

---

An EBRI  
**SPECIAL REPORT**  
AND ISSUE BRIEF NUMBER 124

---

## Retirement Security in a Post-FASB Environment

“Employers want flexibility to manage their finances—including the power to terminate plans if the expense becomes financially crippling; employees want security—they want to receive benefits they have been promised.”

—Charles C. Morgan, Prudential Asset Management Co.

“Companies have found they are no longer in the business of merely making widgets. They are in the business of making widgets and also in the (health) insurance business.”

—William Reimert, Milliman & Robertson

“I think we are heading toward a new definition of necessary benefits, or a core set of benefits, that employers are going to be willing to provide, and those are the predictable ones, the capped ones, and more manageable for them.”

—Meredith Miller, AFL-CIO

“FAS 106 put truth in packaging, but perhaps an unintended effect has been the taking away of benefits that might not otherwise have occurred at the same point in time.”

—David Skovron, Kwasha Lipton

“The financial impacts associated with changes in retiree health benefits are likely to be quite small. The increased annual expense to retirees, resulting from retiree health benefits cost-shifting, will average only \$257 a year.”

—Christopher J. Ruhm, University of North Carolina at Greensboro

“Market analysts generally had figured a company’s retiree health care liabilities at 10 to 15 times its current annual pay-as-you-go expense. Announcements to date, however, show this number seems to be misleadingly low. The true figure could be 20 times or more.”

—Douglas J. Elliott, J.P. Morgan

“It would be real difficult, real difficult for any prefunding tax incentives to pass in the next couple of years. A lot of folks would feel that if we’re going to spend the precious federal dollars that we have, it’s better off trying to increase access to the people who do not have health care coverage, and/or trying to reduce the overall cost of the system.”

—Rick Grafmeyer, Senate Finance Committee

“Retiree health coverage purchased, at the employer’s discretion, with prefunded amounts attributable to employer contributions under a VEBA or a 401 (h) retiree health account qualifies as employer-provided coverage under (IRC) section 106.”

—Harry J. Conaway, William M. Mercer, Inc.

“There is a fundamental problem with how we provide health care to retirees in this country, which warrants systemic reform. Worrying about funding takes us off on the wrong track.”

—David Hirschland, United Auto Workers of America

## Preface

Health insurance for retirees has become a priority for retirees and the nation. Since the enactment of Medicare in 1965, nearly all retirees have had health insurance protection beyond age 65 from Medicare and a Medigap policy, provided by a former employer or purchased themselves. Those who retire prior to age 65 frequently have had protection from their last employer.

National attention focused on retiree health protection from 1987 to 1989 during the debate over the enactment, then repeal, of the Medicare Catastrophic Coverage Act of 1988 and proposals for a long-term care program. Meanwhile, health care cost escalation has led Congress to cut back Medicare expenditure growth. The program continues to account for an increasing proportion of the federal budget, and further controls on growing program costs are likely. Further constraints may mean a greater portion of the elderly's health care costs will be shifted to employers, retirees, or general taxpayers.

In addition, the private sector is also paying closer attention to the implications of rising health care costs and the growing retiree population. Private employers have been required to focus on their retiree health care costs by the Financial Accounting Standards Board (FASB) Standard 106 that requires companies to record unfunded retiree health benefits liabilities on their financial statements (effective for fiscal years beginning after December 15, 1992). Private employers are beginning to reevaluate their retiree health insurance programs, and some are now limiting or eliminating the retiree medical benefits they offer to current and future retirees.

Because of the importance of these issues, in September 1991 the Employee Benefit Research Institute-Education and Research Fund (EBRI-ERF) convened a policy forum to address current and future changes in the private and public provision of retiree health benefits and their impact on the elderly's retirement income security and access to health care. The forum, *Retirement Security in a Post-FASB Environment*, brought together representatives from government, business, labor, academia, and the media.

This report begins with a summary of the discussions that followed each of the formal presentations at the forum. The summary was written by EBRI Fellow Selwyn

Feinstein, who worked as a reporter for the *Wall Street Journal* for 30 years covering labor and economic issues. Forum participants explained how specific companies are initiating changes in plan design to meet retiree health obligations, analyzed the advantages and disadvantages of different funding options, examined possible tax implications of FAS 106, discussed ways in which FAS 106 may affect work and retirement decisions, and examined the current and future public policy environment surrounding these issues.

Following the summary is an article based on a talk given at the forum by Harry J. Conaway, principal and head of the Washington Resource Group for William M. Mercer, Incorporated. Conaway addresses the question of whether retirees will be taxed on the employer-provided portion of their health coverage and the medical benefits and reimbursements they receive under the coverage. In addition, Conaway focuses on some of the related tax issues resulting from prefunding of retiree health benefits.

The next article is based on a presentation given at the forum by Douglas J. Elliott, vice president in the Financial Department of J.P. Morgan. Elliott provides an analysis of how Wall Street's growing awareness of retiree health liabilities may affect stock and bond markets and suggests that communication with investors and analysts could temper negative market reaction.

The third article was prepared for the forum by Christopher J. Ruhm, associate professor of economics at the University of North Carolina at Greensboro. According to Ruhm, reciprocity of retiree health benefits varies across population subgroups and is related to firm size and pension coverage. Therefore, the effects of post-FASB changes will be largely concentrated among persons working in large firms and receiving pensions.

The number of Americans aged 65 and older will increase from 12 percent of the population today to more than 24 percent in the decades ahead. Even if the nation reduces the rate of health care inflation, the increased number of retirees assures that Medicare will claim an increasing portion of the federal budget. If employers continue to provide retiree medical benefits, the growing beneficiary population will still require employers to spend more

money for these benefits. As a result, even if health cost inflation is brought under control, the debate over who pays, how much, and for what, will continue.

Previous EBRI activities relating to pensions and health care in the United States helped to formulate the discussion at the 1991 fall policy forum. (A list of EBRI publications related to retirement security and health care is included at the back of this report.) EBRI will continue its work in the years ahead with the same goal sought by this publication: informed decision making.

We welcome your comments on this publication and your suggestions for future work.

The views expressed in this report are solely those of the forum participants. They should not be attributed to the officers, trustees, members of EBRI, its staff or its Education and Research Fund.

Dallas L. Salisbury  
President  
Employee Benefit Research Institute

## The Inevitable Happens: Making the Improbable Possible

by Selwyn Feinstein, EBRI Fellow

Uncertainties entangle retiree health benefits.

Employers—along with investors and lenders—brood over potentially staggering costs and ponder how to bring liabilities under control.

Workers delay retirement until they earn postcareer benefits, and then agonize whether promises will be kept.

Government officials weigh pleas for tax relief against demands for budget restraint.

Policymakers deliberate a national health reform that could alter the premises on which all plans are built.

Amid the doubts, however, one point appears certain: tomorrow's retirees will be asked to assume a larger share of their own and their families' health bills.

Most of the participants in this EBRI-ERF forum made the point that economic necessity is forcing the benefit shift. The Financial Accounting Standards Board's (FASB) Statement No. 106, which requires companies to acknowledge retiree health liabilities, simply accelerated the inevitable, the panelists said. Several participants outlined changes in benefit plans that they had already installed or were offering to clients. Most other companies were expected to act soon.

This inevitable recognition spurred by FAS 106 may have another even more pervasive consequence: the galvanization of a constituency for change that could alter the national health debate.

How different from seven years ago, observed EBRI's Dallas L. Salisbury. At an EBRI-ERF policy forum on retiree health benefits then, he recalled, the overriding sentiment was, "Why would anyone want to talk about this?"

### ◆ Background

Retiree health coverage first started appearing in the late 1940s and 1950s as what Diana J. Scott of Towers Perrin

called a "throw-away benefit." For most companies, those were plush times, with growing needs for workers and relatively few retirees. When Medicare took over much of the retiree health bill in 1966, the benefit became even more appealing to employers.

The coverage was far from universal. EBRI figured that only 43 percent of Americans aged 40 and over had employment-based retiree health coverage in 1988. Currently, only one in three retirees, or some 7.8 million people, benefit from the coverage, according to Nora Super Jones of EBRI. "Typically, these retirees have proportionately higher incomes than other retirees. They tend to work for large firms or public employers and are more likely to be unionized," she said. Nearly three-quarters of these workers also receive pensions, added Christopher J. Ruhm of the University of North Carolina at Greensboro. However, large groups have been locked out, he said. "Only 19 percent of female retirees, 30.6 percent of Hispanics, and 14.2 percent . . . of those with 1988 household incomes below \$7,500 received retiree health coverage," he said.

For those covered, most plans a few years back simply carried the health benefits of active employees into retirement years for workers and their spouses, said Stewart Lawrence of Martin E. Segal Co. "There was a promise of a service or a benefit, as opposed to the promise of a cost or the promise of a current funding or contribution level," he explained.

Length of employment rarely was a factor in deciding who received full benefits. Workers, however, had to remain with the company until retirement or lose it all.

Few companies then asked retirees to help pay for the coverage, and none asked active workers to help prefund it, Lawrence said. Some firms even picked up the cost of Medicare Part B, Supplementary Medical Insurance.

The coverage was financed pay-as-you-go from current operations. Few companies acknowledged the liabilities on their books or set aside money for future needs. Unlike the requirement for pensions, the government did not require prefunding, and the tax code offered few breaks.

To Robert L. Clark of North Carolina State University, “most employers appeared to be unconcerned with the current and possible future costs” of the benefits they were offering.

Consider the taxi driver encountered some years ago by Howard A. Freiman of Fidelity Management Trust Co. This cabby, Freiman said, had been given free medical coverage for himself and his wife and four children as an inducement to retire from a large manufacturing plant, although he was only 31 years old at the time and had worked at the company for just 12 years.

Asked Freiman in disbelief: “Did the company’s actuaries calculate the cost” of providing that family with “medical benefits for the next 30 to 50 years?”

Many firms, Clark asserted, “seemed to believe that they could cancel retiree health plans whenever they chose.”

What Clark called “a series of new realities” began intruding in the 1980s. Not the least of these was a string of court rulings, starting in 1983, that employers could amend or terminate retiree health benefits only if they had specifically and publicly reserved that right. So the promise could be binding.

And it was proving a heavy load. Americans were getting older and living longer, and they were retiring earlier, many under prodding from employers dangling retiree health benefits designed to entice workers to leave in what had become difficult times. The ratio of active workers to retirees dropped in some industries from eight or nine to one in the late 1960s to as low as two to one, Donald P. Harrington of AT&T said.

The health benefits that retirees were carrying out with them were sharply escalating in cost. From 1987 to 1989, according to a Wyatt Co. survey, outlays for active and retiree medical benefit plans by the nation’s largest industrial companies surged at an average annual rate of 21 percent.<sup>1</sup> That was twice as fast as the national health expenditure growth rate, which, in turn, was swelling more than two percentage points faster than the Gross National Product.

<sup>1</sup>The Wyatt Company, *Managing a Changing Work Force: It’s Time to Take a Look at Your Retiree Benefits* (Washington, DC: The Wyatt Company, n.d.).

Exacerbating the problem, said William W. Spievak of Ball Corp., was cost shifting, the “hidden tax” he put at 40 cents on the dollar that a local hospital was imposing on Ball’s health plan “to make up for Medicare, Medicaid [and] indigent care.” Hewitt Associates, he said, estimated that cost shifting was responsible for “one-third of the health plan premium increases between the years 1987 and 1988.”

What had started out as a throw-away benefit had become a formidable commitment.

“Companies have found they are no longer in the business of merely making widgets. They are in the business of making widgets and also in the insurance business,” asserted William Reimert of Milliman & Robertson. “What kind of risk are you really ready to put your company on the line for?” he asked.

### ◆ FASB Issues Statement 106

Enter FASB to force companies to assess just how large those retiree health benefit risks really were. Scott, who served as a FASB project manager before joining Towers Perrin, explained the board’s mission, as assigned by the Securities and Exchange Commission and the accounting profession: to establish and improve accounting and reporting standards; to enhance the credibility, faithfulness and fairness of financial statements.

A decade of considering retiree health benefits led to the conclusion that pay-as-you-go accounting “ignores the measurement and recognition of the financial effects of promising to provide these benefits, and of the service that employees are rendering in exchange for those benefits,” Scott said.

The accrual accounting mandated by FAS 106 in December 1990, she continued, “attempts to remedy that situation by recognizing the effects of events as they occur, even though the cash flows may not be affected for many years after.”

Without such a recognition, she said, “management doesn’t really have the relevant information with which to manage the company. Creditors don’t have relevant information on which to base credit decisions. Investors don’t have the relevant information on which to base their investment decisions.”

Such an accrual approach “certainly is not revolutionary,” she emphasized. Companies must use it to account for other forms of deferred compensation, including, most notably, pensions.

Under the board’s edict, companies have until fiscal years beginning after Dec. 15, 1992, to start recording on their balance sheets those retiree health benefit liabilities that have not been funded. Accumulated past obligations could be charged off at once or spread out over as long as 20 years.

Even amortized, however, such liabilities could be an awesome jawfull for many companies to swallow.

Douglas J. Elliott of J.P. Morgan said market analysts generally had figured a company’s retiree health care liabilities at 10 to 15 times its current pay-as-you-go expense. Announcements to date, however, show “this number seems to be misleadingly low.” The true figure, he suggested, could be “20 times or more.”

Alcoa, whose liabilities had been estimated at \$538 million, said its figure was closer to \$1 billion, Elliott related. General Electric said its liabilities were \$2.7 billion, rather than the \$1.77 billion that had been figured by the analyst rule-of-thumb. IBM, whose liabilities had been estimated at \$1.89 billion, announced a figure of \$2.3 billion but said 40 percent to 50 percent had already been funded. Elliott said Lockheed’s announced liabilities of \$1 billion more than doubled the estimated \$450 million. USX put its liabilities at \$2 billion to \$3 billion, although the analyst rule-of-thumb figured a \$1.95 billion hit.

By EBRI’s estimate, FAS 106 will force all private employers to recognize \$241 billion as the present value of health obligations due current retirees through 1988.

If all companies recorded their liabilities on their books today, said Elliott, quoting a study by Mark Warshawsky for the American Enterprise Institute, their net worth would drop 15 percent. EBRI quoted a Towers Perrin survey that FAS 106 would reduce pretax earnings of some large employers an average of 10 percent.

“In retrospect,” observed Clark, “it is very puzzling why the leaders of corporate America instituted such contracts without more forethought for the costs and liabilities associated with retiree health plans.”

Harry Smith, a retiree who helped implement such policies while at Sun Co., wondered aloud if “this situation is really a failure of American industry, a failure of consultants to advise what they were getting into as early as 1974, 1975 perhaps. . . . I just wonder,” he added wistfully, “if a group of this type can’t come up with studies, ways of preventing these things from happening.”

While bemoaning the liabilities, no one at the forum faulted the FASB for prodding the projected cost onto center stage.

Technical points were raised. Dale B. Grant of Segal suggested that a company with a fixed-dollar benefit would “show up with a much lower FASB expense” than a company that asked retirees to pick up 25 percent of the cost of an otherwise unchanged plan. “Yet,” she said, “I would bet over time that the one with the fixed-dollar benefit is going to spend more in retiree health benefits.”

Michael J. Gulotta of Actuarial Sciences Associates complained that differences allowed by FAS 106 for handling plan changes, past service liabilities and health care projections could lead to results that would not be comparable from company to company. Scott acknowledged the point but said that she “believes that, overall, the new accounting standard produces information that is more credible and revelent than in the past.”

Still, Gulotta said later, FASB “did us a service” in forcing companies to address the cost of retiree health benefits.

Said Richard Ostuw of Towers Perrin: “FAS 106 has not changed the cost of retiree welfare benefits; the change in accounting rules merely accelerates the timing of recognition of this cost.”

David Skovron of Kwasha Lipton agreed. “FAS 106 put truth in packaging.” But, he quickly added, “perhaps an unintended effect has been the taking away of benefits that might not otherwise have occurred at the same point in time.”

Grant said that some employers were reducing retiree health promises now to cut “FAS exposure as low as possible,” with the expectation that they could always “worry about it later.” But later may never come for companies that encounter rough times, go bankrupt or are sold, she said.

Such benefit reductions are “unfortunate but probably very necessary,” Scott stated.

## ◆ Companies’ Response to FAS 106

For better or worse, FAS 106 has forced companies to confront a new set of unappetizing options.

- Do they acknowledge unfunded accumulated liabilities with a single devastating write-off the first year that would slash net worth and overwhelm earnings? Or do they amortize the obligations over 20 years and thus erode accounts for the next generation?

“It’s an emotional issue to write off, say, a billion dollars. . . . Chairmen don’t like to do that sort of thing,” Elliott allowed. “But if you can see your way clear to doing it, I think the stock market will reward you relatively for writing it all off in the beginning. It basically removes an overhang of future earnings penalties that otherwise is going to exist for you for 20 years.”

- Do employers strip cash from balance sheets, immediately or over a period of years, to fund at least some of these obligations, a step that would both wipe away liabilities and assure workers that promises will be kept?

Some companies will choose to prefund, predicted Ostuw, “because they think benefit security is appropriate, and/or they just think that it’s tidy to match assets and liabilities and keep them all off the balance sheet.”

