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There will be larger expenses for companies sponsoring retiree health plans under FAS 106 than under the current pay-as-you-go system.

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Retiree Health Benefits: Issues of Structure, Financing, and Coverage

- In December 1990, the Financial Accounting Standards Board approved Statement No. 106, requiring many companies to record a liability for retiree health benefits on their balance sheet in order to comply with generally accepted accounting standards, beginning with fiscal years after December 15, 1992.
- Employers can provide full retiree health benefits in retirement, make a contribution toward these benefits, or provide a contribution during employment that can be used by employees to pay for the retiree benefits.
- Currently, employers have few options for tax-favored prefunding of retiree health benefits. Some options are 401(h) accounts, 501(c)(9) trusts, 401(k) options, corporate-owned life insurance, and employee stock ownership plans. Each of these involves significant limitations.
- Though there are some legal restrictions on changing a retiree health plan, some companies have done so.
- In 1988, 43 percent of all people aged 40 and over had retiree health coverage through their own or their spouse's current or former employer. Coverage is more prevalent among men, those working or having worked for a large employer, and those with higher incomes.
- Medicare is by far the largest public health care financing program for the elderly. However, between 1984 and 1988, Medicare financing decreased from 46 percent of the elderly's total health care costs to 44 percent.
- No congressional action is expected on the retiree health issue. Allowing firms to prefund retiree medical liability for current and future retirees would lead to a loss of $37 billion in one year to the federal government, according to the EBRI Tax Estimating and Analysis Model.

◆ 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.

Since the cost of health care during the later years of life may well exceed many individuals' household income, financing health care for the elderly is an important issue. Currently, some level of health insurance is 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.

Among all people aged 40 and over, 43 percent have retiree health coverage through an employer (either their own or their spouse's). Coverage is more likely to be provided to those with higher family incomes and is more likely to be provided directly to men than to women. Sixteen percent of all people aged 40 and over receive retiree health benefits directly from their current employers, while 12 percent work but receive these benefits through their spouses' employers.

Demographics, utilization, and health care costs are increasing the cost to employers of providing this insurance. 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.

FAS 106 requires companies to record unfunded retiree health benefit liabilities[1] on their financial statements, effective for fiscal years beginning after December 15, 1992. According to current accounting standards, companies only record the existence of a plan and the cost for the current period in footnotes to their financial statements, and rarely include any specific numbers. The Employee Benefit Research Institute (EBRI) estimates that earned liabilities (for current private-sector employees and retirees) were $241 billion in 1988. 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.

Retiree health benefits are provided to the majority of those aged 65 and over through the Medicare program. Medicare is funded through a combination of general federal government revenues, payroll taxes, and premiums paid by participants. It has been one of the fastest growing programs in the federal budget, and recent budgets have attempted to slow its rate of growth. In his 1992 budget, President Bush has proposed limiting Medicare spending to $114 billion instead of the $117 billion agreed to in the 1991 budget agreement, although this is still an increase from 1991 spending of $105 billion. For 1992, this decrease in projected spending will occur through reduced payments to some hospitals (primarily teaching hospitals), higher premiums for the elderly, and an increase in the number of state and local employees who pay Medicare payroll taxes. Financing Medicare benefits has caused increasing strain on public funds throughout the 1980s and can be expected to continue doing so in the decades

[1]FAS 106 relates to all postretirement benefits except pensions. However, the most far-reaching and largest of these benefits for most companies is that of retiree health. Therefore, this *Issue Brief* will focus only on retiree health benefits.

ahead.

This *Issue Brief* addresses a wide range of retiree health issues. It begins by reviewing the provisions and potential impact of FAS 106. In response to this newly adopted standard and health care inflation, many companies are considering whether to continue providing a full retiree health insurance benefit or to make a limited contribution toward this benefit. However, changing the benefit promise can prove difficult for employers, as legal issues may arise. Several court rulings have restricted employers' attempts to change retiree health plans, although they have issued conflicting rulings.

For companies continuing to provide some or all retiree health benefits, several methods of prefunding are currently allowed, although they are limited. This *Issue Brief* includes specific examples of how some companies have changed their overall retiree health liabilities and/or used some form of prefunding.

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FASB Statement No. 106, "Employers' Accounting for Postretirement Benefits Other Than Pensions," requires liabilities for retiree health benefits to be recognized explicitly on companies' balance sheets.

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It discusses current coverage of employer retiree health plans as well as which employers are more likely to provide these benefits. Any reduction in coverage may increase pressure on public programs to provide these benefits.

Medicare, the primary source of publicly financed retiree health benefits, is described and the relationship between Medicare and employer plans is discussed. The *Issue Brief* concludes with a discussion of congressional proposals designed to change either employer obligations or the public provision of these benefits.

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

Retiree health benefits were originally offered 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, in more recent years, the changing demographics of the work force, coupled with increasing lifespans and rising health care costs, have left many employers with higher retiree-to-active-worker ratios and caused these liabilities to grow.

