167	318
Medicare	449	e	175	254
CHAMPUS/CHAMPVA	183	e	62	88
Medicaid	86	e	e	70
Uninsured	519	89	153	277
		(percentage within major activity categories)		
Total	100%	100%	100%	100%
Employment Based	55	64	61	46
Direct	36	51	47	20
Indirect	19	12	14	26
Other Private	15	19	11	17
Medicare	11	e	12	14
CHAMPUS/CHAMPVA	4	e	4	5
Medicaid	2	e	e	4
Uninsured	12	11	10	15

Source: EBRI tabulations using the March 1990 Current Population Survey.

[a]Individuals are classified according to their source of primary coverage. Those with more than one source of coverage were included in only one category based on the following hierarchy: employment based insurance, Medicare, CHAMPUS, individually purchased private insurance, and Medicaid.

[b]Includes individuals whose primary activity during the week prior to the survey was working.

[c]Includes individuals whose primary activity during the week prior to the survey was being retired.

[d]Includes individuals whose primary activity during the week prior to the survey was looking for work, keeping house, or going to school. Also includes those who were unable to work, and those whose primary activity was something not mentioned by the survey.

[e]Too small to be statistically significant.

Both private and public financing of retiree health benefits are likely to be limited in the future as health care inflation continues to increase. 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. The combination could leave retirees paying more. This increases the need for individuals to find ways to finance retiree health care in the future. This prospect is likely to force continued reevaluation of how this care is financed and who should pay.

I appreciate the opportunity to testify before you this afternoon. EBRI has published several studies on retiree health care, many of which are listed on the attached bibliography. We would be happy to provide you and your staff copies of any of our publications and I would be happy to answer any questions you may have at this time.

◆ Bibliography

A. Foster Higgins & Co., Inc. *Foster Higgins Health Care Benefits Survey: Report 4, Retiree Health Care.* Princeton, NJ: A. Foster Higgins & Co., Inc., 1990.

Chollet, Deborah J. "Health Care Spending among the Elderly." Working Paper 91-2. Atlanta, GA: Center for Risk Management and Insurance Research, Georgia State University, 1991.

Elliott, Douglas J. "Retiree Health: Issues and Implications." Presented at EBRI's September 25 Policy Forum, "Retirement Security in a Post-FASB Environment," Washington, DC: Employee Benefit Research Institute, 1991.

Employee Benefit Research Institute. *Measuring and Funding Corporate Liabilities for Retiree Health Benefits.* Washington, DC: Employee Benefit Research Institute, 1987.

_____. *Retiree Health Benefits: What Is the Promise?* Washington, DC: Employee Benefit Research Institute, 1989.

Employee Benefit Research Institute/The Gallup Organization, Inc. *Public Attitudes on Medicare.* EBRI Report no. G-8. Washington, DC: Employee Benefit Research Institute, 1990.

_____. *Public Attitudes on Medicare and Retiree Health.* EBRI Report no. G-20. Washington, DC: Employee Benefit Research Institute, 1991.

Hewitt Associates. *Survey of Retiree Medical Benefits, 1990.* Lincolnshire, IL: Hewitt Associates, 1990.

Integrated Administrative Services, Inc. *Postretirement Medical Issues and Responses.* Atlanta, GA: Actuarial Sciences Associates, Inc., 1990.

McDonald, Gregory J. General Accounting Office Statement before the Subcommittee on Health, Committee on Ways and Means, U.S. House of Representatives. 6 May 1991.

Mackin, John. *Rise in State Employee Health Plan Costs Moderates: Survey of State Employee Health Benefit Plans, 1990; Summary of Findings.* New York: Martin E. Segal, 1990.

Piacentini, Joseph S. "Pension Coverage and Benefit Entitlement: New Findings from 1988." *Issue Brief* no. 94 (Employee Benefit Research Institute, September 1989).

U.S. Congress. House. Committee on Ways and Means. Hearing on Employer-Sponsored Retiree Health Insurance. Committee Print, Serial 101-55. Washington, DC: U.S. Government Printing Office, 1990.

U.S. Department of Labor. Bureau of Labor Statistics. *Employee Benefits in Medium and Large Firms, 1987.* Washington, DC: U.S. Government Printing Office, 1990.

_____. *Employee Benefits in State and Local Governments, 1987.* Washington. DC: U.S. Government Printing Office, 1988.

U.S. Department of Health and Human Services, Health Care Financing Administration, 1990 Annual Report of the Board of Trustees of the Federal Hospital Insurance Trust Fund (Washington, DC: Health Care Financing Administration, 1990).

U.S. Department of Health and Human Services, Social Security Administration, Social Security Bulletin, Annual Statistical Supplement, 1989 (Washington, DC, 1989).

◆ Endnotes

[1] 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.

[2] 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.

[3] 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.

[4] The difference between EBRI and the GAO number for current liabilities is due in part to different assumptions about health care cost inflation. EBRI assumes that health care cost inflation will continue to exceed general inflation but that the difference between the rates will gradually decline over the next 25 years, converging at 3.5 percent in the year 2013. GAO assumes that health care cost

inflation will exceed general inflation by 3.5 percentage points in the years 1988 to 2001, by 2.75 percentage points from the year 2016 on.

5 All EBRI tabulations of the August 1988 Current Population Survey are for the civilian noninstitutionalized population of the United States living in households.

6 The Civilian Health and Medical Program for the Uniformed Services (CHAMPUS) provides health insurance coverage for dependents of active duty military workers while the Civilian Health and Medical Program for the Veterans Administration (CHAMPVA) provides similar coverage to the dependents of retired military workers.

7 EBRI estimates may overstate the number of people aged 60–64 receiving group health coverage under H.R. 3205. The analysis assumes that all workers would gain coverage under an employment based plan. However, some employers may choose to enroll their employees in the public plan rather than provide coverage. In addition, part-time workers may not be eligible for their employer's plan following the expansion and would enroll in the public plan.

8 Head of household is defined as the family member with the greatest personal earnings.