But others, said Elliott, may decide not to prefund because they see more attractive ways to invest their money. Or, suggested Grant, they may be wary that national health insurance, if enacted, could reduce their retiree health liabilities. Then they would “be stuck with all those assets and look stupid,” she said.

- If obligations are prefunded, how are the dollars to be squirreled away? The Tax Code grants favored treatment for money that companies set aside to finance pensions. But it allows few tax breaks for advance payments that companies make for retiree health plans.

Some limited funding options are available. Charles C. Morgan of Prudential Asset Management Co. listed 13. These included voluntary employee beneficiary associations, (VEBAs), so-called 501(c)(9) plans for their Tax

Code designation; 401(h) health benefit savings plans and 401(k) retirement savings plans; and various forms of corporate and trust owned life insurance. Each had some tax or other advantage; each was restricted in the way it could ease the load.

But the primary questions that companies must ponder are: what retiree health commitments are appropriate for employers and how much of the cost and risk should workers be left to bear?

“Two equally important but potentially incompatible interests must be reconciled,” Morgan declared.

1. Employers want flexibility to manage their finances—including the power to terminate plans if the expense becomes financially crippling, and
2. Employees want security—they want to receive benefits that they have been promised.”

Ostuw looked at such options and concluded that most employers “will reduce their commitment to retiree health care benefits within the next two years—if they have not already done so.”

Clark presented data from the Bureau of Labor Statistics to show that many medium and large firms already had RIFed their retiree health plans. In 1986, he said, 63 percent of the full-time participants in employer health plans were enrolled in programs that offered coverage to retirees under 65 years old. By 1989, however, the number had dropped to 41 percent. For retirees over age 65, the coverage rate sagged from 57 percent to 36 percent.

Ostuw said companies will continue to reduce coverage because the cost, as measured by FAS 106, “will be unaffordable”; because the current commitment is open-ended, tied as it is to health care costs that are beyond the company’s control; and because benefits now “are not structured equitably,” in that they make no distinctions for length of service and retirement age or between coverage for employees and their dependents.

Fully 70 percent of major employers will make “fairly significant changes,” Ostuw predicted. “Maybe another 20 percent will make relatively minor changes, and the balance will make little or no change.” The restructuring will come, he said, even if Congress allows the same tax

breaks for funding retiree health programs that are currently allowed for pension plans.

Few companies will terminate their retiree health benefits, though some may make workers pick up the full cost, Ostuw said. Many employers will impose caps on pay-outs by setting defined dollar benefits. Other will redefine their commitment from a defined benefit to a defined contribution.

“We will see a fair amount of complaint. . . that companies are cutting back on these benefits, shifting costs to retirees,” Ostuw said. But, he quickly added, “An affordable commitment is much more secure than an unaffordable commitment, and I think that’s a healthy change.”

Meredith Miller of the AFL-CIO was less sanguine. “We are fearful that this reexamination of retiree health benefits is going to lead to a reexamination of other benefits,” she said. “I think we are heading towards a new definition of necessary benefits, or a core set of benefits, that employers are going to be willing to provide, and those are the predictable ones, the capped ones, and more manageable for them.”

The answer, the AFL-CIO asserted in a pamphlet distributed at the forum: “Keep benefits, cut costs.”

Ball Corp., however, viewed the issue differently. Even though its retiree health payments were limited to lifetime maximums of \$30,000 each for employees and spouses, Ball decided it could not afford to retain its retiree health benefits, Spievak said.

The company, he explained, had looked at placing more of the cost on retirees with bigger deductibles, co-pays or increased contributions. It had considered curtailing some of the coverage. It had pondered ways to reduce charges imposed by providers. None of the approaches, however, offered “significant relief,” he said.

“So we took steps that for many in this room would be very drastic. We said that anybody employed after 1/1/90 does not have access to a defined benefit retiree medical plan. We’re out of the defined retiree medical plan business at least for future hires,” he stated.

Installed in its place starting 1991 was a voluntary contributory program that allowed salaried employees—both new and previous hires—to invest at least 2 percent of

their base pay, all after-tax dollars, for their post-career health needs.

So far, though, few workers have taken Ball up on its offer. Without a matching contribution from the company, which Ball is not now making, “you are not going to get a lot of people,” Spievak allowed.

Whatever money is contributed by workers goes into a group annuity contract that accumulates earnings tax free. These earnings are then credited back to the individual contributor’s account.

At retirement, the contributors have two choices. They or their beneficiaries can submit medical bills or health insurance charges for tax-free reimbursements until the account runs dry. Or the retirees can buy an annuity that makes periodic fully taxable payments. Workers who leave before retirement can withdraw their account balances as either a lump sum or annuity, with taxes due on accumulated earnings. Beneficiaries of active workers get a lump sum.

With such a plan, said William J. Miner of The Wyatt Company, who helped design the program, workers get a way to accumulate money that will be spared from taxation if used to pay for postretirement health care. As a nonqualified plan, the coverage is not subject to contribution limits or to nondiscrimination requirements applied to highly compensated executives.

But most importantly, Miner suggested, the plan “facilitates change. . . . You have a take-away from the employee in terms of increased cost sharing, but, at the same time, you can offer this program to employees as a vehicle to save for some of those expenses.”

Other companies will be following Ball’s example, Spievak predicted. Big companies, he explained, have the clout to negotiate “favorable arrangements” with health providers that “minimize the impact of cost shifting” by federal, state and local health programs. But small companies will drop out. This will leave “a disproportionate share of cost shifting” on medium-sized employers, who “will see their retiree health plan costs increase even more,” he stated. “It is our belief that more and more employers are going to stop providing retiree medical care.”

Robert F. Seeman of American Airlines said the carrier also did “a lot of hand wringing” about its retiree health



care liabilities of nearly \$800 million. FAS 106 was “the straw that broke the camel’s back,” he said.

Still, rather than eliminate retiree coverage or drastically reduce it, which were considered, “we chose the alternative of trying to continue providing a reasonable level of retiree coverage,” he said. “We want our employees to feel good about the company.”

The carrier decided that retiree benefits would be retained, but workers would have to prefund 30 percent of the cost, with after-tax dollars deducted from paychecks during their active work years. This was “more equitable,” the company said, than “requiring employees to pay for retiree health care after they retire.”

Starting in 1990, all U.S.-based employees except pilots and flight attendants must make monthly contributions for at least 10 years prior to retirement if they want to participate in the company’s retiree health program. Just about everyone accepted, Seeman said.

Monthly contributions, all through after-tax payroll deductions, initially were set at \$10 for current eligibles and at a sliding scale of \$12 for 30-year olds to \$91.50 for those aged 49 years or older who joined the plan later.

The contributions go into separate 501(c)(9) trusts for union and nonunion employees, to take advantage of tax code breaks for programs established through collective bargaining. But Seeman said the company still was negotiating with FASB to see if assets held by the trusts satisfied conditions imposed by FAS 106, a question raised because the trusts will pay benefits at termination and death as well as for retiree health.

Did “allowing or actually requiring” employee contributions to these trusts solidify a corporate “promise and commitment” to continue a retiree health program? Reimert asked.

“Certainly, on paper, we reserved the right to modify, amend, terminate, suspend the health programs,” Seeman responded. But he agreed, “I think, in fact, we feel that we have somewhat solidified that promise.”

Quaker Oats Co., too, reassessed its coverage and concluded it was possible both to control liabilities and provide “a good retiree medical plan,” said Melanie Pheatt.

The company devised a program, effective in 1989, that recognized length of service, incorporated cost controls and provided broader coverage than the series of plans that the company had first started offering in 1955. Unlike American Airlines, though, Quaker Oats asked employees to contribute to the program after they had retired, not while still on the active payroll.

Retirees with 30 years of service pay 5 percent of the plan cost for themselves and 10 percent for spouses. Retirees with 10 years service pay 25 percent for themselves and 30 percent for spouses. Both pay 25 percent for each covered child. Because Medicare picks up most of the health bills of retirees over age 65, these older participants pay one-third as much as their younger colleagues for the Quaker Oats plan.

Benefits also are linked to years of service, with each retiree getting an annual health expense account equal to \$12.40 in 1991 for each year of qualified service. This pays for deductibles and co-pays as well as vision, dental and hearing care. Out-of-pocket limits also are keyed to years of service.

“Employee acceptance has been excellent,” Pheatt stated. And results from cost-containment efforts in the first 18 months of operation were “promising,” she said.

John K. McMahan of TRW Inc. said a series of divestitures forced that diversified company to come to grips with its retiree health liabilities in 1985 and 1986. “Lo and behold, we became startled at what we considered to be the potential liability for the promises that were out there,” he declared.

The present value of future medical benefits due 55-year-old retirees with 10 years service, McMahan explained, was half again larger than the pension liabilities for this group. For retirees at age 65 after 30-year careers, by contrast, medical benefits ran just one-seventh of the pension load. “We [were] doing it wrong. Providing these benefits was inconsistent with our other reward systems like pensions, vacations, etc., which were based on long service,” he asserted.

Effective with retirements after Aug. 1, 1988, TRW adopted a defined dollar benefit plan linked to years of service that had the effect of requiring no contribution at all in the first year from retirees who had been with the

company for 20 years. Actually, this was the maximum defined dollar amount plan. Each of TRW's constituent businesses was given the option of deciding how much of the maximum it would award.

Gulotta of Actuarial Sciences Associates, which is owned by AT&T, said the telephone company confronted two issues when it evaluated its retiree health benefits: how to redesign its program to snap the link with health costs that "automatically escalates benefits without the corporation getting any credit, and whether money should be set aside to fund these benefits."

AT&T decided to set defined dollar benefits, or caps, to limit its "open-ended commitment" to finance retiree health coverage. The decision won union assent in 1989.

Anyone retiring after March 1, 1990, had to bear the brunt of any cost increases over the caps, which ranged initially from \$500 for single retirees eligible for Medicare to \$5,650 for retired couples under 65. But no retiree would have to pay anything before July 1, 1995.

"The risk of future medical care was shifted" from the company to its retirees, Gulotta said. "It was now up to the union to bargain increases in benefits."

On prefunding, AT&T saw a promise of reduced cash flow in later years that more than compensated for increased cash flow in the near term, Gulotta said. Important, too, funding secured promised benefits, enhancing the company's "reputation as a caring and concerned employer."

As at American Airlines, separate 501(c)(9) trusts were established for union and nonunion employees. The tax code favored funding the union plan, Gulotta explained, because contributions to collectively bargained trusts can be unlimited, are deductible and accumulate tax free. A trust for nonunion workers was less favored by the tax code, but management needed benefit security as much as union workers, he said. This fund was invested in trust owned life insurance.

In response to union concern about the security of health benefits of current nonmanagement retirees, AT&T also transferred assets from an overfunded pension program to a 401(h) plan.

Prudential Insurance Co., for its part, started funding its postretirement health benefits back in 1986, Morgan said. Its current target is the FAS 106 accrual figure rather than the amount it can deduct. "We are motivated by the employee security and the desire [to build] an asset more than a lot of other issues that get addressed," he declared. The money gets invested in insurance continuance fund and trust owned life insurance.

At Phillips Petroleum Co., by contrast, "I don't think that we . . . would ever consider funding the medical plans," Robert Nash said, citing "too many complications. . . and the problem of excess funding potentially, getting it back or not getting it back, and not knowing where you go in the future."

Fidelity Investments knew all about the complications. Freiman related how it had run into a stone wall when it had asked the IRS about using profit-sharing plans as retiree medical funding vehicles.

Fidelity had wanted to amend its 401(k) profit-sharing program to allow employees to allocate a portion of the company's contribution towards retiree medical insurance premiums. When it went to the IRS to ask if profit-sharing plans could be used to fund retiree medical benefits, "the IRS did issue a favorable determination letter, and so we believe the answer is yes," Freiman said.

Fidelity got less satisfaction, however, when it asked for a private letter ruling on the tax issues, specifically: are company contributions to the plan tax deductible? Can earnings accumulate in the plan tax free? Do retirees have to pay taxes on plan benefits paid out for medical insurance premiums?

Freiman said a district IRS office determined that employer contributions are deductible and plan earnings can accumulate tax free.

On the taxability of benefits to retirees, though, "the IRS declined to rule," Freiman said. Nonetheless, fortified by an opinion from the law firm of Ropes & Gray, Fidelity decided to go ahead.

Navigating retiree health plans in the "post-FASB environment" does, indeed, mean piloting through a morass clogged by unanswered questions. How will the IRS rule?

How will the financial community react? What will workers do? What will Congress decide?

### ◆ Tax Implications of FAS 106

Michael Thrasher, deputy assistant chief counsel at the IRS for employee benefits and exempt organizations, offered some insights into the tax issues in response to questions posed by Harry J. Conaway of William M. Mercer, Incorporated.

His answers, Thrasher cautioned, were his “personal views. . . . The Service, the Treasury and, in fact, the Congress have not taken positions on a whole host of these issues. It’s cutting-edge stuff,” he contended.

With that caveat, they plunged ahead, with interpretations that immediately proved contentious to some.

When Conaway asked if section 72 granted a tax exclusion for health benefits paid through an annuity, as Miner had stated was the authority for Ball’s plan, Thrasher suggested, without talking specifically about Ball, that such an “exclusion may not be available.” Section 72-15, he said, “just sends you over to 105, 106 and so forth,” and 105-2 “says if you are going to get the money anyway it’s not excludable.”

The IRS official took a similarly hard line on flexible spending accounts for health. The basic thrust of proposed section 125-2 regulations, he said, bars a carry-over of benefits from year to year.

This was an interpretation that prompted Conaway to observe: “Some of the retiree health plan designs that we’ve heard about today, even though they are not fashioned as under a cafeteria plan, arguably would qualify as flexible spending arrangements under those regulations, and, therefore, would become subject to the 12-month period of coverage rule, the use-it-or-lose-it rule, and the uniform coverage rule, and that is an issue that people need to be aware of.”

Miner protested stoutly. “This concept that’s being posited here, that a retiree health plan that would qualify as a flexible spending arrangement has to. . . have these risk-sharing, risk-distribution characteristics and meet the use-it-or-lose-it rule and others, is really not something that

has been embedded in the rules for years and years but is rather something of a novel or new creation within the past decade,” he contended. The regulations under section 72, which date back to the 1960s, include an example of an accident and health plan that qualifies as a flexible spending arrangement but does not have the risk-sharing and distribution characteristics.

“It seems to me,” he continued, “what the Service has done here with this rule is really enact some legislation without really any statutory change that would substantiate it.” It was a point to which Thrasher responded: “Any time we do more than simply repeat the statute we can be accused of that.”

Thrasher also had little comfort for plan designers who believe that contributions to 401(h) postretirement medical accounts attached to pension plans can amount to 25 percent of the combined pension-401(h) contribution. The old law did provide such a safe harbor, he said. But the law passed in 1989 came up with a different definition. “They didn’t say 25 percent is okay. They just said over 25 percent is not.” In his view, the test is not 25 percent but whether the postretirement medical plan is subordinate to the pension. “I think you have to be careful there,” he warned.

### ◆ FAS 106 and the Financial Community

Plan designers need to be equally cautious in figuring how the financial community will react to the liability requirements imposed by FAS 106.

“Neither I nor anyone else legitimately knows what the stock market is going to do with these retiree health numbers,” Elliott asserted. “There simply haven’t been enough announcements to have any sort of base, [and] I do not believe that analysts have made up their minds how to think about this number yet.”

Still, he predicted the market will react to announced liabilities that are surprises. It will react, too, to very large numbers, even if anticipated. One large manufacturer’s estimate that its liabilities will be \$4 billion to \$6 billion “is likely” to have an effect “over time,” Elliott said. “The market is rational, but it’s not that rational.”

Even while emphasizing the massive imponderables, Elliott ventured what he called “a blatant guess,” that

“maybe half the obligation is really reflected in the stock price.”

He had more confidence in predicting how debt markets will react. For the average company, the effect of FAS 106 disclosures is going to be “fairly minimal,” he declared. “Sophisticated investors and the rating agencies are already aware of the problem.” Most will look at cash flows rather than the new liability numbers, he said. Then, too, the maturities of debt issues are shorter term than the retiree health obligations.

As in the stock market, though, big negative surprises “could precipitate stronger reactions,” including higher costs on borrowings and a market reluctance to lend.

Companies would do well to make certain the market is prepared for whatever liabilities are reported, Elliott advised. The firms need not rush to adopt FAS 106 before the deadline; most would do better blending in with the crowd, he said. But he would write off the full retiree health liabilities immediately rather than let them nibble away at profits for 20 years. “The stock market is basically affected more by earnings than it is by book value,” he explained.

## ◆ Effects of Reduced Benefits on Work and Retirement

Far more complex are decisions about work and retirement and how they might be affected by FAS 106 and the certain curtailment of retiree health benefits.

A recent *EBRI Issue Brief* on retiree health benefits indicated that benefit cutbacks “may lower employee morale and reduce a firm’s ability to attract and hold employees.”<sup>2</sup> This has not happened at Ball Corp., however. “We have not, as yet, and I emphasize as yet, had the first rejection of an employment offer for lack of a retiree medical plan,” Spievak said. “Younger new hires don’t even want to hear it,” he explained. “Their attitude is, gee whiz, I never really expected it to be there. I don’t expect Social Security to be there. I’m not even sure that [the] time when I’m going to retire is ever going to come.”