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 accumulated postretirement benefit obliga-

[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.

tion (that is, the actuarial present value of benefits attributed to employee service rendered to a particular date) that exceeds plan assets will be recorded as a liability on the company's balance sheet.[3]

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. Under FAS 106, employers are required to develop an estimate of the expected future annual change in their health care costs 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. In making their best estimate of health care cost trends, employers would probably use different estimates for various types of health care services (for example, medical, dental, and prescription drugs) and different rates during various periods of time.

The rates at which the benefits' expected future cost is discounted (to their present value) must also be assumed and 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.

As of the date a company adopts FAS 106, there is already an obligation for the postretirement benefits attributable to current and former employees' service to that date (the accumulated postretirement benefit obligation, or APBO). The APBO, less any plan assets and previously accrued costs, is called the transition obligation. This obligation can be recognized on the balance sheet in one of two ways: it can be recognized all at once as a one-time charge to that year's earnings or it can be disclosed in the notes to the financial statements and recognized evenly as a charge to earnings over the plan participants' average remaining years of service (through the expected retirement date) or over 20 years, if greater.[4]

Increases in postretirement benefits through plan amendments or plan initiation are considered retroactive under FAS 106, unless the plan initiation specifically associates increased benefits with service rendered after the plan initiation date. Any resulting increase in APBO of retirees and active workers is amortized over the remaining service period (to full eligibility date) of active employees not yet eligible but expected to receive a benefit.

Several cost components make up the expense recorded in companies' income statements: service cost, interest cost, return on plan assets, the amortization of prior service cost, gains and losses, and the transition obligation. The service cost is the cost of the benefit earned for employees' service during the year. The interest cost is the expected increase in the APBO due to the passage of time. The return on plan assets (only for funded plans) is the actual earnings on those assets. Amortization of prior service cost is to phase in the cost of plan amendments and/or plan initiation that takes place after FAS 106 is adopted. Gains and losses arise from experience that differs from the assumptions and changes in assumptions and may be recognized either immediately or on a delayed basis.[5] The final component is the amortization of the transition obligation explained above.

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.

[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]However, at any point in time, the cumulative amortization of the transition amount cannot be less than the cumulative amount that would have been recognized on a pay-as-you-go basis. If it is greater, additional amortization of the transition obligation must be recorded.

[5]There is a prescribed minimum amortization of gains and losses based on amounts in excess of a "corridor" that is 10 percent of the greater of the APBO and the market-related value of plan assets.

Furthermore, the Securities and Exchange Commission (SEC) stated in SEC Staff Accounting Bulletin No. 74 (SAB 74) in December 1987 that public companies must disclose the "material" effects that any currently known changes, including accounting changes, may have on future financial statements. In this bulletin, the SEC states that it wants employers to estimate the effect of accounting changes such as FAS 106 in their next SEC filings if it is expected to be material.[6] Such an estimate is necessary unless the employer adopts FAS 106 or does not know and cannot reasonably estimate what the standard's impact is expected to be in the year of the change.

◆ 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 transition obligation 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).[7] 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) estimates 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.[8]

A study by Hewitt Associates of 463 medium-sized and large private employers found that the median annual medical cost for retirees is 1.1 percent of active payroll, which is expected to increase to 6.25 percent of payroll after FAS 106 is fully adopted (Hewitt Associates, 1990). A survey of 97 large employers by Towers, Perrin, Forster & Crosby Inc. found that FAS 106 would reduce their pretax earnings by 10 percent, on average, among those who answered. However, there were substantial differences among companies. Annual net income of some companies may decrease between 30 percent and 60 percent, by one estimate (Integrated Administrative Services, 1990).

Some analysts believe that the market has already taken these liabilities into account, and their disclosure on the financial statements will not significantly affect stock market prices.

An April 1989 study by Johns Hopkins University and the Health Insurance Association of America interviewed 200 financial officers of companies that offered retiree health coverage.[9] Of those responding, 58 percent believed that FAS 106 would lower profits, while only 19 percent thought it would lower stock prices (Bacon, Kasper, and Gabel, 1990).

[6]SAB 74 actually goes beyond this and encourages employers to disclose the potential impact of other significant matters that the employer believes might result from the adoption of FAS 106 or any other accounting standard. SEC Staff Accounting Bulletins are not considered binding but are considered authoritative, and most companies follow them (Williams, 1990).

[7]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.

[8]The difference between EBRI and the GAO number for current liabilities is due in part to different assumptions about health care 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 2002 to the year 2015 and then by 2 percentage points from the year 2016 on.

[9]On average, these plans covered 3,772 active employees and nearly 2,000 retirees aged 65 and over. The authors note that the study was done fairly soon after the release of the original exposure draft of the statement, so the respondents may not have completely investigated its full impact.

Considering the magnitude of these retiree health liabilities, putting them on financial statements is unappealing to some companies. Even among companies that advance fund retiree health obligations, very few have fully funded the obligations. Employers offering retiree health coverage may begin reviewing various retiree health plan designs.

◆ 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 retiree health benefits 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 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.

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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.

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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.

◆ 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 Retire-

ment 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.

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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.

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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. Participants and beneficiaries can bring suit to (1) recover benefits due them under the terms of their plans, (2) enforce their rights under the terms of the plans, or (3) clarify their rights to future benefits under the terms of the plan. 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.