<sup>2</sup>See Jennifer Davis, “Retiree Health Benefits: Issues of Structure, Financing, and Coverage,” *EBRI Issue Brief* no. 112 (Employee Benefit Research Institute, March 1991).

Even less certain is how a change in retiree benefits will affect the timing of a worker’s decision to retire.

A survey conducted for EBRI by The Gallup Organization, Inc. found that 55 percent of nonretired Americans would not retire without employer-provided health insurance before they were eligible for Medicare.<sup>3</sup> In another EBRI/Gallup poll, 69 percent said they would rather have employer-paid retiree health benefits than company stock that could be cashed out at retirement.<sup>4</sup>

“In the absence of retiree health insurance, the high cost of individual health insurance for persons aged 50 to 64 is an important factor discouraging many older workers from retiring,” Clark said, adding: “I believe that economists and other policy analysts have systematically overestimated the importance of pensions in the retirement decision and underplayed the role of retiree health insurance.”

Still, said Clark, citing the 1988 Current Population Survey, 55 percent of all retirees over 55 years old had neither a pension nor retiree health benefits.

Ruhm offered a different perspective. “Very large financial incentives are required to induce substantial changes in average retirement ages,” he said. One study he cited calculated that a 30 percent reduction in Social Security benefits for persons retiring at age 62 would raise average retirement ages only three months. A 20 percent across-the-board cut would keep workers around only two months longer.

“The financial impacts associated with changes” in retiree health benefits, however, “are likely to be quite small,” he declared. Assuming only one in three retirees receives the benefits and employers further limit their commitment, “the increased annual expense to retirees . . . will average only \$257 a year,” he said.

“Small average effects do not eliminate the possibility of large impacts in individual cases,” he acknowledged.

<sup>3</sup>Employee Benefit Research Institute/The Gallup Organization, Inc., *Public Attitudes on Medicare and Retiree Health*, EBRI Report no. G-20 (Washington, DC: Employee Benefit Research Institute, 1991).

<sup>4</sup>Employee Benefit Research Institute/The Gallup Organization, Inc., *Public Attitudes on Employee Ownership*, EBRI Report no. G-4 (Washington, DC: Employee Benefit Research Institute, 1989).

Nonetheless, “changes of this magnitude are likely to have only slight impacts on retirement decisions, particularly since [retiree health benefits are] typically provided to relatively well-off workers, who are least often liquidity constrained.”

Harrington, however, came to a different conclusion. He laid out a series of scenarios to show how “alternatives in employer-provided health benefits will impact retirement ages and security.”

As for employers offering pensions and company-paid retiree health benefits starting at age 55, he said, dropping the health plan could force would-be retirees to work another five years to make up for the cost of buying their own replacement coverage.

For workers retiring at age 65 or older, however, the focus shifts. With Medicare picking up a large share of a retiree’s medical cost, Harrington said, retiree health benefits cost companies considerably less. And retirees lose less if the employer benefits are terminated.

If workers remain on the job after age 65, the company continues to be the primary medical payer, so it ends up with higher medical bills, although it retains an experienced worker and is spared a pension cost.

A company’s response to such variables, he concluded, rests largely on its employment needs: those companies with well-funded pension plans and surplus workers should do “nothing with respect to changing the age at which retiree medical coverage commences.” For companies that want workers to remain, however, “a change in the age at which retiree medical benefits begin is in order,” he said.

“Whether to continue to absorb full medical cost inflation is another issue.” Employees will have to share in the cost, he said.

## ◆ Public Policy Issues

Broader public-policy questions get bundled into the retiree health issue, including the nation’s labor force needs. As expressed by Jones of EBRI: “Companies have often responded to economic downfalls by reducing their work force through early retirement rather than layoffs. But is this approach best for society as a whole?”

With a graying population, she asserted, the coaxing out of older workers “may lead to a loss of skilled workers and production in the economy.” Workers, moreover, may need the added years to save. Keeping them active also could reduce the drain on Social Security and Medicare and increase revenue from income tax.

Conversely, though, “It may not always be desirable to force individuals to work until they reach age 65,” she said. Their jobs may be too demanding.

Also at issue, said Jones, is whether “scarce tax dollars should be used to subsidize benefits concentrated among the higher income employees, or the middle-income employees, while doing nothing for the uninsured population as a whole.”

EBRI estimated that granting tax breaks to companies to prefund all their current and future retiree medical liabilities in one year would have cost the U.S. Treasury \$37 billion in 1989. If amortized over 15 years, the first year tax loss would have been \$9 billion in 1989. Tax breaks such as these “would have to be offset by either a tax increase or some reduction elsewhere,” Jones said.

This against a backdrop that includes 34.4 million Americans under age 65 with neither private health insurance nor access to publicly financed care in 1989, and a federal budget deficit that is expected to swell to \$348 billion in fiscal 1992.

And, perhaps the most difficult problem to resolve: amid cries for an overhaul of the entire U.S. health delivery mechanism, should retiree health benefits be treated independently or as a subset of the whole?

To David Hirschland of the United Auto Workers, the answer was clear. “There is a fundamental problem with how we provide health care to retirees in this country, which warrants systemic reform,” he said. Worrying about funding “takes us off on the wrong track.”

Spievak agreed. “We need health care reform as a whole,” he said. “We intend to support state and federal initiatives aimed at providing universal access.”

While the general health debate has seethed, policymakers have considered four options for retiree health care, according to Jones.

### ***Prefunding Incentives***

Several proposals were introduced in the 101st Congress to provide at least limited tax breaks to companies prefunding retiree health benefits. None garnered much support, however, despite business backing, and no similar legislation has been introduced in the 102nd Congress.

### ***ERISAfication***

Some policymakers have suggested this as a *quid pro quo* for prefunding incentives, Jones said. The Employee Retirement Income Security Act of 1974 set minimum funding, participation and vesting requirements for pensions. Now some advocates would extend these to retiree health plans, as well.

### ***COBRA Extension***

The Consolidated Omnibus Budget Reconciliation Act of 1985 requires employers to allow workers, their families and beneficiaries to purchase health insurance for a limited period after the employees leave their jobs or die. The charge is usually 102 percent of the company's premium. Proposals introduced in Congress in 1991 would expand the coverage to widowed, divorced and legally separated spouses aged 50 and older until they attain other coverage or become eligible for Medicare.

### ***Medicare Expansion***

Rep. Dan Rostenkowski (D-IL), Chairman of the House Ways and Means Committee, introduced a comprehensive health care reform proposal in 1991 that, among other features, would gradually reduce the Medicare eligibility age from 65 to 60 by 1997. The proposal won the backing of the AFL-CIO, to "level the playing field" for companies with a disproportionate number of retirees, Miller said. But the federation still pushed for national health care reform.

Three congressional staffers held out little chance that any legislation would emerge soon.

Rick Grafmeyer, tax counsel for the Senate Finance Committee, said it would be "real difficult, real difficult" for any prefunding tax incentives to pass in the next couple of years.

"A lot of folks," he said, "would feel that if we're going to spend the precious federal dollars that we have, it's better off trying to increase access to the people who have no health care coverage, and/or trying to reduce the overall cost of the system, versus trying to provide a security blanket, or something akin thereto, to a group of people who may very well be covered by Medicare."

Rather than broaden tax breaks for employer-provided health care, "some people in Congress" would cut them back, he said. "Right now, the tax expenditure for health benefits on the federal level is about \$38 billion for 1991, and on the state and local level it's potentially about \$20 billion," he stated, citing a Congressional Budget Office study.

"There are some people," he declared, "who would say that we should take some of those dollars away from people who are receiving what they would deem to be better health benefits than most people get in the country, and allocate that money to people who have no health benefits and try to increase the access."

Chris Jennings, deputy staff director of the Senate Special Committee on Aging, said that members of Congress and their staffers recognize that retiree health benefits are a problem. But, he said, they are "scared" of the issue because they do not have any answers, can find no offsetting revenue-raising possibilities and see more importance in helping the uninsured and containing costs.

On the specific policy initiatives advanced so far, Jennings forecast that little progress would be made. The huge potential cost dooms prefunding tax incentives, he said. ERISAfication is unlikely unless there are some "major, major problems that are very visible to the Congress." A COBRA extension would be cheap to the federal government but "business will hate it and retirees will say, what the hell is going on" when they see bills of \$2,000 to \$3,000. Medicare expansion, too, is likely to get mired. He did not see it moving without "a comprehensive reform approach, which I don't see happening this year or next year."

Tricia Neuman, on the professional staff of the House Ways and Means Committee, made it unanimous for the congressional aides. Citing a preliminary estimate from the General Accounting Office, she said that the Medi-

care expansion bill could reduce a company's health costs "up to 60 percent per retired employee" over the lifetime of the retiree. But this is a break, she indicated, that probably will elude employers for a while. "This year . . . it's highly unlikely that there will be any legislation that would even make incremental improvements in health coverage."

Deborah J. Chollet, of Georgia State University and an EBRI Fellow, sensed, however, that pressure is building for change that could smash through the legislative bottleneck.

The very retirees who forced the repeal of the Medicare Catastrophic Coverage Act in 1988—because they felt the government was unfairly charging them for benefits their former employers already were providing—are the same people who are likely to leap into action again if they see their employer-based retiree health benefits slip into jeopardy, she said.

Many of these are middle-income retirees, most with annual earnings between \$35,000 and \$50,000, a minority in the general population, she said. But "the poor in this country are not the people who drive public policy," she asserted. "It's middle-income voters who drive public policy." In Chollet's view: "The political and policy impact of this group of people is highly disproportionate to their numbers."

And these people, Chollet said, are "going to be spectacularly unhappy" at the realization that they are being asked to carry more of both the absolute cost of retiree health care and the risk of inflation. "Just as they defeated Medicare Catastrophic, my guess is they will be right there ready to bring it back when, in fact, the baby boom is at risk of inadequate insurance benefits in retirement."

Early retirees, she said, also will press for change as they increasingly find themselves, first, abandoned by employers and, then, unable to purchase health insurance on the private market.

A minority of the population always has found itself uninsurable, she explained. Now, however, this group is expanding with "a growing baby boom, who, in larger and larger numbers, are going to find that they themselves are medically underwritten out of insurance plans, that they

are uninsurable," she said. "Suddenly, uninsurables can very well become virtually the majority population," all pushing for private insurance reform, she said.

And there is yet a third constituency, Chollet said, this one for a "global solution" for medical cost inflation, by people suddenly placed at risk.

"Employers say that they themselves can't control health care costs. It is not an unreasonable thing for people to conclude that [if] their employer is not willing to bear that risk, and not capable of managing increasing health care costs, how in the world are they going to be capable of doing that?" she asked.

"It's likely," she said, "that people will look even more strongly to the federal government for a cost control solution, and that is likely to be a regulatory action."

Miller, too, saw pressure for change not evident before FAS 106 and the resultant redrafting of retiree health plans. Prefunding tax incentives would not be coming from Congress "this year, next year, or in the next few years," she said. But, she reported, the retiree health issue has prompted employers and workers to sit down together, in committees established through collective bargaining, to look at the broader issue of national health care reform.

So, at the very least, FAS 106 has forced employers to acknowledge retiree health care liabilities. It has accelerated the inevitable recognition that some of these costs will have to be shed.

But, more than that, the accounting standard has fueled the debate for change, of not just retiree health benefits but of our national health care system.

It still is far too early to predict how this debate will evolve. Dragging new politically potent constituencies into the deliberation, however, almost certainly is going to produce actions on a timetable unimaginable before FAS 106 burst onto the scene.

## Selected Issues on the Tax Treatment of Retirees on Health Coverage and Benefits

by Harry J. Conaway, William M. Mercer, Incorporated

### ◆ Introduction

Confronted with rapidly increasing health costs, federal cutbacks in Medicare spending, and new financial accounting and disclosure requirements, many employers are reevaluating their retiree health plans. For most employers, the agenda for reviewing retiree health plans usually includes:

- planning benefit coverage modifications (e.g., increasing deductibles and co-pays and limiting coverage of certain expenses);
- instituting utilization controls (e.g., utilization review and managed care);
- limiting the employer's premiums and contributions<sup>1</sup> and increasing employees' and/or retirees' premiums and contributions;
- prefunding the employer's costs; and
- prefunding the employees' and/or retirees' costs.

The focus on plan design, cost containment, and prefunding too often causes employers (and their advisors) to overlook important retiree taxation questions: will retirees be taxed on the employer-provided portion of the health coverage and will retirees be taxed on the medical benefits and reimbursements they receive under the coverage.

This discussion examines selected technical issues relating to these questions, in two parts: the first part<sup>2</sup> focuses on the major requirements for determining whether retirees are taxed either on their health coverage or on the medical benefits and reimbursements provided under their

health coverage,<sup>3</sup> and the second part<sup>4</sup> addresses some of the additional issues that prefunding may create with respect to the tax treatment of retiree health coverage and benefits.<sup>5</sup>

While retiree health design and prefunding options raise tax issues independent of retiree taxation<sup>6</sup>—and thus beyond the scope of this article—many options, particularly some of the more innovative ones,<sup>7</sup> also raise unresolved issues about whether retirees will be taxed on the coverage and benefits.<sup>8</sup> For example, will the Internal

<sup>3</sup>These requirements generally apply regardless of whether the retiree health plan is prefunded or not and, if it is prefunded, regardless of whether it is prefunded through a welfare benefit fund, a life insurance or annuity contract, or a qualified retirement plan.

<sup>4</sup>See Issues #6 through #9.

<sup>5</sup>Also, both parts of this article reflect a broader, analytic structure that reasonably reflects the existing law and Internal Revenue Service (IRS) guidance but that has not been formally endorsed by the IRS.

<sup>6</sup>For example, may an employer deduct its contributions to a welfare benefit fund, such as a voluntary employees beneficiary association (VEBA), for future retiree health benefits under section 419 of the Internal Revenue Code (IRC), and does the fund's income on these contributions grow tax-free or is it taxable as unrelated business income under section 512? And if the VEBA invests the employer's contributions in life insurance on the employer's employees, will section 264(a)(1) apply through the "otherwise deductible" rule of section 419(a)(2) to deny the employer's deduction for its contributions to the fund?

<sup>7</sup>Most of the straightforward approaches to prefunding retiree health do not permit an employer to accumulate sufficient, tax-favored reserves. For example, the income on retiree health reserves in a welfare benefit fund for nonunion employees typically is subject to unrelated business income tax, and employer contributions to a 401(h) retiree health account under a pension plan are subject to strict limits dependent in part on the amount of the employer's pension contribution.

As a result, some employers have begun considering more innovative ways to design and prefund their retiree health plans on a tax-favored basis. For example, some employers are considering making amounts accumulated under qualified profit-sharing plans, life insurance and annuity contracts, and other entities available for retiree health benefits. Unfortunately, some of these innovative approaches create tax uncertainties for employees and retirees.

<sup>8</sup>In addition to the unresolved current law issues, the likelihood that tax-favored prefunding would reduce Federal revenues leads many to believe that if employers begin adopting innovative retiree health design and prefunding approaches that warrant favorable tax treatment, the IRS will begin working to unfavorably resolve any open issues, at least on a prospective basis. And if the IRS doesn't act, the current federal deficit would likely force Congress to take action.

<sup>1</sup>In this discussion, the terms *premiums* and *contributions* both generally include typical health premiums paid to an insurance company and contributions to a welfare benefit fund or another entity for health coverage. In addition, in appropriate cases, *premium* refers to the imputed premium an actuary calculates for a particular health plan.

<sup>2</sup>See Issues #1 through #5.



Revenue Service (IRS) treat a retiree health plan as a flexible spending arrangement (FSA) that must satisfy certain FSA requirements in order for retirees not to be taxed on the health benefits? Similarly, if an employer allows retirees to use qualified profit-sharing plan benefits to purchase retiree health coverage, will the retirees be taxed on either the profit-sharing benefits or the resulting health coverage?

◆ **Issue #1. What tax provisions are available to exclude health coverage and medical benefits and reimbursements from a retiree’s gross income?**

Section 106 of the Internal Revenue Code (IRC) is available to exclude employer-provided health coverage from a retiree’s gross income.<sup>9</sup> In general, health coverage is “employer-provided” if it is attributable to employer contributions, including for example employer premium payments to an insurance company and employer contributions to a welfare benefit fund.<sup>10</sup>

Section 105(b) is available to exclude from a retiree’s income medical benefits and reimbursements provided under employer-provided coverage that is itself excludable under section 106,<sup>11</sup> and section 104(a)(3) is available to exclude medical benefits and reimbursements under employee-paid coverage.<sup>12</sup>

<sup>9</sup>Section 106 says that the “gross income of an employee does not include employer-provided coverage under an accident or health plan.” The IRS interprets the term “employee” to include a retiree. See, e.g., Rev. Rul. 62-199, 1962-2 C.B. 38; Rev. Rul. 75-539, 1975-2 C.B. 45; Rev. Rul. 82-196, 1982-2 C.B. 53; and GCM 39038 (September 27, 1983).

<sup>10</sup>Unless specifically provided to the contrary, the term *employer contributions* includes only employer premiums and contributions that have not been includable in the employee’s or retiree’s income. If employer contributions have been includable in an employee’s or retiree’s income, they are referred to as *employee contributions*.