Most of the court actions have focused on the issues of the specific benefit promise and employer rights to change the range of benefits offered or the extent of coverage. The issues of which documents legally describe the benefits and if they indicate whether these benefits were to continue throughout retirement were addressed in *International Union, United Automobile, Aerospace and Agricultural Implement Workers of America v. Yard-Man, Inc.*[10]

In terms of the benefit promise, the Sixth Circuit held in *Yard-Man* 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 *Moore v. Metropolitan Life Insurance Company,*[11] in which the benefits were not bargained, the Second Circuit ruled that, since Metropolitan Life 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. Therefore, the totality of the employer's communications to the employees was not the relevant contract. In this case, the relevant contract was the official plan documents and summary plan descriptions.

An additional factor to be considered in determining the parties' intent in the framework of contract law is what the *Yard-Man* court interpreted as a lifetime benefit "inference." 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, such as the Sixth Circuit in *International Union, UAW v. Cadillac Malleable Iron,*[12] have upheld this type of reasoning. Other courts have disagreed; the Eighth Circuit in *Anderson v. Alpha Portland Industries, Inc.*[13] stated that since Congress exempted welfare benefits from ERISA's vesting requirements, the intent to vest these benefits seems "illogical."

Firms that have filed for Chapter 11 bankruptcy and then attempted to curtail retiree health benefits present a separate set of issues. As a result of the LTV Corporation's attempt to terminate retiree benefit programs after filing for bankruptcy, Congress enacted the Retiree Benefit Bankruptcy Protection Act of

[10]716 F.2d. 1476 (6th Cir. 1983) *cert. denied* 465 U.S. 1007 (1984).

[11]856 F.2d. 488 (2d Cir. 1988).
[12]728 F.2d 807 (6th Cir. 1984).
[13]836 F.2d 1512 (8th Cir. 1988).

1988.[14] This act states that, in order for an employer to modify retiree health benefits after filing for Chapter 11 bankruptcy, the change must be (1) necessary to the completion of the reorganization and (2) approved by the court. Any change must be agreed to by retiree representatives, either the union (if collectively bargained) or a court-appointed committee of retirees.

While Congress has passed some legislation, the courts, in applying contract law, have provided a general framework for resolving retiree entitlement questions.

◆ Funding Options

Companies maintaining retiree health benefits may have a number of concerns, including reducing costs and cost volatility and managing the effects of the funding on corporate and retiree taxes. As a result, decisions on how to fund these obligations are concerned with both tax-advantaged vehicles and investment strategies. Generally, the choice of vehicle may be largely based on tax ramifications. The investment strategy used within that vehicle, discussed in the next section, may be chiefly intended to exploit tax benefits or to achieve an optimal cash flow.[15]

Figuring a retiree medical health liability is not as simple as calculating the present value of known costs. The unknowns of medical inflation, medical innovations, technology, and utilization patterns complicate the estimation. In addition, the government may change aspects of Medicare, thereby affecting employer plans, or it may enact national health care reform. How, then, can companies plan for and fund their retiree health liabilities?

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, corporate-owned life insurance (COLI), and employee stock ownership plans (ESOPs). Not all are tax-deductible means of funding or setting money aside, and each has specific limits. The following summary and table 1 outline these differences.

501(c)(9) Trusts or VEBAs

501(c)(9) trusts, also called voluntary employee beneficiary associations (VEBAs), were originally established for use by multiemployer plans through the Internal Revenue Code (IRC) and the Labor Management Relations Act of 1947 (Taft-Hartley Act). As a result of increasing health care costs and increasing inflation, ERISA extended VEBAs to single-employer plans. 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.[16] 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

[14]These provisions were originally included in the Continuing Appropriations for Fiscal Year 1987 for a specified period and then continued with the Retiree Benefit Bankruptcy Protection Act of 1988.

[15]An optimal cash flow in this situation would match cash inflows with cash outflows. In retiree health funding, this means having investments mature when benefits need to be paid.

[16]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.

Table 1
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.

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.[17]

Nondiscrimination regulations were added by the Deficit Reduction Act of 1984 (DEFRA) and state that each plan benefit is subject to Internal Revenue Service (IRS) overview to prohibit discrimination in both design and operations.[18] DEFRA disallowed accounting for future inflation in funding VEBAs and changed the law to subject earnings to federal income tax.[19] DEFRA also imposed a 100 percent excise tax on employers whose welfare benefit fund provides any type of disqualified benefit.

A separate account must be held for key employees, with contributions counting against defined benefit section 415 limits.[20] A reversion of assets from a VEBA

[17]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.

[18]This holds only for contributions for postretirement medical and death benefits in VEBAs. Also, nondiscrimination rules do not apply to plans maintained through a collective bargaining agreement. VEBA nondiscrimination rules are in section 505 of the Internal Revenue Code.

[19]This does not apply to VEBAs covering groups that are at least 90 percent collectively bargained. Assets held before DEFRA's enactment are grandfathered. Also, the taxability of earnings holds only for postretirement medical benefits, as these may not be taken into account when figuring reserve limits. Earnings on reserves for other benefits are not taxed as long as the reserves for these benefits do not exceed the new funding limits.