<sup>11</sup>Section 105(b) provides that the gross income of an employee does not include amounts received through an accident or health plan to reimburse the employee for expenses incurred for medical care (as defined in section 213(d)) to the extent that such amounts are (i) attributable to contributions by the employer which were not includable in the gross income of the employee or (ii) paid by the employer.

<sup>12</sup>Section 104(a)(3) provides that an employee’s gross income does not include amounts received through an accident or health plan for personal injuries or sickness, other than amounts that are (i) attributable to employer contributions that were not includable in the gross income of the employee or (ii) are paid by the employer. These “other amounts” are excludable under section 105(b).

Sections 106, 105(b), and 104(a)(3) are the only provisions in the tax law that exclude from income employer-provided health coverage and medical benefits and reimbursements provided under employer-provided and employee-provided health coverage.<sup>13</sup>

◆ **Issue #2. What requirements must a health plan satisfy in order for retirees to exclude health coverage and medical benefits and reimbursements from gross income under sections 106, 105(b), and 104(a)(3)?**

In the IRS’s view, the section 106 exclusion applies only to employer-provided coverage under a health plan that satisfies various requirements. Similarly, only medical benefits and reimbursements under a health plan that satisfies these requirements are nontaxable under section 105(b) or 104(a)(3) (depending on whether the coverage is attributable to employer contributions or employee contributions, respectively). (For purposes of this discussion, a health plan that satisfies these requirements for favorable tax treatment will be referred to as a *qualified health plan*.)<sup>14</sup>

In what may be the IRS’s developing view of the qualified health plan requirements,<sup>15</sup> all health plans must satisfy a generally applicable requirement, and then certain health plans—those that fit within the FSA definition in the proposed cafeteria plan regulations—must satisfy several additional requirements.

The requirement for all qualified health plans is that the medical benefits and reimbursements provided thereunder

<sup>13</sup>For example, section 132, which governs the tax treatment of employee benefits, does not apply to health benefits expressly provided for in sections 106, 105(b), and 104(a)(3). See section 132(j). Also, section 72 does not exclude medical reimbursements under life insurance and annuity contracts or under qualified retirement plans, but instead incorporates the requirements of sections 106, 105(b), and 104(a)(3) to determine the tax treatment of such payments. See sec. 1.72-15(b) of the regulations.

<sup>14</sup>The term *qualified health plan* is not used in either the Internal Revenue Code or the Treasury regulations under sections 106, 105(b), and 104(a)(3).

<sup>15</sup>The IRS has not issued guidance that systematically presents the requirements a health plan must satisfy for favorable tax treatment. However, existing regulations (including the proposed cafeteria plan regulations under section 125), other formal guidance (e.g., IRS rulings), and the public and private statements of various IRS officials indicate that a systematic view along the lines of the “IRS’s view” described herein may be under active development.

be paid “specifically for medical care.”<sup>16</sup> The IRS interprets this to mean that a qualified health plan must not provide benefits or reimbursements that a covered individual would be entitled to receive whether or not he receives medical care.<sup>17</sup>

Thus, for example, an arrangement that will provide a retiree with \$1,000 regardless of whether he incurs medical expenses will not be a qualified health plan for tax

<sup>16</sup>See sec. 1.105-2 of the regulations. Also, the proposed cafeteria plan regulations—sec. 1.125-2, Q&A-7(a)—describe several generally applicable requirements for qualified health plans. Nevertheless, only the “specifically for medical care” requirement appears to have a meaningful practical effect.

<sup>17</sup>For example, in Rev. Rul. 69-141, 1969-1 C.B. 48, the IRS concluded that even though distributions could be made from a qualified plan in the event of illness, such distributions retained their character as deferred compensation because the employee was entitled to the amounts regardless of whether he incurred medical expenses. See also Rev. Rul. 59-158, 1959-1 C.B. 34; Rev. Rul. 77-123, 1977-1 C.B. 28; PLR 8753008 (October 1, 1987); and PLR 8824013 (March 16, 1988). Various court cases involving accident and health benefits under qualified retirement plans have also discussed (sometimes more implicitly than explicitly) the “specifically for medical care” requirement. See, e.g., *Stewart v. United States*, 313 F. Supp. 195 (W.D. Pa. 1970); *Masterson v. United States*, 478 F. Supp. 454 (N.D. Ill. 1979); *Wood v. United States*, 590 F.2d 321 (9th Cir. 1979); *Caplin v. United States*, 718 F.2d 544 (2d Cir. 1983); *Gordon v. Commissioner*, 88 T.C. 630 (1987); *Biesler v. Commissioner*, 814 F.2d 1304 (9th Cir. 1987); and *Berman v. Commissioner*, 58 T.C.M. (CCH) 916 (1989) and 925 F.2d 936 (6th Cir. 1991).

Most recently, sec. 1.125-2, Q&A-7(a) of the proposed cafeteria plan regulations includes the following statement regarding whether a reimbursement will be treated as “specifically for medical care”: “A reimbursement is not paid specifically to reimburse the [employee] for medical expenses if the [employee] is entitled to these amounts, in the form of cash or any other taxable or nontaxable benefit (including health coverage for an additional period), without regard to whether the employee incurs medical expenses during the period of coverage.” This regulation also says that this requirement applies to all health plans, whether or not included in a cafeteria plan. Note also that the parenthetical—“including health coverage for an additional period”—is intended to prevent the continuation or granting of additional health coverage based on the extent to which an individual’s reimbursements for a coverage period are less than the total premiums or the maximum reimbursement amount for the period.

Beyond these general statements, there is no guidance on the “specifically for medical care” requirement. For example, would an arrangement violate the “specifically for medical care” requirement if, at the time a reimbursement is made, the amounts were available only for medical care expenses, but in another year they were scheduled to become available irrespective of medical needs? Also, can accelerated death benefits under a life insurance policy satisfy the “specifically for medical care” requirement to the extent the individual is incurring medical expenses, so that some of these benefits can be excluded under section 105(b) or 104(a)(3)? And what about payments under a long term care policy that are available for medical and nonmedical needs but are paid for medical expenses?

purposes even if the retiree receives the \$1,000 after he has incurred \$1,000 in medical expenses. As a result, employer-provided coverage under this arrangement would not be excludable under section 106, and reimbursements would not be excludable under section 105(b) or 104(a)(3).

Furthermore, in the IRS’s view, health plans that fit within the FSA definition must satisfy certain additional requirements to be treated as qualified health plans. Here are the additional FSA requirements:<sup>18</sup>

- The coverage period for a health FSA generally must be 12 months;<sup>19</sup>
- A health FSA must provide uniform maximum coverage throughout the coverage period;<sup>20</sup>

<sup>18</sup>The additional FSA requirements are in sec. 1.125-2, Q&A-7(b) of the proposed regulations.

<sup>19</sup>Health plans that are not FSAs may be qualified health plans even though they may have coverage periods that are much less or much more than 12 months. As applied to health FSAs, the 12-month requirement is intended, in combination with the “specifically for medical care” requirement, to restrict a covered individual from gaining favorable tax treatment of unreimbursed medical expenses without regard to the section 213 rule that unreimbursed expenses are deductible only if they exceed 7.5 percent of the taxpayer’s adjusted gross income.

For example, without the 12-month rule, a covered individual who made contributions to a health FSA could “carry over” unused amounts for medical reimbursements from one year to the next, without ever violating the “specifically for medical care” requirement. The 12-month rule thus forces a covered individual either to “use” all of the FSA amounts to reimburse medical expenses for the 12-month coverage period or to “lose” any amounts left unused as of the close of the period. Finally, contrary to the views of some commentators, the 12-month requirement is unrelated to the section 125 prohibition on deferred compensation under a cafeteria plan.

<sup>20</sup>The uniform coverage requirement means that the maximum amount of medical reimbursements available under an FSA at any time during its coverage period must be available at all times during the coverage period. Thus, for example, if an employee elects coverage under an FSA with an annual reimbursement maximum of \$2,400, the full \$2,400 must be available beginning with the first day of the coverage period even though the employee, as of that date, may have paid only \$200 in premiums for the FSA coverage. Of course, it is permissible to reduce the maximum by reimbursements for prior expenses during the coverage period.

This requirement is intended to assure that some meaningful amount of risk is transferred under an FSA from the premium payor (e.g., the covered individual) to the insurer (e.g., the insurance company or the employer). Applied specifically to health FSAs, it is intended to prevent FSAs from operating like individual savings accounts by increasing the maximum reimbursement amount over the coverage period only as the covered individual makes additional premium payments.

- Reimbursable medical expenses under a health FSA must be incurred during the coverage period;
- A health FSA may not reimburse premiums for other health coverage;<sup>21</sup> and
- A health FSA may reimburse a medical expense only if the employee provides a written statement from an independent third party stating that the expense has been incurred and that the expense has not and will not be reimbursed under any other coverage.<sup>22</sup>

### ◆ Issue #3. How do you determine whether a health plan fits within the “FSA” definition?

In the proposed cafeteria plan regulations,<sup>23</sup> the IRS says that a health plan is an FSA if the maximum reimbursement amount that is reasonably available for a coverage period is not substantially in excess of the total premium for such coverage. And, more particularly, a maximum amount is not substantially in excess of the total premium if it is less than 500 percent of the total premium.<sup>24</sup>

Finally, the regulations say that, in making this determination, the total premium includes both employee-paid and employer-paid premiums.<sup>25</sup>

The most common example of a health FSA is an account-based medical expense reimbursement arrangement under a cafeteria plan. Typically, this arrangement is funded entirely with employees’ salary reduction contributions and provides each employee with a maximum reimbursement amount equal to the total salary reduction contributions the employee is scheduled to pay for the coverage period, which is usually the calendar year. As the employee incurs medical expenses over the year, reimbursements are charged against the maximum amount.

Under the IRS’s view, the FSA definition and the additional FSA requirements are potentially applicable to all health plans, including for example some dental and vision plans and self-insured retiree health plans funded with employer contributions outside of cafeteria plans.<sup>26</sup> Many commentators argue, however, that this view is not justified by existing IRS guidance, particularly where the

---

employers with contributions (e.g., salary reduction contributions under a cafeteria plan) that were available to the employees in a taxable form, a plan may too easily allow employees to avoid the 7.5 percent threshold under section 213. The 500 percent test is just a crude measure of whether a meaningful amount of risk has been shifted.

<sup>25</sup>Also, IRS officials informally explain that the 500 percent test is applied by taking into account both actual premiums to a separate entity (e.g., an insurance company or welfare benefit fund) and, when appropriate, imputed or actuarially determined premiums (e.g., a self-insured health plan paid entirely by the employer).

Unfortunately, the IRS has not provided any additional guidance about how to apply the 500 percent test. For example, is it applied separately to each covered individual and also separately from one year to the next, or is it applied to a health plan in the aggregate with respect to the entire group of covered individuals. If the former approach is correct, a uniform health plan for a large group of individuals may be an FSA for some but not all of the individuals (for example, as an individual’s lifetime maximum is reduced through prior reimbursements). Similarly, a health plan may not be an FSA for an individual’s first year of coverage, but as the individual receives reimbursements and thus reduces the remaining maximum, the health plan may become an FSA for that individual.

<sup>26</sup>IRS officials point to the last sentence of sec. 1.125-2, Q&A-7(a) of the proposed regulations, which discusses the application of the generally applicable health plan requirements to health FSAs, as supporting this view: “These [health plan] rules apply with respect to a health plan without regard to whether the plan is provided through a cafeteria plan.” The officials also point to the 500 percent test under the FSA definition, which takes both employee-paid and employer-paid premiums into account and thus arguably is designed to apply to health plans funded with nonelective employer contributions.

---

<sup>21</sup>An individual’s premium payments for coverage under a qualified health plan may qualify as medical expenses within section 213 and thus may be deductible by the individual to the extent that they, in combination with the individual’s other unreimbursed medical expenses, exceed 7.5 percent of the individual’s adjusted gross income. Thus, if a qualified health plan that is not an FSA reimburses a covered individual’s premium payments for other health coverage, the reimbursement may be excludable under section 105(b). The intent of the “no premium” reimbursement rule for health FSAs is to make it more difficult for a covered individual to “zero out” an FSA at the close of a coverage period and thus to avoid the 7.5 percent threshold under section 213 by running premium payments that would otherwise be made with after-tax dollars through a health FSA. This same concern arguably applies to all elective or discretionary medical expenses, but the IRS would seem to be on very thin ice if it attempted to preclude health FSA reimbursements of these expenses.

<sup>22</sup>This substantiation requirement reverses the rule that applies to all other qualified health plans—that proof of the actual medical expenses is not required in order for an individual to exclude a reimbursement under section 105(b), so long as the amount of the reimbursement does not exceed the actual expense. See sec. 1.105-2 of the regulations. This reversal is intended, in part, to prohibit health FSA designs that would make advance reimbursements of future, and often hypothetical, medical expenses.

<sup>23</sup>See sec. 1.125-2, Q&A-7(c) of the proposed regulations.

<sup>24</sup>The rationale is that where the maximum reimbursement amount under a plan is not substantially more than the premium, the plan does not shift a meaningful amount of risk from the premium payer to the insurer, whether the insurer be an insurance company, a welfare benefit fund, or the employer. Without meaningful risk shifting, particularly where the premiums are paid by employees or by

health plan is attributable to employer contributions that were not available to an employee or retiree in any taxable form.<sup>27</sup>

Some innovative retiree health designs risk coming within the IRS's definition of an FSA and thus, in the IRS's view, being subject to the additional FSA requirements. For example, some employers have considered adopting retiree medical accounts that are credited with employer-provided amounts, determined either on a flat, per capita basis or by taking an employee's years of service with the employer into account.<sup>28</sup> A retiree may then receive medical reimbursements from the account during his retirement years, until all amounts in the account have been paid as reimbursements.

Under the IRS's view, these retiree medical accounts would likely fit within the FSA definition. Thus, they would not qualify for favorable tax treatment because, for example, the coverage period would extend beyond 12 months and retirees may receive reimbursements of premium payments for other health coverage.<sup>29</sup> The IRS

<sup>27</sup>These commentators argue that the last sentence of sec. 1.125-2, Q&A-7(a) of the proposed regulations (quoted in the preceding footnote) refers only to the requirements that are presented in Q&A-7(a)—these are the requirements that apply generally to all health plans—and does not refer to the additional FSA requirements set forth in Q&A-7(b). In spite of the IRS's apparent intent, this does appear to be the better literal reading of this last sentence. In addition, some commentators argue that because the additional FSA requirements are set forth in proposed regulations for cafeteria plans, the requirements can be fairly read as applicable only to arrangements under cafeteria plans.

Finally, some commentators point out that the policy reasons for the additional FSA requirements—preventing easy avoidance of the 7.5 percent threshold under section 213 on deductions of unreimbursed medical expenses, and assuring a meaningful shifting of risk from premium payers to insurers—do not apply when the health plan in question is funded primarily with employer contributions that were not otherwise available to employees in any taxable forms.

Thus, the argument goes, these health plans should not be subject to the FSA requirements.

<sup>28</sup>Basing coverage amounts under a self-insured health arrangement on employees' years of service may raise discrimination issues under section 105(h).

<sup>29</sup>For example, assume an arrangement that provides each retiree with up to \$10,000 in medical expenses reimbursements. Assume also that a retiree receives medical reimbursements of \$1,500 during his first year of retirement. If the \$10,000 maximum reimbursement amount is not more than 500 percent of an actuary's imputed premium for this coverage, the IRS view is that the arrangement would be an FSA and thus would have to satisfy the FSA requirements. Of course, the "no premium" requirement would prevent the arrangement from reimbursing employee-paid premiums for other coverage, and the "specifically for medical care" and 12-month requirements would

would apply this analysis without regard to whether the medical accounts are unfunded or are funded through a welfare benefit fund (e.g., VEBA), a life insurance or annuity contract, or a qualified retirement plan, including a 401(h) retiree health account<sup>30</sup> and a qualified profit-sharing plan.<sup>31</sup>

#### ◆ Issue #4. Are health premium-only arrangements subject to the qualified health plan requirements, including the FSA requirements?

Some employers are considering arrangements under which they would provide a retiree with a specified amount to pay premiums for health coverage.<sup>32</sup> For

force a "forfeiture" of the unused portion of the maximum amount as of the close of the first year (i.e., \$8,500 in this example).

<sup>30</sup>Section 401(h) provides rules allowing an employer to establish a retiree health account as part of a qualified pension plan, including either a defined benefit plan or a money purchase pension plan, without violating the incidental benefit prohibition on retiree health benefits under qualified pension plans. See sec. 1.401-1(b)(1)(i) of the regulations. Subject to certain limits, the employer may make deductible contributions to the 401(h) account, the income on the 401(h) contributions will grow tax-free, and the accumulated amounts may be used to provide retirees with health benefits.

Some 401(h) accounts operate like defined benefit plans, with amounts accumulating on a pooled basis and each retiree's benefits determined under the terms of the health plan. Other 401(h) accounts are designed like defined contribution plans, with each retiree having a separate account and each retiree's benefits limited to the amount credited to his account. Particularly in the latter cases, the health plan may arguably fit within the FSA definition because the maximum reimbursement available to a retiree—based on the amount credited to the retiree's account—may not exceed 500 percent of an actuary's imputed premium for coverage under the plan. See also M.E. Oppenheimer (Employee Benefits and Exempt Organizations Division, Office of the Chief Counsel, Internal Revenue Service) and R.S. Rizzo (partner in law firm of Jones, Day, Reavis & Pogue), "Health Employee Stock Ownership Plans (HSOPs): Do They Work?", *ALI-ABA Course of Study—Pension, Profit-Sharing, and Other Deferred Compensation Plans*, March 20-22, 1991, pp. 649-657 (San Francisco, California). (This outline addresses the potential application of the FSA rules to separate retiree health accounts within a 401(h) account.)

<sup>31</sup>Amounts attributable to employer contributions under a qualified profit-sharing plan may be used to provide retiree health benefits without violating the incidental benefit limit for such plans. See, e.g., sec. 1.401-1(b)(1)(ii) of the regulations and Rev. Rul. 61-164, 1961-2 C.B. 58. See also note 47 below. With the exception of 401(h) accounts, defined benefit plans and money purchase pension plans may not provide retiree health benefits.

<sup>32</sup>This type of arrangement may be attractive to an employer that wants to limit the dollar amount it spends on health coverage for each retiree. The arrangement may operate either on an unfunded basis—the amounts are paid by the employer out of corporate assets—or on a funded basis—the amounts are attributable to employer contributions under a welfare benefit fund, insurance

example, an employer may provide that each retiree may direct the employer to use up to \$1,000 in unfunded, employer credits per year to pay premiums for one or more of several health plans. If the annual premium for a retiree's desired coverage is more than \$1,000, the retiree must pay the difference (usually, with after-tax dollars). Under the arrangement, the retiree would not be permitted to use the employer credits for any purpose other than to pay health premiums; that is, the credits could not be used to reimburse nonpremium medical expenses.

Some are concerned that these premium-only arrangements might have to be qualified health plans in order for retirees to avoid tax on the premium payments and resulting health coverage. If this is correct, the low dollar maximums under most of these arrangements would cause them, under the IRS's view, to be FSAs subject to the FSA requirements. And because the arrangements would automatically fail the "no premiums" requirement, a retiree would be taxed on the premium and resulting health coverage.<sup>33</sup>

Absent IRS guidance on this issue, many commentators are comfortable with the view that premium-only arrangements do not have to satisfy the FSA requirements in order for the premiums and resulting coverage to be tax-free to retirees. There appear to be at least two lines of analysis supporting this view.

The first says that even if premium-only arrangements have to be qualified health plans in order for retirees not to be taxed on the premiums and resulting coverage, the qualification determination for these arrangements is made without regard to the FSA requirements. In other

words, premium-only arrangements are exempt from the FSA definition and thus are not subject to the FSA requirements.

This argument is based on a distinction in the proposed cafeteria plan regulations between (i) arrangements that reimburse not only health premiums, but also other medical expenses, and (ii) arrangements that pay only premiums. The proposed regulations can be fairly read as intending that only the former arrangements have to satisfy the FSA requirements (including the "no premiums" requirement) to achieve favorable tax treatment.<sup>34</sup> This argument may be bolstered by the view that, notwithstanding the public statements of several IRS officials, the existing guidance does not apply the proposed FSA requirements to arrangements, such as these premium-only arrangements, that are outside of cafeteria plans.<sup>35</sup>

The second line of analysis is that the section 106 exclusion applies broadly to all employer premium arrangements and the resulting coverages under qualified health plans, regardless of whether the premiums are themselves paid under qualified health plans. In other words, section 106 requires only that the coverage purchased with the premium payment be a qualified health plan. Under this line of analysis, a taxpayer does not have to rely on section 105(b) to exclude employer premiums from gross income (even though section 105(b) may exclude such premiums when they are paid under a health plan). Instead, pre-tax treatment of premiums and coverage is more directly achieved under section 106 where the premiums are paid

---

contract, or qualified retirement plan. The present analysis focuses on the unfunded version of the arrangement, but would apply as well to funded premium-only arrangements.

<sup>33</sup>Of course, a retiree would be taxed either on the premiums or the health coverage purchased with the premiums, but not on both. Another concern raised by some commentators is that the retiree's discretion to direct that the unfunded employer credits be used for one or another health plan might be sufficient retiree "dominion and control" to cause the employer dollars used to pay the elected premium not to qualify as employer contributions under section 106, thereby causing the retiree to be taxable on the selected health coverage. However, employee or retiree discretion among two or more *nontaxable* health plan options should not preclude the employer dollars from qualifying as employer contributions under section 106, particularly where the dollars are being paid under an unfunded arrangement. See note 38 below and Issue #8 below for further discussion of this question.

---

<sup>34</sup>For example, the prohibition on the reimbursement of premiums under a health FSA "does not prevent premiums for current health coverage (including coverage under a health FSA) from being paid on a salary reduction basis through the ordinary operation of the cafeteria plan." See sec. 1.125-2, Q&A-7(b)(4) of the proposed regulations. Also, sec. 1.125-2, Q&A-7(f) of the proposed regulations, which defines "flexible spending arrangements," includes the following example:

Assume that an employer with 1,000 employees maintains a cafeteria plan under which the employees may elect among several benefit options, including insured health plans and HMOs. The plan provides that the required premiums or contributions for the benefits are to be made by salary reduction. Even though the plan may characterize employees' premium payments and other contributions as flexible spending contributions or credits, the operation of the cafeteria plan to permit employees' contributions to be made on a salary reduction basis does not, standing alone, cause the plan (or any benefit thereunder) to be treated as a flexible spending arrangement.

<sup>35</sup>See note 27 above.

out of amounts attributable to employer contributions and the resulting coverage is under a qualified health plan.<sup>36</sup>

◆ **Issue #5. What if a premium-only arrangement permits “carry overs” of unused employer credits or permits reimbursements of premiums paid for coverage under plans not maintained by the employer?**

Some have expressed additional concern that, notwithstanding the preceding discussion, a premium-only arrangement will have to satisfy the FSA requirements and thus will not achieve favorable tax treatment if the arrangement permits unused employer credits for one year to be carried over to pay premiums in subsequent years. Similarly, some commentators are concerned that a premium-only arrangement will have to be a qualified health plan and thus will have to satisfy the FSA requirements if it permits employer credits to be used to reimburse the retiree for premiums for health plan coverage that is not otherwise maintained by the employer, such as individual Medigap coverage or coverage under a spouse’s employer’s health plan.<sup>37</sup>

Premium-only arrangements with either or both of these features grant retirees some additional discretion over the employer credits and thus may appear more like medical expense reimbursement accounts, which typically must be qualified health plans that satisfy the “specifically for medical care” and FSA requirements to gain favorable tax treatment.<sup>38</sup>

<sup>36</sup>Supporting this view is the fact that section 106 exists at all. Premiums come within the “medical care expense” definition of section 213 and thus a qualified health plan’s reimbursement of premiums may be excludable under section 105(b). In light of this alternative basis for excluding employer-paid premiums, if section 106 also required that premiums be paid under or out of (instead of to) a qualified health plan, section 106 would not provide any tax benefit that is not also provided under section 105(b); section 106 would be unnecessary. Also, it is clear that, in practice, the IRS does not take the view that employers’ premium payments for health coverage for active employees and retirees—e.g., employer payments directly to an insurance company or a welfare benefit fund—must be made under or out of qualified health plans.

<sup>37</sup>An employer may find these features attractive to encourage retirees not to purchase health coverage from the employer—thereby saving the employer any explicit or implicit employer subsidy—and instead to opt for other, unrelated health coverage.

<sup>38</sup>Alternatively, the additional retiree discretion over the ultimate use of the unfunded employer credits may arguably cause the credits, when used to purchase retiree health coverage, not to qualify as

Nevertheless, existing IRS guidance does not suggest that these features would shift the basis of a retiree’s tax exclusion on the employer-paid premiums and resulting coverages from section 106 to section 105(b). As before, whether qualified health coverage is excluded from tax under section 106 depends on whether it is purchased with amounts attributable to employer contributions. In this context, this determination presumably would be based on whether the retiree has been taxed on the employer credits over which he has discretion, and current law does not provide a clear basis for taxing a retiree on unfunded employer credits that are not available to the retiree other than as premiums for qualified health plan coverage.<sup>39</sup>

Similarly, with respect to the reimbursement of retiree premiums paid to unrelated health plans, the IRS has consistently ruled that verifiable premium reimbursements made under a legal obligation by the employer to the employee or retiree may be treated as premium payments excludable under section 106 (rather than as medical expense reimbursements excludable only under section 105(b)).<sup>40</sup>

Of course, there is also a question of whether there might be a policy reason for the IRS to require that premium-only arrangements with these or similar features satisfy the FSA rules in order for retirees not to be taxed on the premiums. But as the employer credits are unfunded and are not available to the retirees in any taxable form, the premium-only arrangements do not permit retirees to convert otherwise after-tax benefits into nontaxable benefits in avoidance of the 7.5 percent threshold under section 213.<sup>41</sup> Thus, there do not appear to be strong policy reasons for applying the FSA requirements to these premium-only arrangements.

employer contributions under section 106. Thus, a retiree would not be able to exclude the purchased coverage from income under section 106. See note 33 above and Issue #8 below for further discussion of this question.

<sup>39</sup>For example, section 83 would not trigger retiree taxation because, under the arrangement, there would not be a transfer of property from the employer to the retiree before the actual provision of the health coverage, which would then be excludable under section 106. See Issue #8 below for possible theories for taxing an employee or retiree on account of discretion over the ultimate use of amounts attributable to employer contributions.

<sup>40</sup>See, e.g., Rev. Rul. 57-33, 1957-1 C.B. 303; Rev. Rul. 61-146, 1961-2 C.B. 25; Rev. Rul. 75-241, 1975-1 C.B. 316; Rev. Rul. 82-196, 1982-2 C.B. 53; and PLR 9019023 (February 9, 1990). See also *Marshall v. Commissioner*, 10 EBC 1683 (Tax Court) (January 5, 1989).

<sup>41</sup>See notes 19, 21, 24, and 27 above.

## ◆ Issue #6. Does prefunding retiree health affect the tax treatment of health coverage and medical reimbursements?

The basic model for prefunding retiree health involves either the employer or the employees (or both) making contributions to a separate fund, plan or other entity for future retiree health coverage and benefits. The foremost examples of separate entities are welfare benefit funds, such as voluntary employee beneficiary associations (VEBAs); life insurance and annuity contracts; and qualified retirement plans, such as 401(h) retiree health accounts and profit-sharing plans (including 401(k) plans).<sup>42</sup> Amounts accumulated under these separate entities are then used to pay premiums for health coverage or to pay the medical reimbursements under the retiree health plan.

In order for prefunded health coverage and medical reimbursements to qualify for favorable tax treatment under sections 106, 105(b), and 104(a)(3), the coverage and reimbursements must satisfy all of the same requirements that apply to unfunded health plans. Thus, all of the preceding issues raised with respect to unfunded retiree health plans also apply to prefunded retiree health plans.

Thus, for coverage under a prefunded retiree health plan to be excluded from a retiree's income under section 106, the coverage must be employer-provided (i.e., attributable to employer contributions) and the plan must be a qualified health plan. Similarly, a prefunded health plan will be a qualified health plan only if the reimbursements are "specifically for medical care" and, if (under the IRS's view) the prefunded plan is an FSA, the plan satisfies the FSA requirements.<sup>43</sup>

While these are the same basic requirements that unfunded health plans must satisfy to gain favorable tax treatment, prefunding can make the "employer-provided" determination under section 106 more complex. For example, to what extent will amounts attributable to employer contributions that have accumulated under a

separate fund, plan or other entity for a number of years continue to qualify as employer contributions for purposes of determining whether retiree health coverage is employer-provided under section 106? Will employee or retiree discretion about the ultimate use of the accumulated amounts for coverage under different retiree health plans or for other benefits, including taxable annuity and deferred compensation benefits, cause the amounts not to qualify as employer contributions under section 106?

## ◆ Issue #7. Do employer contributions that have accumulated under a separate fund, plan or other entity continue to qualify as employer contributions for purposes of the "employer-provided" determination under section 106?

As previously discussed, section 106 excludes from a retiree's income employer-provided coverage under a qualified health plan; i.e., coverage that is attributable to employer contributions that have not been includable in the employee's or retiree's gross income. Existing guidance on prefunded health plans strongly supports the conclusion that retiree health coverage purchased with employer contributions that have accumulated under a separate fund, plan or other entity will qualify as employer-provided coverage under section 106 if the contributions have not been includable in the income of the employee or retiree and the employer retains control over the ultimate use of the contributions.<sup>44</sup>

<sup>44</sup>Section 106 may be satisfied where employer contributions (and earnings thereon) are set aside in a separate fund or plan and only later used to provide retiree health coverage. For example, section 1.106-1 of the regulations provides that "[t]he employer may contribute to an accident or health plan either by paying the premium (or a portion of the premium) on a policy of accident or health insurance covering one or more of his employees, or by contributing to a separate trust or fund . . . which provides accident or health benefits directly or through insurance to one or more of his employees." The condition that the employer contributions not have been includable in the employee's or retiree's income is based on the provisions of sections 106, 105(b), and 104(a)(3). The condition that the employer retains control over the ultimate use of the employer contribution is not a requirement for favorable tax treatment under current law, but favorable treatment is more clearly achieved where the employer does retain such control. See, e.g., GCM 31934 (April 15, 1961), which says that section 106 excludes retiree health coverage purchased under a qualified profit-sharing plan "automatically at the employer's direction." Also, some are concerned that the IRS is moving in the direction of making this requirement a formal one. See Issue #8 below.

<sup>42</sup>See notes 30 and 31 above and note 47 below on the incidental benefit rules for qualified retirement plans.

<sup>43</sup>The 500 percent FSA determination is made without regard to whether an arrangement is funded or not. See Issue #3 above.

Thus, for example, retiree health coverage purchased, at the employer's direction, with prefunded amounts attributable to employer contributions under a VEBA or a 401(h) retiree health account qualifies as employer-provided coverage under section 106.<sup>45</sup> And this result occurs even if the prefunded amounts under a VEBA are not originally set aside to purchase retiree health coverage and thus could have been used, at the employer's direction, to provide other benefits to active or retired employees.

Also, this same favorable tax treatment would apply where the employer contributions are allocated to individual accounts under the fund, plan or entity, but the employer retains control over the ultimate use of the contributions to purchase health coverage.<sup>46</sup> For example, assume that an employer makes contributions to a qualified profit-sharing plan that are allocated to individual employee accounts and the employer provides that a specified portion of each account will be used to purchase retiree health coverage.<sup>47</sup> These amounts will continue to qualify as attributable to employer contributions under section 106, and thus a retiree would not be taxed on the retiree health coverage purchased with these profit-sharing amounts.<sup>48</sup>

<sup>45</sup>Section 106 excludes from income retiree health coverage purchased under a welfare benefit fund, such as a VEBA, where the coverage is attributable to employer contributions that have not been includable in the employee's gross income. And an employee or retiree is not taxable on employer contributions accumulated under a VEBA by an employer to fund its share of retiree health coverage. For example, section 402(b) does not apply because the VEBA is a tax-exempt entity under section 501(a). The same analysis would apply to employer contributions under a 401(h) account. Also see note 48 below on applying section 106 to retiree health coverage under a 401(h) account.

<sup>46</sup>Thus, for example, if the employer has determined that it will spend on health coverage only the amount of employer contributions (and earnings) that have been credited to the retiree's account under a VEBA or 401(h) account, the coverage will qualify as employer-provided under section 106 notwithstanding the individual allocation of the employer contributions. There is no clear basis for taxing an employee or retiree where the use of these prefunded amounts is determined by the employer.

<sup>47</sup>Many commentators believe that a qualified profit-sharing plan may provide retiree health benefits with up to 100 percent of an employee's accrued benefit without violating the incidental benefit limitation of section 401(a). In any case, it is clear that up to 25 percent of an employee's benefit may be used for this purpose without violating the incidental benefit limit. See note 31 above on the incidental benefit rule for profit-sharing plans.

<sup>48</sup>Section 106 applies to retiree health coverage that is purchased under a qualified retirement plan, including both a 401(h) account and a profit-sharing plan, with amounts attributable to employer

## ◆ Issue #8. Will health coverage purchased with prefunded employer contributions qualify as employer-provided coverage under section 106 if the employee or retiree has discretion over the ultimate use of the contributions?

Some prefunded retiree health designs would give employees and retirees discretion over the ultimate use of the prefunded employer contributions. For example, an employer that maintains a VEBA might allow retirees to use specified amounts thereunder to purchase health coverage or other permissible benefits, some of which would be taxable to the retirees.

Similarly, an employer might allow employees to direct that all, some, or none of each year's employer contribution under a qualified profit-sharing plan be allocated to a retiree health account for the future purchase of retiree

---

contributions. The tax treatment of all distributions (including distributions of health coverage) under all qualified retirement plans is initially governed by section 402(a), which says that "the amount actually distributed to any distributee" is taxable to the distributee under section 72. Section 72 explicitly provides that other exclusions under the tax law may apply to exclude amounts subject to section 72 from gross income. See sections 72(a) and 72(e)(1)(ii), and secs. 1.72-1 and 1.72-15 of the regulations. Also, sec. 1.72-15(h) of the regulations states that retiree health coverage provided under a 401(h) account is excluded from gross income.