[20]These limits place a cap on the size of the benefit that can be funded on a tax-advantaged basis. Therefore, contributions to the 501(c)(9) may lower the amount that can be funded through a pension plan for these employees.

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.[21] 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.

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). 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.[22] These transfers are limited to only the amount the employer would pay during the year for current retiree health expenses[23] 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.

The transfer will not violate the requirement that contributions to 401(h) accounts be "subordinate" to the pension retirement benefits. The transfer is made more stringent in that all current participants in the pension plan must be fully vested in all accrued benefits at the time of the transfer.[24] Finally, the expenses for the year of the transfer and for each of the four years following the last transfer must be at least as high as those for the highest of the two years preceding the year of transfer. This was designed to discourage employers from attempting to accumulate medical expenses in order to have a larger transfer into the 401(h) account during the allowed years. The federal government, plan participants, and employee representatives (if collectively bargained) must be given notice of the transfer at least 60 days prior to its occurrence.

The transfer will be treated in pension plan administration as if there had been a net experience loss, and employers will have 10 years to amortize this amount (this is different from the five years for other types of net experience losses). Any money transferred that is not used to pay for health benefits is transferred back to the pension plan; while not subject to income tax, it is subject to the excise tax on reversions from the pension plan.

[21]However, this does not include contributions made to the pension plan to fund the plan's past service credits.

[22]Taxable years of the employer beginning after December 31, 1990, and before January 1, 1996. There are special transitional rules for transfers in 1990.

[23]The transfer is also reduced by the amount that the employer has previously contributed toward these liabilities. Key employees (legally defined, taking into account compensation, position, and ownership of the company) cannot be included in the calculation of liabilities or employer cost.

[24]Those who were terminated or left their jobs within a year of the transfer must also be vested.

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).

The transfer allows both the government and the plan sponsor to benefit, at least in the short term. The simple example in table 2 shows that the transfer results in higher after-tax income for the plan sponsor and a higher tax collected by the government. This is because the retiree health expenses are no longer coming directly from the employer's income, and therefore the employer is not taking a tax deduction. Some feel that the long-term effects may vary widely and future government revenues may be lowered because of increased pension contributions in the future.

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.

Table 2
Effect of a Transfer to a 401(h) Plan on the Plan Sponsor's Income and on Federal Government Receipts

Item	Previously, without Transfer into 401(h) Account	Currently, with Transfer into 401(h) Account
Income before Taxes and Retiree Health Expenses	$1,000	$1,000
Direct Retiree Health Expenses	$100	—
Income before Taxes	$900	$1,000
Tax Rate (Estimate)	0.30%	0.30%
Amount of Taxes (to Federal Government)	$270	$300
Income after Taxes	$630	$700

Source: Employee Benefit Research Institute.

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 to a 401(k) plan, including employer and employee contributions, are limited to the lesser of $30,000 (or 25 percent of the defined benefit plan dollar limit, if greater) or 25 percent of compensation. Earnings on contributions accumulate tax free to the employer, and qualified lump-sum distributions may qualify for special five-year forward averaging on the employee's tax return. Contrary to the rules governing other 401(k) contributions, nonelective or matching employer contributions can be distributed only in the event of death, disability, or separation from service. There are some provisions for hardship withdrawals; but these withdrawals, except for those made for medical expenses, are subject to a 10 percent excise tax.

In retirement, distributions to the retiree are taxable and can then be used to pay premiums for medical care. The premiums can only be deducted to the extent that they, along with other health care costs, exceed 7.5 percent of an employee's adjusted gross income.

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.

Tax-deferred cash value results from the insurance premiums that are not needed to pay current death claims and policy expenses. This money is kept by the insurer and credited annually with earnings, which are not taxable income for the sponsoring company. This accumulated cash value is an asset of the company (although it cannot be used to directly decrease the size of any FAS 106 liability).

COLI can be nonleveraged; that is, no loans are taken out on a policy or its cash value. In nonleveraged COLI, the assets build up and the policies are held to term. Direct corporate ownership of the assets eliminates trust expenses, nondiscrimination requirements, the limitations on funding, and the irrevocable dedication of funds to benefits. Benefits paid to the employer are tax free.

The company can receive some of the investment proceeds through partial withdrawals or through loans, both with few adverse tax effects. Only if a policy is surrendered are there tax ramifications. Loans have a special attraction since more than the investment value can be borrowed and, within limits, interest on policy loans is tax deductible.

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.

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Employee stock ownership plans (ESOPs) have recently become another vehicle for funding retiree health benefits.

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The disadvantages of COLI are that the first few years' premiums offer no tax advantages (unless combined with some type of trust) and that COLI is nearly irreversible due to the tax ramifications of surrendering the policies. Therefore, the company is vulnerable to future tax law changes. It is estimated that, after seven years from beginning a COLI, some plans will have sufficient cash inflows from loans and death proceeds (reduced by loans) to meet the cost of loan interest and any remaining premiums and enough net cash inflow to meet postretirement health insurance outlays.