Sections 72(m)(3) and 79(b)(3) inferentially support this analysis. These sections explicitly override the application of the section 79 exclusion for group-term life insurance where such insurance is purchased under a qualified retirement plan, and they thus create a reasonable inference that section 79 would have otherwise been available (through section 72) to exclude such insurance from income. See also sec. 1.72-15(b) of the regulations, which states that the tax treatment of health benefits under a qualified retirement plan subject to section 72 is determined not by section 72, but instead by sections 105 and 104 (depending upon whether the amounts are attributable to employer contributions or employee contributions, respectively).

While section 106 is not explicitly referenced in the section 72 regulations, section 106 (like section 79) qualifies as an exclusion under the tax law that may apply, through section 72, to health coverage purchased with employer contributions and then distributed under a qualified retirement plan. Indeed, long ago, the IRS ruled that section 72 permits the application of section 106 to exclude from income retiree health coverage purchased through a qualified profit-sharing plan with amounts attributable to employer contributions. See GCM 30304 (October 4, 1957), PLR 5710288190A (October 28, 1957), and GCM 31934 (March 15, 1961), all of which relate to employer prefunding of retiree health coverage under a qualified profit-sharing plan. The IRS has not taken this position more recently.



health coverage. A more flexible design would allow a retiree to make an annual election to use all, some, or none of his profit-sharing benefits to purchase health coverage for that year.

As previously discussed, granting an employee or retiree discretion about the ultimate use of prefunded employer contributions will cause the contributions not to qualify as employer contributions under section 106 if the discretion causes the contributions to be includable in the employee's or retiree's income.<sup>49</sup> This would appear to be the case in the above example, where the retirees can direct the use of VEBA amounts for health coverage or other permissible benefits, including some taxable benefits.<sup>50</sup>

More troubling, however, is the concern of some commentators that, in certain cases, employee or retiree discretion over the ultimate use of prefunded employer contributions may cause the contributions not to qualify as employer contributions under section 106 even though the contributions have not been includable in the employee's or retiree's income. This concern seems to be based on the view that where an employee or retiree has "dominion and control" over the ultimate use of employer contributions, the contributions should be recharacterized as employee contributions for section 106 purposes. As a result, a retiree would be taxed on any health coverage purchased with these amounts.

It is not clear which retiree health designs might trigger a recharacterization of employer contributions for section 106 purposes. At one extreme, any employee or retiree discretion over the use of prefunded employer contributions might be sufficient. Thus, for example, it might be too much discretion to provide employees with the opportunity, before each year, to direct that a portion of next year's employer contribution under a profit-sharing plan be irrevocably allocated to a retiree health account. If

so, the employer contributions allocated to an employee's retiree health account would be treated as employee contributions under section 106 even though section 402(a) protected the employee from being taxed on the contributions when they are made to and are accumulating under the profit-sharing plan.

A more mainstream design that provides some employee and retiree discretion, and thus may be vulnerable to a "dominion and control" analysis, is a profit-sharing plan that permits an employee, before his profit-sharing benefits become available for distribution, to direct that all or a portion of his account balance be used to purchase retiree health coverage. Thus, for example, if profit-sharing benefits are not available to an employee until after separation from service, the employee's retiree premium election would have to be made before such date. And after separation from service, the retiree would be precluded from changing his premium election (or perhaps would be permitted only to reduce his premium to zero).

Of course, the IRS has not issued guidance applying a "dominion and control" analysis to this and similar situations. Nevertheless, in trying to assess what the IRS's view might be, one should review what the IRS has said in analogous situations. This reveals that, in relevant part, the IRS has concluded that an employee will be taxed on taxable benefits that the employee could have received presently, but elected not to (constructive receipt), and that an employee will be taxed on an otherwise nontaxable benefit (such as health coverage) where, in order to receive this benefit, the employee decided to forgo a taxable benefit at the same or some future date (assignment of income).<sup>51</sup>

Assume, for example, that an employer's contributions under a VEBA or qualified profit-sharing plan are set aside

<sup>49</sup>This result flows directly from sections 106, 105(b) and 104(a)(3) and the regulations under these sections. For example, reimbursements under health coverage that is attributable to employer contributions that have been includable in an employee's income are not excludable under section 105(b), but instead are excludable under section 104(a)(3).

<sup>50</sup>The IRS would presumably argue that constructive receipt or assignment of income principles would trigger retiree taxation in this situation. See note 54 below on adopting a cafeteria plan for retirees to avoid taxation in this and similar situations.

<sup>51</sup>See Rev. Rul. 75-539, 1975-2 C.B. 45 (constructive receipt triggers tax on retirees who have an election between health coverage and unused sick leave credits), and PLR 9104050 (November 1, 1990) (assignment of income causes employee to be taxable on current health coverage where employee had an election between coverage and currently nontaxable but ultimately taxable pension contributions). See also GCM 38047 (August 14, 1979); GCM 37479 (March 29, 1978); GCM 37014 (February 25, 1977); GCM 36359 (October 6, 1975); and GCM 35049 (September 22, 1972). Finally, GCM 31934 (April 15, 1961) appears to limit the availability of section 106 under a profit-sharing plan to situations where the profit-sharing benefits are automatically used at the employer's direction to purchase health coverage.

when made for the future purchase of retiree health coverage and that a retiree is allowed to direct that the contributions (and earnings thereon) be used to purchase coverage under one or more of several qualified health plans; the amounts could not be used for any other benefits. Since an election among two or more nontaxable options would presumably not cause the employee to be taxed under constructive receipt, assignment of income or any other tax principles, this discretion should not cause the prefunded amounts to fail to be attributable to employer contributions for purposes of section 106.<sup>52</sup>

However, now assume that, in addition to the nontaxable options, the design is altered to allow a retiree to direct that the employer contributions (and earnings) be used to provide a taxable benefit such as life insurance, severance pay, or deferred compensation. Based on what the IRS has concluded in analogous situations, this added flexibility might cause the IRS to argue that the retiree's discretion to use the contributions for either taxable or nontaxable benefits would trigger recharacterization of the employer contributions as employee contributions for section 106 purposes even though section 402(a) protects the retiree from having to currently include the contributions in income.<sup>53</sup> Thus, if the retiree elected to use the contributions to purchase health coverage, the coverage would fail to be employer-provided and thus would not be excluded from tax under section 106.<sup>54</sup>

In spite of all this, many commentators are comfortable with the view that current law does not support the argument that employer contributions that are not taxable to an employee or retiree (for example, by reason of section 402(a)) should be recharacterized as employee contributions for section 106 purposes where the employee or retiree has some discretion over the ultimate use of the amounts.<sup>55</sup> Instead, retiree health coverage should be treated as employer-provided and thus as excludable from income under section 106 if, as the current statutory and regulatory rules seem to provide, the coverage is purchased with amounts that are attributable to employer

---

In general, the IRS takes the position that an employee's election between taxable benefits and nontaxable benefits causes the employee to be taxed on either the taxable benefits that he could have, but did not, receive (constructive receipt) or on the otherwise nontaxable benefits he did receive (assignment of income). However, if the employee's election is made under a cafeteria plan that satisfies section 125, the election does not trigger taxation and the employee is taxed only on the taxable amounts or benefits he actually receives.

Thus, the argument goes, if a cafeteria plan protects active employees from taxation on amounts over which they have "dominion and control," it should similarly protect amounts attributable to employer contributions from failing to qualify as employer-provided amounts under section 106 where the employees or retirees have discretion regarding the use of the amounts for retiree health benefits.

There are numerous issues relating to whether a cafeteria plan "funded" with employer contributions under welfare benefit funds, life insurance and annuity contracts, and qualified profit-sharing plans will satisfy section 125. For example, may retirees be participants in a cafeteria plan? (The answer appears to be yes, if the cafeteria plan is a continuation of a cafeteria plan for the active employees.) Would a cafeteria plan "funded" with amounts attributable to employer contributions under a welfare benefit fund, annuity or life insurance contract, or qualified retirement plan violate the deferred compensation prohibition under section 125? (The answer appears to be no, so long as the maximum amount that may be used for health premiums and other benefits for a year will be either distributed to the retiree or used for benefits during the year.) Also, may a cafeteria plan be "funded" with amounts accumulated under a fund, a life insurance or annuity contract, or a qualified plan? (The answer appears to be yes, as the rules do not restrict the source of funds that participants may use in a cafeteria plan to purchase benefits.) Finally, if the cafeteria plan is "funded" with qualified retirement plan benefits, is there a conflict between the qualified plan requirement that benefit assignments be revocable (section 401(a)(13)) and the cafeteria plan limits on mid-year benefit election changes? (The answer appears to be no. For example, salary reduction agreements must be revocable under California law, but the cafeteria plan limits on mid-year changes haven't prevented California employers from adopting cafeteria plans with salary reduction.)

<sup>55</sup>Sections 106, 105(b) and 104(a)(3) and the regulations thereunder focus on whether an employee has been taxed on employer contributions in determining whether it should be treated as an employee contribution. These rules apply principles similar to the section 72 rules for determining an employee's contributions and whether an employee has "basis" under a contract or plan.

---

<sup>52</sup>An active employee who has the right to select employer-provided coverage under one of several qualified health plans is not treated as having constructively received a taxable benefit or as having impermissibly assigned otherwise taxable income for a nontaxable benefit. Accordingly, section 106 protects the employee from tax on whichever health coverage the employee receives. The result should not differ where the employee's election among several, employer-provided qualified health plans is within a VEBA, 401(h) account, or a qualified profit-sharing plan.

<sup>53</sup>In this situation, the assignment of income principle, reflected in PLR 9104050 (January 1991) (see note 51 above), would seem to be the theory that best justifies recharacterizing these employer contributions under section 106.

<sup>54</sup>Some commentators have suggested that if the IRS were to apply the constructive receipt, assignment of income and other similar tax principles to recharacterize employer contributions as employee contributions for section 106 purposes, an employer could adopt a retiree cafeteria plan that would be "funded" with amounts accumulated under the welfare benefit fund, annuity contract, or qualified retirement plan, whichever the employer wants to use to prefund retiree health. The cafeteria plan arguably would shield retirees from tax on account of retiree options between taxable and nontaxable options and would prevent application of the constructive receipt, assignment of income, and other tax rules to recharacterize employer contributions for section 106 purposes.

contributions and on which an employee or retiree has not been taxed.

### ◆ Issue #9. What requirements apply to a health plan that makes medical reimbursements out of amounts accumulated under a separate fund, plan or other entity?

As discussed previously,<sup>56</sup> medical reimbursements under a health plan are excluded from income under section 105(b) (in the case of amounts attributable to employer contributions) and section 104(a)(3) (in the case of amounts attributable to employee contributions) only if the plan is a qualified health plan. The same rules apply regardless of whether the retiree health plan is prefunded or not.<sup>57</sup> Thus, a prefunded health plan must satisfy the “specifically for medical care” requirement and, if (under the IRS’s view) the plan is an FSA, the plan must also satisfy the FSA requirements.

For example, assume a health plan under which a retiree may receive reimbursements for medical expenses up to the amount accumulated under his account in a qualified profit-sharing plan (or, for example, under his account in a 401(h) account or a deferred annuity contract). In order for the health plan to be a qualified health plan, the plan may not make payments irrespective of whether the retiree incurs medical expenses; the plan’s payments must be “specifically for medical care.”<sup>58</sup>

And if the total amount in the retiree’s account is not more than 500 percent of an actuary’s imputed premium

<sup>56</sup>See Issue #2 above.

<sup>57</sup>Sections 105(b) and 104(a)(3) may be satisfied where the medical reimbursements are provided under a prefunded health plan. See sec. 1.105-1 of the regulations. Also, sec. 1.104-1(d) of the regulations says the following: “Section 104(a)(3) also applies to amounts received by an employee for personal injuries or sickness from a fund which is maintained exclusively by employee contributions. . . . If the employer and his employees contribute to a fund or purchase insurance which pays accident or health benefits to employees, section 104(a)(3) does not apply to amounts received thereunder by employees to the extent that such amounts are attributable to the employer’s contributions.”

<sup>58</sup>In addition, various court cases require that a qualified profit-sharing plan be explicitly maintained as having a dual purpose—clearly distinguishing between the deferred compensation benefits and the health benefits under the plan. See note 17 above. While the decisions in these cases are not as clear as one would like, it appears that the courts insist on compliance with the dual purpose requirement to assist in assuring that the health portion of the plan satisfies the “specifically for medical care” requirement.

for such a plan, then (under the IRS’s view) the health plan would be an FSA and would be a qualified health plan only if it satisfied the 12-month coverage period, uniform coverage, no premiums, and other FSA requirements. Again, in the IRS’s view, these FSA rules would apply regardless of whether the health plan is funded through a VEBA, a life insurance or annuity contract, or a qualified retirement plan.<sup>59</sup> Of course, because applying the FSA requirements would undercut the tax effectiveness of this and similar health plan designs, an employer would likely consider making certain design changes, such as “annuitizing” the account balance to produce a lower, annual maximum reimbursement amount or switching to a premium-only arrangement.<sup>60</sup>

### ◆ Conclusion

In reviewing their retiree health plan design, cost containment, and prefunding options, employers (and their advisors) must not overlook the possible effects of these options on the tax treatment of employees and retirees. Under some options, particularly the more innovative ones, there are important and unresolved issues about whether the employees and retirees should be taxed on the employer-provided retiree health coverage and/or on the medical benefits and reimbursements provided under the coverage.

Because the IRS has not yet issued guidance on many of the issues, employers (and their advisors) should identify the important retiree tax issues that relate to the design and prefunding options, and then develop reasonable arguments, based on all existing guidance, in support of their positions. Also, employers will have to know the levels of risk with which they are comfortable and uncomfortable, with respect to both current law and the possibility that the IRS or Congress might adopt an adverse position in the future. Finally, if this retiree tax analysis is undertaken as part of the plan design process, employers (and their advisors) may be able to make design modifications that will minimize the tax risks without sacrificing important corporate or employee benefit goals.

<sup>59</sup>See Issues #2 and #3, and notes 26 and 27, above.

<sup>60</sup>The former change would reduce the amount subject to the “specifically for medical care” and 12-month coverage period requirements and thus the amount vulnerable to forfeiture at the close of the coverage period. The latter change would avoid the FSA requirements altogether. See Issue #4 above.

## Financial Market Reactions to FAS 106

By Douglas J. Elliott, J.P. Morgan

Retiree health care costs are a significant obligation for America's largest companies, and there are no easy solutions to reduce their size. This discussion examines the likely effects on the stock and bond markets of Wall Street's growing awareness of these costs and suggests a few methods for managing the likely market reactions. The stock and debt markets are likely to react somewhat differently from each other and will be discussed separately.

### ◆ Debt Market Reactions

The debt markets are likely to show minimal reactions to the average company's disclosures under FAS 106, for two main reasons: (1) sophisticated investors and rating agencies are already aware of the problem of high retiree health care costs, and (2) it is a long-term rather than a short-term problem.

It is clear that the rating agencies, along with many sophisticated investors, are already aware of the problem. An article in Standard and Poor's *Credit Week*<sup>1</sup> thoroughly explains S&P's method of estimating the impact of FAS 106. One important point, which is true for all the rating agencies, is that the agencies focus very heavily on cash flow rather than on accounting numbers.

Standard and Poor's reportedly intends to use the new accounting numbers provided by FAS 106 primarily to improve its own estimates of future cash flows. In a sense, S&P will use the FAS 106 numbers to back into the cash flow numbers provided by the previous accounting standard. S&P will then estimate the future cash flows as they do at present but with somewhat better information. Of course, S&P's special access to the companies it rates already enables S&P to get better information than is available to the public or to most analysts.

Another consideration in estimating the impact of FAS 106 is that the retiree health obligation is primarily a long-term obligation. Even for the big "rust belt" compa-

nies with the largest annual retiree health payments, the real problem is the tremendous cash cost down the road, not the smaller cash costs in the near term. Since most debt consists of short or medium term obligations, most debt will mature before the obligation highlighted by FAS 106 significantly affects cash flows.

Where the market does react, the reaction will most often be negative, because I do not believe that the market truly understands yet the size and difficulty of the obligation.

Back in October, J.P. Morgan examined the five largest companies that had made announcements about their projected retiree health obligations under FAS 106. The announced numbers were compared to our best estimates of what the market was expecting. Although virtually no analysts were willing to make predictions about the size of this obligation, the consensus among those following the issue at the time was that the FAS 106 obligation would average 10 times to 15 times the current annual pay-as-you-go cost. For the larger "rust-belt" companies that were likely to be hardest hit, the multiple would be closer to the lower end of the range.

Table 1 compares the announced figures with the mid-range estimate (that is, 12.5 times pay-as-you-go costs). The announcements all came in considerably higher than the "market expectations." This is consistent with a study by Mark Warshawsky, for the American Enterprise Institute, which concluded that if the FAS 106 liability were put on the books today by all companies with retiree

Table 1  
FAS 106 Announcements

Company	Announcement	Rule of Thumb
ALCOA	\$1,000 million	\$538 million
General Electric	\$2,700 million	\$1,769 million
IBM	\$2,300 million	\$1,894 million
Lockheed	\$1,000 million	\$450 million
USX	\$2-\$3,000 million	\$1,950 million

<sup>1</sup>Scott Sprinzen and Saul Sampson, "Credit Comments," *Credit Week*, (May 20, 1991).

health benefits, their total net worth would decrease by approximately 15 percent. That implies a pay-as-you-go multiple of 20 times or more.

When considering these estimates it is important to remember the degree of imprecision in these numbers. They are a quantification of predictions about the next 40 or more years; underlying these numbers are crucial assumptions about the future of the United States and world economies and about the shape of our nation's health care system. FAS 106 will require a single number, along with some simple sensitivity analysis, but companies have considerable leeway to choose their point estimate within a reasonable range. This is why most announcements in advance of formal adoption of FAS 106 have provided a range of values. For example, the "Big 3" automakers have all announced wide ranges of expected FAS 106 obligations: Chrysler \$4–\$6 billion; Ford \$5–\$9 billion; and GM \$16–\$24 billion.

The disparities between announced and expected obligations and studies by Warshawsky and others have caused those who follow the issue to increase their expected multiples. Even so, my own view is that most financial analysts are still lagging behind events.

In those cases where the market does react negatively, companies may have to raise the yields they pay; improve other terms; shorten maturities; or in extreme cases, give up on debt issuance until they can change the market's view of their situation. It is interesting to note that some companies that have arranged recent borrowings have persuaded their banks to continue using the old accounting for covenant calculations for the term of these new borrowings.

In summary, until debt market expectations catch up, the surprises are going to be largely negative. While it is difficult to say how much effect these negative reactions will have, probably only a small number of companies need to be strongly concerned. The majority of companies will have only minor effects. This is supported by the limited evidence of bond market reactions to the few companies that have made announcements.

### ◆ Stock Market Reactions

Any reasonable estimation of future stock price reactions to FAS 106 announcements must rely on a good deal of

judgement and inference from other similar situations. Ideally, we would perform an empirical study of how stocks traded before and after the underlying companies announced their estimate of the FAS 106 liability. Unfortunately, there are four broad reasons why this will not work yet.

First, there have been few announcements, making it difficult to use statistical techniques. Second, companies have generally announced the liabilities in conjunction with other important news; this muddies the waters and makes it all the more important to have a large sample. Third, the companies that have announced thus far are largely self-selected. They may believe that they are best served by announcing early. Fourth, analysts and investors are still deciding what they think about retiree health. It is possible that we will either have a delayed reaction for those companies that have already announced or that later announcements will be treated differently than those thus far.

It may be worth dwelling for a little longer on the self-selection factor. Companies that have voluntarily chosen to announce early clearly believe it to be to their advantage to act early. Generally this is because they are better situated than their competitors, because of previous funding; low size of the obligation; or the existence of a plan of action that will reduce their obligation significantly. For example, IBM had already funded 40 percent to 50 percent of its entire retiree health obligation. The company took the hit, arguing that it had already funded much of the cost, so there was no reason to penalize IBM. Other companies in similar situations also have reason to act now.

Alternatively, we may see a few companies with other larger problems who choose to "clean up" their FAS 106 liability at the same time they make other announcements, figuring that a little more bad news does not really make a difference. Other reasons for early announcements include attempts to pressure unions or to make defensive responses to the announcements of competitors.

Self-selection may quickly become a less important factor, since the SEC has been putting heavy pressure on publicly traded companies to announce their estimate of the obligation. Many companies will publicly announce such estimates in their 1991 annual reports, which will generally be issued in the first quarter of 1992. Some of the

major recent announcements have occurred in conjunction with the issuance of prospectuses to raise debt or equity, which again probably reflects SEC pressure.

Despite these uncertainties, I am willing to make a few assertions based on logic and reasoning from similar types of situations. First, the stock market will react negatively to the announcement of large retiree health obligations, even if knowledgeable observers are not surprised by the actual numbers. I do not personally believe that analysts and investors have focused as much attention as they ought to on this issue. The parade of announcements will force them to do so. As a corollary to this, I believe that there will be a delayed negative reaction to those companies which have already announced their numbers.

Second, and less arguable, the companies that will be hardest hit by the stock market will be those whose obligations are both large and in excess of reasonable expectations. While the stock market has made notorious misjudgments, stock prices do generally reflect previous news announcements, and any information that can be readily inferred from financial statements. It should be possible to form reasonable estimates for a company based on its pay-as-you-go numbers, the nature of its workforce, and the situation of its competitors. If these factors do not produce good estimates, the market will react when the company announces its own estimates.

I have formed these conclusions based on my general view of the financial markets combined with studies done by J.P. Morgan of the stock market's reactions to analogous situations. For example, we have studied the market's reaction to FAS 87, the accounting rule that governs pensions, on which FAS 106 is modeled.

Reactions to FAS 87 announcements were generally not as severe as people had predicted before their implementation. Consequently, many people are using that situation as a basis for their prediction that the market will show little reaction to FAS 106.

However, there are significant differences between that standard and FAS 106. At the time of the changeover to FAS 87, pension funds already were substantially funded, making it difficult to determine whether the net result would be a revelation of underfunding or of overfunding. There is no such uncertainty with FAS 106; almost all companies have little or no funding, guaranteeing that the

accounting impact will be negative. The question becomes: "is it a \$100 million or \$200 million problem?" Because the market has not fully focused on the fact that this problem exists, all numbers look bad.

Another apt comparison may be what happens when a company announces a reduction in dividends. This is an interesting comparison because dividend cuts can very often be anticipated. Analysts can usually identify which companies are continuing to make dividend payments at levels beyond their long-term ability to support. As might be expected, the stock price tends to decline significantly after the announcement of a dividend reduction. This would support a conclusion that FAS 106 announcements, even if the numbers are as expected, may hurt stock prices.

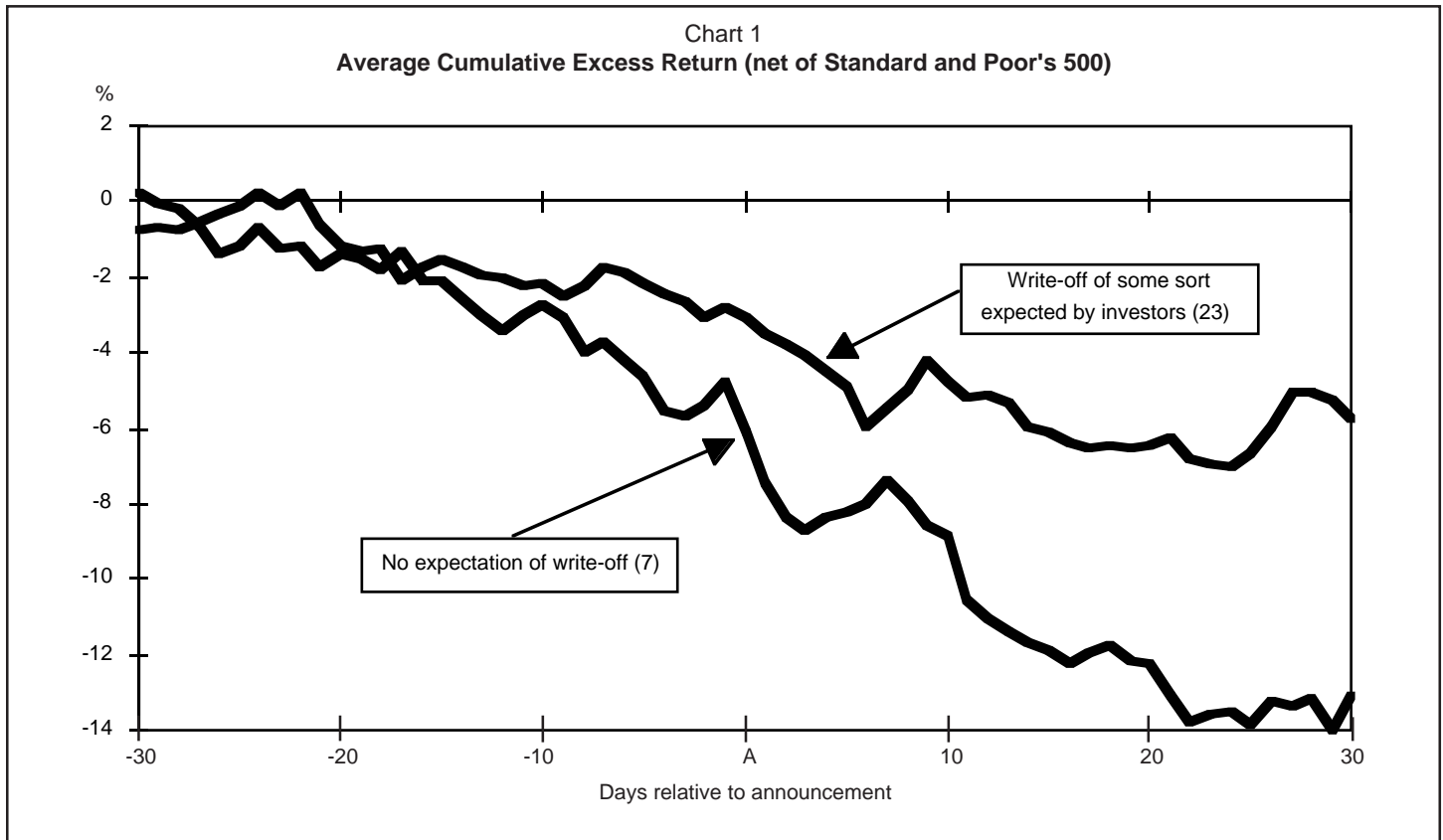
A similar effect occurs when companies announce write-offs. As chart 1 shows, a J.P. Morgan study has concluded that large write-offs (that is, of more than 10 percent of a company's net worth) have generally led to stock price declines, whether or not a write-off of some kind had been generally expected by those who followed the stock. Logically enough, the reaction was much sharper for those companies for whom a write-off was not generally expected, but even expected write-offs did lead to declines. Even in those cases where some type of write-off had been expected, the hit was significant—30 days afterwards the stock price was about 6 percent lower than it was 30 days before the announcement.

This may be a fair analogy for retiree health, since the write-offs analyzed in this study may be similar in magnitude to what the companies more severely affected by FAS 106 may be announcing.

Another question is whether the retiree health obligation is already reflected in a company's stock price. One approach is to look at a stock's market price versus its book value. In chart 2, there are four groups of companies. At the far left is a group of companies where the retiree health liability would be more than one-half of net worth. On the far right there is a group where the liability is less than 10 percent of net worth.<sup>2</sup>

In general, stocks trade above book value, but stocks of companies with a large retiree health problem trade, on average, at only a small premium and those with small

<sup>2</sup>The base group of companies is taken from Fortune 200 companies.



problems trade, on average, at a larger premium. However, this analysis is inconclusive because these companies have some common characteristics. Companies with large retiree health problems tend to be cyclical manufacturers with strong unions. They also often have environmental problems. These or other common characteristics may be the true determinants of the ratio of stock prices to book values.

Summing up, I do expect negative stock market reactions for companies with large obligations, especially when the numbers are surprisingly large. The available empirical evidence does not contradict these conclusions, which are based largely on logic and reactions to similar situations, but there is not sufficient evidence to prove these predictions either.

I should probably note for the record that these conclusions are likely to be contested by academic financial experts. There is a strong belief that markets are “efficient” and accurately reflect any news or conclusions that can reasonably be inferred from past news. I largely agree but feel that certain factors, such as retiree health obligations, have not been adequately followed in the past by

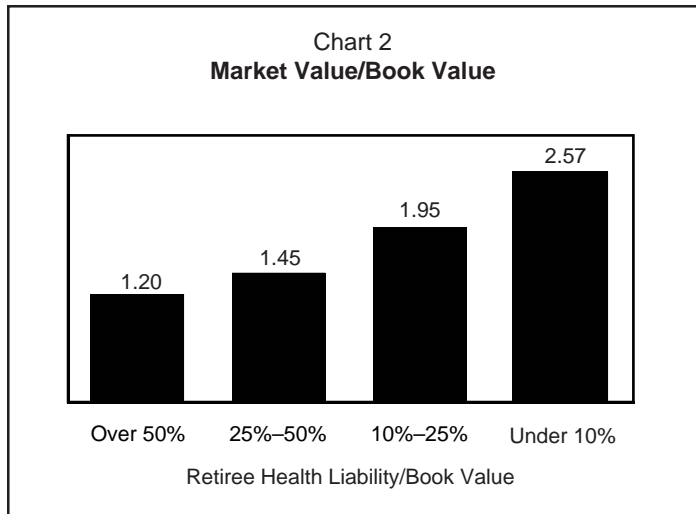
many of the analysts and investors who influence the stock market.

Others might also argue that the retiree health obligation will not be paid by the companies because it is too large a burden for corporations to bear and the government or some other societal force will rescue the companies. Also, at least some retiree health obligations may be unenforceable legally, which will allow companies the room to reduce their obligations. I do accept that there are forces acting to improve the situation, but I do not believe that the reduction will be as large as others may believe.

### ◆ Communications Issues

There are steps companies can take to temper negative market reaction. Communication with investors and analysts, both equity and fixed-income analysts, is important. To some extent, a company has the ability at this point to tell the story the way it wants.

Obviously, if a company tries to convince an analyst of something unbelievable, either the analyst will see



through the story now or will see through it later and penalize the company then. However, the company still has room to paint the financial picture more favorably and explain why that view makes sense.

If a company has a lot of short-term paper, communication with fixed-income analysts is probably more important. A company should be able to avoid having a long-term problem scare short-term investors into closing a crucial funding source.

In general, preparation is important now. While 1993 may seem like a long time from now, it is important for a company to take time to prepare its story and determine how to present it.

Accounting strategies affect communications strategies too. There are two big issues. First, a company needs to decide when to adopt FAS 106. For most companies it does not make sense to do it sooner than necessary. It is probably better to be part of a large group of companies confessing to the same large obligations at the same time.

But, there are a number of exceptions to this rule. If a company has either big losses or gains that it would like to roll this obligation into, either to hide or offset the obligation, it may be beneficial to move early. If a company has a small obligation, it may be good to adopt FAS 106 now and highlight it. Similarly, if a company has partially funded its obligation, such as IBM had, it is probably good to act now and impress people. Or, if a company is undergoing other retiree health benefit actions such as union negotiations or benefit plan changes, it may be advantageous to adopt FAS 106 at the same time.

The other major accounting question for a company is whether to write off the obligation all at once or amortize it over 20 years. Companies that can afford to write off the costs all at once without violating debt covenants should do so even though it is an emotional issue to write off such an amount.

The stock market will probably reward a company in the long run for writing off all the costs at the beginning. This course of action removes an overhang of future earnings penalties that otherwise is going to exist for 20 years. The stock market is affected more by earnings than by book values. People look at price to book value, but more commonly they look at price to earnings. So, this action is simply a cosmetic way of making things look better in the future than they would if the costs are spread out.



## Retiree Health Benefits, Retirement Ages, and Income Security

by Christopher J. Ruhm, University of North Carolina at Greensboro

### ◆ Introduction

This discussion examines some possible effects of the Financial Accounting Standards Board (FASB) Statement No. 106 on retirement ages and the financial security of retirees. Changes in retiree health benefits (RHB) that affect the timing of retirement or the incomes of senior citizens raise potentially important public policy questions.

During the last 40 years, the number of Americans aged 55 and above has risen by more than 40 percent. This rapid aging has been combined with a dramatic decrease in the labor force participation rates of older men. For example, 46.8 percent of men aged 65 and over were in the labor force in 1948, as compared to only 16.5 percent in 1988 (U.S. Department of Labor, 1989). These trends have increased the ratio of nonworking senior citizens to younger workers and raised concerns over the size of government expenditures devoted to the Social Security, Medicare, and Medicaid programs. Modifications in RHB that act to delay retirements may help to alleviate these concerns. Conversely, changes that hasten retirements would increase them.

At the same time that their work involvement has been declining, the relative economic status of older Americans has been improving. Between 1967 and 1984, the household incomes of the elderly (65 and over) rose by 42.4 percent, those of the nonelderly by a much smaller 10.7 percent.<sup>1</sup> Relative changes in poverty rates are even more dramatic. In 1967, 28.1 percent of senior citizens were in poverty, as compared to 11.8 percent of the nonelderly. By 1984, the poverty rate of persons aged 65 and over had fallen to 12.4 percent, while the percentage of poverty-stricken younger Americans had risen to 14.5 percent.

Despite the improving economic status of senior citizens, pockets of poverty remain. For example, in 1984, 18.5 percent of persons over the age of 85 and 20.1

percent of widows (aged 65 and above) had incomes below the poverty line. Thus we should be particularly alarmed if changes in RHB raise the financial burdens of the elderly poor. Negative impacts on wealthier senior citizens, however, generate less concern.

This discussion provides information on who currently receives RHB, examines the magnitude and timing of changes in RHB that may result from the passage of FASB Statement No. 106, and speculates on worker responses to these changes.