ESOPs

Employee stock ownership plans (ESOPs) have recently become another vehicle for funding retiree health benefits. Again, the assets of a stand-alone ESOP cannot be used against the FAS 106 liability, and the distributions are taxable to the retiree. Similar to the method used for 401(k) plans, this method of funding focuses more on the employer's ability to communicate the intended use of the funds when

received by the employee than on direct funding for retiree health benefits. However, according to an EBRI/Gallup poll conducted in September 1989, 69 percent of those aged 18 and over would rather receive employer-paid health insurance benefits after retirement than a share in the ownership of the company that could be cashed out at retirement (Employee Benefit Research Institute/The Gallup Organization, Inc., 1989).

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The choice of investment strategy depends on a firm's plan design, employee and retiree demographics, and the firm's financial status, among other factors.

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An added advantage of ESOPs is that the fund could be leveraged to provide more tax benefits to the employer. In a leveraged ESOP, the plan borrows money to pay for the company stock, which is then held in a trust. The company makes the necessary contributions to the ESOP, which the ESOP then uses to pay down the loan. The stock is then allocated to the employees' accounts. In this loan, the interest may be tax deductible for the organization making the loan, so that the organization can often offer a lower rate on the loan.[25]

Combinations

Some companies are creating combinations of these previously discussed plans. The most prominent to date is the "HSOP," so called because it combines a 401(h) and an ESOP. This type of plan is still under review by the IRS. Others combine aspects of 501(c)(9) trust and COLI. In a 501(c)(9) trust, as long as the policies are held until death, the trust will pay no income tax.[26] However, there is no leveraging possible with this product.

Undoubtedly, such combinations and innovations will continue, especially without a full-funding option from the federal government.

None of these options provide for funding retiree health liabilities to the extent that companies can fund pension liabilities. There is no option that allows companies to fully fund these benefits with all the tax advantages of pension funding.

◆ Investment Strategies

The choice of investment strategy depends on a firm's plan design, employee and retiree demographics, and the firm's financial status, among other factors. One investment method is to try to hedge the liability by matching inflation, either medical or overall inflation. Alternatively, a company can simply attempt to maximize investment returns. Companies can also use dedicated or immunized bond portfolios (described later) similar to those used for pension obligations. Finally, the funds can be placed in "safe" investments. Companies using this final approach are generally waiting until more money accumulates in the fund or in anticipation of Congress establishing a tax-advantaged method of funding.

In an attempt to hedge the liability by matching medical inflation, companies can invest in heath care businesses and hospitals. As medical prices increase, these businesses should go up in value, thus increasing the value of the investments. However, the volatility of businesses in the health care field may be more than

[25]The law sets out certain criteria for those organizations that can use this deduction and limits its use to ESOPs that own 50 percent of the company's stock.

[26]If set up in a 501(c)(9) trust, none of the investment earnings on the life insurance contracts are subject to the tax normally assessed on these trusts, since the inside insurance cash value buildup is tax-deferred and the policies will be held until death.

companies are willing to undertake. This method will most likely be used by firms with a medical service benefit approach to their retiree health benefits, since these firms carry the investment and medical inflation risk.

Alternatively, a company can invest to hedge overall inflation, usually through bonds. This is a partial hedge against medical inflation and tends toward minimizing the risks (potential volatility and future unknowns) associated with funding a postretirement medical benefit liability. A company with a defined dollar benefit plan might favor this approach because the employees carry the medical inflation risk.

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A bond portfolio, either immunized or dedicated, may prove to be a viable alternative for funding retiree health obligations.

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The third method of investment focuses on investment return, on the assumption that, regardless of what the liability is, the best way to fund the liability is to attempt to achieve the highest possible return on current assets. This method does not attempt to match the liabilities or the future needed cash flows. Some companies, assuming that the future level of retiree benefits is too difficult to estimate and too large to ignore, may decide that this is the most effective investment strategy.

A bond portfolio, either immunized or dedicated, may prove to be a viable alternative for funding retiree health obligations. An immunized portfolio attempts to lock in a specified bond yield during a specific period of time. The aggregate yield to maturity of the bonds selected equals the specified yield, and the aggregate duration of the bonds equals the time period over which the portfolio locks in that yield. However, this type of portfolio needs frequent rebalancing to maintain the yield to maturity and the duration. This investment strategy can be used with either a defined dollar benefit plan or a medical service benefit plan. However, the latter would be more difficult due to the uncertainty of the yield needed to match future medical inflation.

A dedicated bond portfolio can also be used for the defined dollar plan. This bond portfolio also results in a series of cash flows matched to the time that employees are likely to start receiving these benefits. The portfolio should be chosen so that the yield is greater than the expected inflation. A dedicated bond portfolio would be more difficult to implement for a medical service benefit because the interest rate needed (medical inflation) is difficult to estimate with sufficient precision.

A study by the Salomon Brothers Asset Allocation Group argued that bonds are not a good investment strategy for a company providing a medical service benefit (Bader and Rodgers, 1989). The study found that the liabilities of retiree health benefits are sensitive to changes in both interest rates (or general inflation) and medical inflation. Notably, the study found that liabilities are relatively insensitive to simultaneous changes in these indices.