### ◆ Who Receives Retiree Health Benefits?

A useful starting point for considering the potential effects of the accounting changes in RHB is to investigate who currently receives this benefit. This information is based on data obtained from a Harris Survey that was conducted for the Commonwealth Fund between March and September of 1989. The sample includes retired men between the ages of 55 and 64 and retired women aged 50 to 59. The data are weighted by age, race, and sex, so as to be nationally representative.<sup>2</sup>

Only 33.0 percent of surveyed retirees received health insurance from a previous employer (see table 1). This coverage rate is similar to the estimates obtained by other researchers. For example, an EBRI analysis of the August 1988 supplement to the Current Population Survey indicates that an identical 33 percent of retirees over the age of 40 obtained RHB.<sup>3</sup>

The probability of receiving RHB varies substantially across population subgroups. In particular, persons disadvantaged in the labor market are less likely than others to receive this type of health coverage. As shown in table 1, only 19.0 percent of female retirees, 30.6 percent of Hispanics, 14.2 percent of those with 1988 household incomes below \$7,500, and 25.7 percent of

<sup>1</sup>Statistics on the economic status of the elderly are obtained from Hurd, 1990.

<sup>2</sup>Further details on the data set are provided by Louis Harris and Associates, Inc. 1989.

<sup>3</sup>This statistic is from unpublished EBRI data provided by William Custer.

Table 1  
Probability that Different Groups of Retirees  
Receive RHB

All Retirees	33.0%
Female	19.0
Hispanic	30.6
Nonwhite	35.2
Receives Pension (other than Social Security)	72.2
Home Ownership	
Owns home	35.3
Home paid for	39.1
Household Income in 1988	
\$7,500 or less	14.2
\$7,501–\$15,000	25.7
\$15,001–\$35,000	39.3
Over \$35,000	37.5
Firm Size	
100 or fewer	16.6
101–500	27.6
501–1,000	33.5
Over 1,000	55.1

Note: Data are obtained from the 1989 Harris-Commonwealth Survey. The sample includes nonworking men between the ages of 55 and 64 and women between the ages of 50 and 59. The data are weighted by age, race, and sex to produce projectable results for the entire cohort of nonworking Americans of the age group surveyed.

those with 1988 household incomes between \$7,501 and \$15,000, received RHB. In contrast, retirees with advantaged labor market positions, high incomes, and substantial wealth obtained RHB disproportionately frequently. Thus, 35.3 percent of homeowners received RHB (39.1 percent of those owning their home outright), as did almost 40 percent of persons with annual household incomes exceeding \$15,000.

Firm size is also of key importance. Where just 16.6 percent of persons retiring from small firms (100 or fewer employees) received RHB, 55.1 percent of those leaving companies employing 1,000 or more workers did so. The percentages for medium size firms are intermediate between these two extremes.

Perhaps the most striking statistic is that on pension coverage. Almost three-quarters (72.2 percent) of persons retiring with a pension also received RHB. Conversely, just 17.8 percent of those lacking pension coverage did so. This strong relationship occurs, in part, because pension coverage is also disproportionately obtained by unionized

workers, employees of large firms, and persons receiving high pay relative to others with similar skills and qualifications.

The information contained in table 1 suggests that post-FASB changes in RHB may have relatively modest effects on the retirement behavior and income security of mature adults. More specifically, the impact will be small or nonexistent for the two-thirds of workers receiving no employer-provided health coverage upon retirement. Effects that do occur will be concentrated among persons working in large firms and receiving pensions.

### ◆ Changes in Retiree Health Benefits

Firms currently providing RHB may respond to the FASB accounting changes by altering or eliminating retiree health coverage. A recent survey (A. Foster Higgins & Co., Inc., 1990) revealed that 28 percent of surveyed companies had increased employee contributions for RHB within the previous two years or expected to do so in 1991, 18 percent began requiring deductibles, and 14 percent had decreased benefits.<sup>4</sup> The most significant change, however, would be to switch from a defined benefit plan (where the employer guarantees a certain level or type of future insurance coverage) to a defined contribution plan (where the firm simply contributes a certain amount to each employee's health insurance account). Although 5 percent of surveyed firms contemplated making such a shift in 1991, none of the companies sampled had done so during the previous two years.<sup>5</sup>

Although there is no way to determine how fast companies may shift to providing RHB on a defined contribution rather than a defined benefit basis, information on changes in pension coverage is instructive. In 1975, 13 percent of workers covered by pensions participated in a primary defined contribution plan; the remaining 87 percent received primary coverage from a defined benefit pension. By 1987, primary coverage was from defined contribution plans for 30 percent of individuals, with defined benefit plans accounting for the remaining 70 percent (Turner & Beller, 1989). If a similar pattern is observed for RHB over the next 10 to 15 years, defined

<sup>4</sup>Because this survey did not use a random sample, the results may not be nationally representative.

<sup>5</sup>The discussion in this paragraph is based on information contained in Davis, 1991.

contribution plans will gain considerably in importance. Nonetheless, the majority of workers with RHB will continue to obtain coverage through defined benefit plans and the effects on retirement incentives and income security are likely to be relatively modest.

As discussed above, pension and RHB coverage are strongly correlated, with the result that trends in the two types of benefits are likely to mirror each other quite closely. It is therefore not surprising that the doubling of private pension coverage, which occurred between 1950 and 1975, was accompanied by a subsequent increase in RHB. Pension coverage rates have remained virtually unchanged since 1975, however, which suggests that dramatic future increases in RHB coverage should not be expected.

## ◆ Retiree Health Benefits and Retirement Ages

It is notoriously difficult to predict how changes in economic incentives will influence individual work and retirement decisions. Discussion of how modifications in RHB may affect the timing of retirement should therefore be thought of as highly speculative. It is argued below that FASB Statement No. 106 is likely to have relatively small average effects on retirement decisions of mature adults. This conclusion could be incorrect, however, if employers restructure RHB or health insurance costs rise by more than anticipated.

There is no question that workers respond to economic incentives when making retirement decisions. For example, Social Security provisions allowing “early retirement” at age 62 and retirement with “full” benefits at 65 have led to substantial increases in the number of retirements occurring at these ages. Similarly, incentives in private pension plans which discourage individuals in their late fifties or early sixties from remaining with their current employers raise job mobility and retirement rates at these ages (e.g., see Kotlikoff & Wise, 1989).

However, very large financial incentives are required to induce substantial changes in average retirement ages. For instance, Burtless & Moffitt (1984) estimate that a more than 30 percent reduction in the Social Security benefits of persons retiring at 62 would raise average retirement ages by only around three months. A 20 percent across-the-board cut in Social Security payments is similarly

estimated to postpone retirements by an average of only two months (Burtless & Moffitt, 1985). The losses in pension wealth that are required to produce early employment terminations are also extremely large.<sup>6</sup>

Conversely, the financial impacts associated with changes in RHB are likely to be quite small. Only one-third of retirees obtain health insurance from a previous employer and the majority of covered workers contemplating retirement in the near future are likely to continue receiving benefits at similar or only slightly reduced levels as those currently provided.

To see this more concretely, consider an example with the following plausible assumptions: 1) the percentage of retirees with RHB remains constant, at 33 percent, over the next 10 years; (2) 20 percent of employers presently offering RHB switch from defined benefit to defined contribution plans (this is a faster rate of adoption than for private pensions over a corresponding time period during the late 1970s and early 1980s); (3) employer contributions to defined contribution plans are half as large as for defined benefit plans; (4) companies retaining defined benefit plans require workers to bear 20 percent of the costs; and (5) the average annual costs of RHB are \$3,000 per retiree.<sup>7</sup> Under these assumptions, the increased annual expense to retirees, resulting from RHB cost-shifting, will average only \$257 per year.

The additional cost to retirees is so small because of the relatively low RHB coverage rates and because the reduction in benefit levels is modest for most covered workers. Changes of this magnitude are likely to have only slight impacts on retirement decisions, particularly since RHB is typically provided to relatively well-off workers, who are least often liquidity constrained.

Small average effects do not eliminate the possibility of large impacts in individual cases. For example, some companies are considering or have implemented changes which make RHB coverage dependent on length-of-

<sup>6</sup>Gustman and Steinmeier, 1989, calculate that, for persons starting jobs with defined benefit plans at age 25, continued employment past age 65 results in an average loss in pension wealth equal to at least one-quarter of earnings.

<sup>7</sup>The \$3,000 per worker cost is in line with the expenses borne by companies providing generous RHB. For instance, AT&T estimates that their 1989 health costs were \$319 million for 102,200 retirees (Davis, 1991). This averages \$3,127 per person.

service at retirement. Workers taking jobs with these companies relatively late in life may then need to remain with the firm until a later age, in order to build up seniority, or they will receive lower health benefits in retirement.

## ◆ Conclusion

This paper suggests that recent FASB accounting changes related to retiree health benefits will have modest effects on the retirement decisions and financial security of workers currently approaching retirement age. The effects are small because a minority of retirees currently receive RHB, and changes in the structure of financing will occur slowly. Furthermore, RHB are disproportionately received by relatively advantaged and wealthy senior citizens. The impact on elderly poverty is therefore likely to be even lower.

Even were the financial impacts of changes in RHB considerably larger than those predicted above, it is not obvious that retirement decisions or income security would be substantially affected. FASB Statement No. 106 requires that employers recognize an existing liability; it does not create a new liability. If such a recognition compels changes in the structure or financing of RHB, it presumably indicates that the pay-as-you-go approach was temporarily masking the need for changes which would have been subsequently required in any case. When such modifications were ultimately implemented, they would probably have similar effects on retirement decisions and income security as those discussed above.

Small average impacts for today's mature workers may conceal larger individual variations, and a minority of retirees will suffer a disproportionate financial burden from changes in RHB. A more important concern for public policy, however, is the more than two-thirds of retirees who receive no employer-provided retirement health benefits of any kind (other than mandatory employer contributions to Medicare).

## ◆ References

- A. Foster Higgins & Co., Inc. *Foster Higgins Health Care Benefits Survey: Report 4, Retiree Health Care*. Princeton, NJ: A. Foster Higgins & Co., Inc., 1990.
- Burtless, Gary and Robert Moffitt. "The Effects of Social

Security Benefits on the Labor Supply of the Aged." In Henry Aaron & Gary Burtless (eds.), *Retirement and Economic Behavior*. Washington DC: The Brookings Institution, 1984.

- Burtless, Gary, and Robert Moffitt. "The Joint Choice of Retirement Age and Postretirement Hours of Work" *Journal of Labor Economics* (April 1985): 209–236.
- Davis, Jennifer. "Retiree Health Benefits: Issues of Structure, Financing, and Coverage." EBRI *Issue Brief* no. 112 (Employee Benefit Research Institute, March 1991).
- Gustman, Alan L. and Thomas L. Steinmeier. "An Analysis of Pension Benefit Formulas, Pension Wealth, and Incentives from Pensions" In Ronald Ehrenberg, ed., *Research in Labor Economics*, Vol. 10, 1989, pp. 53-106.
- Hurd, Michael D. "Research on the Elderly: Economic Status, Retirement, and Consumption and Saving." *Journal of Economic Literature*, vol. 58, no. 2 (June 1990): 565–637.
- Kotlikoff, Laurence and David Wise. *The Wage Carrot and the Pension Stick: Retirement and Labor Force Participation*. Kalamazoo, MI: W.E. Institute for Employment Research, 1989.
- Louis Harris and Associates, Inc. *Older Americans: Ready and Able to Work*, New York, NY: Louis Harris and Associates, 1989.
- Turner, John A. and Daniel J. Beller. *Trends in Pensions*. Washington, DC: U.S. Government Printing Office, 1989.
- U.S. Department of Labor. Bureau of Labor Statistics. *Handbook of Labor Statistics*. Washington, DC: Government Printing Office, 1989.

## Speakers and Participants at September 25, 1991 Employee Benefit Research Institute- Education Research Fund Policy Forum, “Retirement Security in a Post-FASB Environment”

### Forum Speakers

Deborah J. Chollet—Georgia State University  
 Robert Clark—North Carolina State University  
 Harry J. Conaway—William M. Mercer, Incorporated  
 Douglas J. Elliott—J.P. Morgan  
 Howard A. Freiman—Fidelity Management Trust Company  
 Rick Grafmeyer—Senate Committee on Finance  
 Dale B. Grant—Martin E. Segal Company  
 Michael J. Gulotta—Actuarial Sciences Associates, Incorporated  
 Donald P. Harrington—AT&T  
 Chris Jennings—Senate Special Committee on Aging  
 Stewart Lawrence—Martin E. Segal Company  
 John K. McMahon—TRW  
 Meredith Miller—AFL-CIO

William J. Miner—The Wyatt Company  
 Charles C. Morgan—The Prudential Asset Management Company  
 Tricia Neuman—House Ways and Means Subcommittee on Health  
 Richard Ostuw—Towers, Perrin, Forster & Crosby  
 Melanie Pheatt—Quaker Oats Company  
 Christopher J. Ruhm—University of North Carolina at Greensboro  
 Dallas L. Salisbury—Employee Benefit Research Institute  
 Diana J. Scott—Towers, Perrin, Forster & Crosby  
 William W. Spievak—Ball Corporation  
 Nora Super Jones—Employee Benefit Research Institute  
 Michael Trasher—Internal Revenue Service

### Forum Participants

B.K. Atrostic—U.S. Department of Treasury  
 Vivian Berzinski—Arnold & Porter  
 Stan Bowman—Office of Representative Rod Chandler  
 Phillip Caper—Codman Research Group, Incorporated  
 Joseph Cassells—Institute of Medicine  
 David Certner—American Association of Retired Persons  
 David Channer—Morrison Knudsen Corporation  
 Malcolm Cheung—John Hancock Mutual Life Insurance Company  
 Anna Chylta—Office of Senator David Pryor  
 Judy Coffey-Hedquist—Baxter Healthcare Corporation  
 Alan Cohen—Senate Budget Committee  
 Michael Cooper—The Boeing Company  
 Paul Cullinan—Congressional Budget Office  
 June Dawkins—Federal Reserve System  
 Louis Enoff—Social Security Administration  
 Gerald Facciani—W F Corroon/Facciani Division  
 Selwyn Feinstein—EBRI Fellow  
 John Feldtmose—A. Foster Higgins & Company, Incorporated  
 Marilyn Field—Institute of Medicine  
 Steve Findlay—U.S. News & World Report  
 Rhonda Gold—Bristol-Myers Squibb Company  
 Marian Gornick—Health Care Financing Administration  
 Ann Hardison—Office of Senator Bob Graham  
 Gary Hart—Carter Wallace, Incorporated  
 David Helms—E.I. du Pont de Nemours & Company  
 Ken Hirsch—Equitable Life Assurance Society  
 David Hirschland—International Union, UAW  
 Jeannette Hobson—Gateway Consulting Group, Incorporated  
 Terry Hoopes—Department of Labor, PWBA  
 James Houff—Bureau of Labor Statistics  
 Gillian Hunter—U.S. Department of Treasury  
 Judith Hushbeck—American Association of Retired Persons  
 Thomas Jaros—The Principal Financial Group  
 Ann LaBelle—Advisory Council on Social Security  
 Dan Leach—Lutheran Medical Center  
 Anne Lennan—Society of Professional Benefit Administrators  
 David Lindeman—Pension Benefit Guaranty Corporation

William Link—The Prudential Insurance Company of America  
 James Lockhart—Pension Benefit Guaranty Corporation  
 Brian Lutz—House Aging Subcommittee on Retirement Income  
 Brendan Lynch—The Travelers Corporation  
 Karl Lyon—Eli Lilly and Company  
 Shaka Maharajh—Booke & Company  
 Leslie Mardenborough—The New York Times Company  
 Frank McArdle—Hewitt Associates  
 Mark Meiners—University of Maryland, Center of Aging  
 Curtis Mikkelsen—J.P. Morgan/Morgan Guaranty Trust Company  
 Barry Myers—Kaiser Foundation Health Plans, Incorporated  
 Robert Nash—Phillips Petroleum Company  
 John Naughton—Massachusetts Mutual Life Insurance Company  
 Chris Patrick—Goldman, Sachs and Company  
 Martha Phillips—House Budget Committee  
 Kenneth Reifert—Merrill Lynch and Company  
 William Reimert—Milliman and Robertson  
 Paul Rivera—Xerox Corporation  
 Ellin Rosenthal—Tax Analysts  
 Mark Schafer—Hay/Huggins  
 Ray Schmitt—Congressional Research Service  
 Jeffrey Shovlin—Federal Reserve System  
 David Skovron—Kwasha Lipton  
 Edward Smith, Jr.—Chancellor Capital Management  
 Harry Smith—Retired EBRI Trustee  
 Donald Snyder—General Accounting Office  
 Adam Spector—SEI Corporation  
 David Sullivan—Financial Accounting Standards Board  
 Roger Taylor—The Wyatt Company  
 Richard Tomlinson—The Upjohn Company  
 Doreen Tonking—J.P. Morgan  
 Marsha Venturi—Buck Consultants, Incorporated  
 John Wade—National Rural Electric Cooperative Association  
 Melynda Dovel Wilcox—Kiplinger's Personal Finance Magazine  
 Patricia Willis—U.S. Department of Labor  
 Donald Wood—Bureau of Labor Statistics