If it can be assumed that interest rates and medical inflation will be strongly linked in the future, companies would not need to worry about either one separately, since their effect on liabilities would be offsetting. In this situation, companies providing a medical service benefit would prefer to invest in cash and inflation-sensitive equities over any type of bond portfolio.

Similarly, the chief investment officer of Goldman, Sachs & Co. has stated that the key to linking the investment policy with liabilities was estimating the liabilities' duration. He states, "One investment strategy is to invest the funds in a way so the changes in inflation and interest rates have the same effect on the liabilities and assets" (Burr, 1989).

◆ Company Changes to Retiree Health Benefits—Plan Design and Financing

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).

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Some companies will continue to offer coverage but will gradually introduce cost sharing (or shifting some costs to the retirees) in order to curb future expenses.

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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. 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).

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. Other companies are reducing their liabilities to zero by creating a defined contribution plan that is presented to employees as an opportunity for them to set aside money to pay for health benefits in retirement.

As mentioned, some companies will continue to offer coverage but will gradually introduce cost sharing (or shifting some costs to the retirees) in order to curb future expenses. Some examples follow.[27] A subsequent grouping has examples of companies with employee-pay-all programs.

International Business Machines (IBM) will cap its retiree health liabilities: the company pays the full premium up to $7,000 for those under age 65 and up to $3,000 for those aged 65 and over. The caps will apply to IBM employees retiring after December 31, 1991. Given current trends in health care costs, the company estimates that these limits will be reached by the late 1990s, when they will consider various options.

American Telephone and Telegraph (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.

Data General provides health coverage for retirees through a defined dollar benefit based on years of service (that is, there is a cap on the amount that will be provided to retirees for health insurance). Employees

[27] All of these examples are drawn from telephone conversations with the respective companies.

with 20 or more years of service receive the highest possible contributions from the company, while those with fewer years of service receive a lesser portion. The remaining cost of retiree health insurance is paid by the retiree. The cap is reviewed annually.

Quaker Oats plans to maintain retiree medical benefits while helping to contain actual costs as well as FASB liabilities through its Retiree Health Incentive Plan. The plan, which will be updated annually to reflect inflationary changes, is composed of two parts: comprehensive medical coverage and the health expense account. Quaker pays the 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 pays its retiree medical benefits on a pay-as-you-go basis, but in the light of the new FASB requirements the company redesigned its plan effective January 1, 1990, to include employee contributions. 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. The company will use two 501(c)(9) trusts (one for union employees and one for nonunion employees) for investing active employees' after-tax contributions for retiree medical benefits.

For Bell Atlantic Corporation, recent collective bargaining for nonmanagement employees produced a cap on contributions made by the company. Once retiree medical costs reach that cap, employees will pay the difference. The company uses a bargained 501(c)(9) trust to fund these benefits. All Baby Bells have protected their liability in some way.

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.

Ralston Purina continues to provide company-paid retiree health benefits to current retirees. For future retirees, the company will continue to offer medical benefits; however, Ralston is phasing out its contribution to the medical plan, and eventually the retiree medical plan will be completely paid for by retirees.

Ralston introduced an ESOP in January 1989. This plan provides employees with an opportunity to set aside money for retirement. The company increased its match from $0.50 on the dollar to a dollar-for-dollar match on employee contributions up to 6 percent of pay.

The creation of the ESOP and the change to the retiree medical program were two separate actions. Ralston communicates that funds accumulated in the ESOP can be used to pay any retiree expenses, including retiree medical contributions.

The Ball Corporation of Muncie, Indiana, has revised its employer-paid retiree health benefit programs to launch 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.

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 with fiscal year 1991–1992. To qualify, a partici-

pant must be a retiree from the Procter and Gamble Profit Sharing Plan or an active participant in the Profit Sharing Plan who is eligible to retire. Earliest point of eligibility for an active employee is at age 55 with 20 years of service. 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.

There are other examples of companies changing their retiree health benefits recently, largely in response to FAS 106, medical inflation, and changing demographics.

◆ 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 (table 3).[28] 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 was an increase from 16 state plans in 1988. The number of states that do not provide any money toward the cost of retiree coverage decreased from 24 to 16 during these two years. 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). The Government Accounting Standards Board (GASB) is not currently working on a statement such as FAS 106 for retiree health insurance liabilities of public employers.

Employer-provided retiree health coverage differs by gender (table 3). While 16 percent of all those aged 40

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

Table 3
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.

and over work and receive coverage through their current employer, 23 percent of men aged 40 and over fall in this category, compared with 10 percent of women aged 40 and over. Again, almost 12 percent of all those aged 40 and over work and receive coverage through a spouse's plan, although 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 65 and over (table 4). 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 4). 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

Table 4
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.

coverage though 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 to 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 5). 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.

There are several reasons that people may not have retiree health coverage. From a public policy perspective, an insight into this can be gained from the activity that these persons were involved in during the one week prior to the survey. For example, if most of those without retiree health coverage were in school, a policy of requiring schools to provide this coverage would have wide-ranging effects. Of those aged 55–64 (not Medicare eligible) without retiree health insurance, 43 percent were working, compared with 8 percent of those aged 65 and over without retiree health insurance (table 6). Housekeeping was another major activity for both age groups, while retirement was more prevalent among the older age group. Four percent of those aged 55–64 without retiree health insurance and 5 percent of those aged 65 and over without this benefit were unable to work. Another 4 percent of the younger age group had a job but did not work the particular week in question, most likely because they were ill or on vacation.

Table 5
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.

Employer-provided retiree health benefits are expected to continue in the future. Among persons between the ages of 18 and 65, 60 percent expect to receive retiree health benefits through their employer, according to a poll conducted in January 1990 (Employee Benefit Research Institute/The Gallup Organization, 1990).[29]

[29]Strictly, this question was asked to those aged 18 and over who were not eligible to receive Medicare benefits.

Table 6
Major Activity of Individuals Aged 40 and Over without Retiree Health Coverage, by Age, August 1988

	Age of Respondent	
Major Activity	55–64	65 and over
Total (thousands)	11,426	20,376
Working	42.6%	7.8%
With Job, but No Work Previous Week	4.0	0.5
Looking for Work	0.8	0.1
Housekeeping	28.2	37.6
School	0.1	0.0
Unable to Work	4.3	4.8
Retired	20.0	49.3

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.

Younger respondents and those with higher incomes were most likely to expect to receive these benefits.

◆ Medicare

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. These costs have grown rapidly over the last decade. Between 1977 and 1987, the total cost of health care for the elderly nearly quadrupled, growing 265 percent in current dollars, compared with 169 percent for similar costs among the nonelderly population (table 7).

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. Total Medicare benefit payments (for the elderly and disabled) were $21.7 billion in 1977, increasing to $86.3 billion in 1988, increasing to $105 in 1991.

Medicare is divided into two parts. Part A is financed through the mandatory Hospital Insurance (HI) payroll taxe and pays for most inpatient hospital care, limited nursing home care, home health agency visits, and hospice care for terminally ill patients.[30] It requires cost sharing in the form of deductibles and coinsurance. Part B is voluntary and is financed with participant premiums and general federal revenues through the Supplementary Medical Insurance (SMI) trust fund. Part B provides payments for physicians' services, outpatient hospital services, rural health clinic office visits, and related physician supplies.

Currently, Medicare Part B reimburses physicians at 80 percent of the Medicare approved "reasonable" charge. The patient is required to pay the remaining 20 percent as coinsurance, although this may be covered through an employer plan. Medicare pays physicians either on an "assigned" or "unassigned" basis. Physicians who agree to accept assignment for a particular service agree to accept the Medicare approved rate as payment in full. In most states, physicians can balance bill up to 125 percent of the Medicare approved rate (140 percent for evaluation and management services). Under Medicare's participating physician program, physicians may choose to accept assignment on *all* services provided to Medicare beneficiaries, in which case they are not permitted to balance bill Medicare patients.

The Omnibus Budget Reconciliation Act of 1989 (OBRA '89) includes provisions that will reform the way Medicare Part B reimburses physicians. These provisions, designed to control Medicare Part B expenditures, may affect the retiree health care burden of beneficiaries or employer plans. OBRA '89 provides for a new method of physician payment—the resource-based relative value scale (RBRVS)—which values Medicare physician payments relative to one another based on the resources utilized in providing care (that is, the physician's time, skill, and intensity of the service; his or her practice expenses; and his or her

[30]Terminally ill is defined as life expectancy of six months or less, although this coverage has a maximum of 210 days.

malpractice burden). RBRVS is scheduled to be implemented over five years, beginning January 1, 1992. Additionally, OBRA '89 limits the percentage of the Medicare-allowable rate that nonparticipating physicians can balance bill. The new law, effective in 1991, blocks nonparticipating physicians from charging more than 125 percent of the Medicare-allowable fee in 1991, 120 percent in 1992, and 115 percent in 1993.[31] OBRA '89 also provides for limits on aggregate Medicare physician expenditures, referred to as Volume Performance Standard (VPS), effective in 1990. VPS is set annually.

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.

[31]In 1991, the allowable fee is the reasonable charge; in 1992 and thereafter, it will be based on RBRVS.

The elderly's costs for health care have risen much faster than their incomes. This is a result of health care costs persistently (and by wide margins) exceeding increases in major components of the elderly's income: Social Security payments, pension distributions, and investment income. Between 1977 and 1988, the elderly's per capita consumer spending for health care[32] rose an estimated 226 percent, approximately 67 percent faster than their average income (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

[32]Consumer costs for health care are defined as out-of-pocket spending, Medicare premiums, and privately insured premium spending.

Table 7
Estimated Total and per Capita Personal Health Care Spending among the Elderly and Nonelderly, Selected Years, 1977–1987

	Total (billions)		Per Capita	
Year	Aged 65 and over	Under age 65	Aged 65 and over	Under age 65
1977	$ 43.4	$ 105.7	$1,785	$ 537
1984	119.9	221.9	4,202	1,024
1988	158.2	284.3	5,235	1,283
Total Growth 1977–1987	264.5%	169.0%	193.3%	138.9%

Source: Unpublished estimates from the U.S. Department of Health and Human Services, Health Care Financing Administration, and Deborah J. Chollet, "Health Care Spending among the Elderly," Working Paper No. 91–2 (Atlanta, GA: Center for Risk Management and Insurance, Georgia State University, 1991).
Note: Estimates double count Medicaid payments of Medicare Part B premiums.

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).

With FAS 106 requirements, employers may not only see their current costs increase but also experience additional costs added, as Medicare covers less of the elderly's health care bill.

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.[33] The method of integration with Medicare determines the beneficiary contribution necessary to make up for the lower Medicare payments under RBRVS. There are six major ways that employer plans can be integrated with Medicare: Medigap coverage, a coordination-of-benefits plan, a Medicare exclusion plan, Medicare Part B, a carve-out plan, and Medicare supplement plan (table 8).

- 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.

Table 8
Retiree Health Plan Integration with Medicare

Integration Technique	Percentage of Firms
Firm Pays Medicare Supplement	13%
Firm Pays Medicare Part B	11
Firm Pays for Medigap Coverage	8
Firm Offers Carve-Out Plan	52
Firm Offers Coordination of Benefits Plan	27
Firm Offers"Medicare Exclusion Plan	14

Source: Gregory de Lissovoy, Judith D. Kasper, Steven Di Carlo, and Jon Gabel, "Changes in Retiree Health Benefits: Results of a National Survey," *Inquiry* (Fall 1990): 291.
Note: The percentages do not add to 100 percent because some firms offered multiple plans. Based on a survey of 204 firms.

[33]While this is true for retirees, for current workers older than age 65, Medicare is the secondary payer.

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.

◆ Public Policy Proposals

Retiree health benefits were discussed in the 101st Congress and several bills were introduced. Discussions have raised concerns over equity, benefit security, and revenue implications.

The House Ways and Means Committee held hearings in mid-1989 on possible options for government action in the area of employer-sponsored retiree health programs. At the hearing on June 14, 1989, Kenneth Gideon, Assistant Secretary for Tax Policy of the U.S. Department of the Treasury, said that "Expanding tax incentives would redound to the benefit of those employers, and their employees, that have already promised to provide retiree health benefits, but would not necessarily ensure that others receive any benefits, thus potentially expanding the inequities between those individuals whose employers choose to take advantage of the tax incentives and those whose employers do not" (U.S. Congress, 1989). Treasury representatives also testified that long-term revenue losses from the transfer of excess pension assets to retiree health benefits would be far greater than short-term revenue gains and cautioned against this tax expenditure (the provision was enacted in 1990). Congressional interest in allowing tax favored prefunding was not evident during this hearing.

However, legislation designed to enhance the security of employer-provided retiree health benefits was introduced in both houses of Congress during the first and second sessions of the 101st Congress. During the first session, Reps. Rod Chandler (R-WA) and Ronnie Flippo (D-AL) and Sen. David Pryor (D-AR) cosponsored the Retiree Health Benefits Preservation Act (H.R. 1865/S. 812), which would have permitted employer tax deductions for advance funding of retiree health and long-term care insurance.

The Retiree Health Benefits and Pension Preservation Act (H.R. 1866), introduced by Chandler and Flippo, was more comprehensive and, in addition to the provision above, would have eliminated the possibility of pension plan terminations and reversions, though surplus assets would have been allowed to fund retiree health plans or ESOPs. The bill would have also eliminated the 150 percent full-funding limitation and any lump-sum distributions.

Chandler and Sen. Bob Packwood (R-OR) introduced the Health and Long-Term Care Security Act of 1990 (H.R. 4134, S. 2199), which would have provided limited favorable tax treatment to employers who set aside funds to pay for retiree health benefits.

None of these proposals gained significant support in Congress, and they were not passed, with the exception of the pension asset transfer proposal discussed earlier, as part of OBRA '90. This lack of action was in part due to the effect that a large, costly new tax incentive would have on the federal budget.

The EBRI Tax Estimating and Analysis Model (TEAM) estimated the cost of allowing different types of prefunding on federal government revenues. Allowing firms to prefund retiree medical liability for current and future retirees on a one-time payment basis would lead to an estimated loss of $37 billion in that year to the federal government. If the prefunding were amortized over 15 years, the first year loss to the federal government would be an estimated $9 billion. Any changes in the tax code relating to retiree health benefits will have a definite effect on federal government revenues.

The influence of FAS 106 on companies sponsoring retiree health plans and the increased funding needs of the Medicare system are unlikely to encourage Congress to address issues relating to the funding of private retiree medical benefits in the future. The current budget crunch and newly enacted budget reforms that require policymakers to offset any proposed tax cuts with spending cuts in entitlement programs or a tax increase elsewhere make the enactment of proposals that would expand the deductibility of funding these benefits even more unlikely. In fact, the recently enacted provisions allowing limited use of excess pension assets to fund retiree health benefits may be the only relief for employers seeking to fund these costs in advance on a tax-favored basis.

◆ 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 constraints on cost growth in the program are being proposed by President Bush in his 1992 budget.

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.

This *Issue Brief* was written by Jennifer Davis of EBRI with assistance from the Institute's research and education staffs.

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