

Retiree Health Benefits: What the Changes May Mean for Future Benefits

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Issue Brief

- This *Issue Brief* addresses a wide range of retiree health issues. It reviews the provisions and impact of FAS 106 and includes a discussion of how companies have changed their overall retiree health liabilities. It describes Medicare, the primary source of publicly financed retiree health benefits, and its changing relationship with employer plans. In addition, it analyzes other financing arrangements. The *Issue Brief* concludes with a discussion of policy issues that will potentially affect workers, future retirees, and employers.
- Changing demographics are likely to have serious implications for the financing and delivery of health care services as the baby boom generation reaches retirement age.
- FASB Statement No. 106, "Employers' Accounting for Postretirement Benefits Other Than Pensions" (FAS 106)—approved in December 1990—has dramatically changed the way most private companies account for their retiree health benefits and other postretirement nonpension benefit obligations. FAS 106 requires liabilities for retiree health benefits to be recognized explicitly on balance sheets. It applies many of the same principles that were used in accounting for pensions (FAS 87 and FAS 88) to other postretirement benefits (e.g., health coverage, life insurance, long-term care insurance, and housing).
- In response to FAS 106 and increases in health care costs, some firms have dropped retiree health benefits, while others still have no plans to change their existing benefit provisions. However, the vast majority of companies have made numerous changes in their retiree health benefit programs. Of those companies indicating a modification or considering one, the most common was a change in cost sharing provisions, followed by caps on company contributions, and annual adjustments in retiree contribution amounts.
- The Medicare managed care program was created by Congress in 1982 under the Tax Equity and Fiscal Responsibility Act and became operational during 1985. This program allows Medicare beneficiaries to enroll in one of three types of managed care contracts: risk HMOs, cost HMOs, and health care prepayment plans. Employers have discovered that Medicare HMOs, especially risk HMOs, offer employers and retirees a "win-win" alternative to the traditional fee-for-service Medicare program and traditional retiree health benefits.

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Introduction

In 1960, 9 percent of the U.S. population was aged 65 and over (Day, 1993). By 1990, this proportion had

increased to 13 percent, and it is expected to reach 16 percent by 2020 and 20 percent by 2050. Overall, the elderly use more health care services than the nonelderly. In 1988, the elderly accounted for 33 percent of all health care spending (U.S. Congress, 1989), and in 1991, the elderly accounted for 32 percent of all personal health care spending.¹ **Changing demographics are likely to have serious implications for the financing and delivery of health care services as the baby boom generation reaches retirement age** (Davis, 1991; Employee Benefit Research Institute, 1992).

Since the cost of health care during the later years of life may well exceed many individuals' family income, financing health care for the elderly is an important issue. Currently, some level of health insurance is provided to most elderly persons through a combination of benefits from employers and the government—employment-based health insurance and the Medicare program. However, employers (including state and local governments) are under economic pressure to reduce retiree health benefits, and the federal government is under budgetary pressure to reduce the level of spending in the Medicare program.

Concern over retiree health benefits arises for a number of reasons. Prior to December 15, 1992, companies only recorded the existence of a plan and the cost for the current period in footnotes to their financial statements and rarely included any specific numbers. However, in December 1990, the Financial Accounting Standards Board (FASB) approved Financial Accounting Statement No. 106 (FAS 106), "Employers' Accounting for Postretirement Benefits Other Than Pensions." FAS 106 requires companies to record unfunded retiree health benefit liabilities on their financial statements in order to comply with generally accepted accounting

standards, beginning with fiscal years after December 15, 1992.² As a result, the retiree health care liabilities required to be listed on a balance sheet in accordance with FAS 106 will far exceed the costs that appeared in the financial statement footnotes prior to this standard. **FAS 106 has caused many employers to reexamine their role in providing health benefits for current and future retirees.** In fact, employer attempts to modify and/or drop retiree health benefits have resulted in numerous court cases and have been the focus of many collective bargaining agreements (Davis, 1991).

State and local governments are also concerned with providing retiree health benefits for workers. In 1995, 1.3 million retirees and 3.8 million active workers participated in state government benefit plans. **During the late 1980s, increases in retiree health benefit costs in state governments were roughly double the medical component of the consumer price index, and many states continue to pay the full cost of this coverage** (Yaggy and Jackson, 1995). In addition, some public employees are not eligible for Social Security or Medicare, making retiree health benefit promises relatively more important. While not subject to the requirements of FAS 106, state governments are subject to guidelines recommended by the Government Accounting Standards Board (GASB), which is currently looking into a FAS 106-type standard for government accounting (Government Finance Officers Association, forthcoming).

Retiree health benefits are provided to the majority of those aged 65 and over through the Medicare program. Medicare is funded through a combination of general federal government revenues, payroll taxes, and premiums paid by participants. It has been one of the fastest growing programs in the federal budget and is the subject of recent intense debate in budget negotiations

¹ Employee Benefit Research Institute estimates based on data from the 1987 National Medical Expenditure Survey.

² Financial Accounting Statement No. 106 (FAS 106) relates to all postretirement benefits except pensions. The most far-reaching and largest of these benefits for most companies is that of retiree health. Therefore, this Issue Brief will focus only on retiree health benefits.

between President Clinton and the Republican-controlled Congress. In order to balance the federal budget, congressional Republicans have proposed reforms to Medicare that would increase premiums, reduce reimbursement rates to health care providers, offer incentives to Medicare beneficiaries to join Medicare health maintenance organizations (HMOs), and allow Medicare beneficiaries to open medical savings accounts that would be funded with tax-deductible contributions. President Clinton is also committed to Medicare reform. As a result, current and future Medicare beneficiaries can expect to see significant changes in the Medicare program.

Retiree health benefits have become a more important issue for workers and employers since the Medicare trust fund went into negative cash flow during FY 1995. Earlier projections indicated that the trust fund would continue to post gains until FY 1997, with a depletion date of 2002. However, recent reports indicate that the trust fund posted a \$35 million loss in FY 1995. Any future Medicare reform will almost certainly include cuts in benefits, increasing the elderly's dependence on retiree health benefits.

The effects of the aging population on retirement programs can already be seen in the Social Security Old-Age and Survivors Insurance (OASI) program. Past population shifts are reflected in the decrease in the ratio of OASI-covered workers to OASI beneficiaries from 16.5 in 1950 to 3.7 in 1993. In response, taxes imposed on employers and employees to finance the mostly pay-as-you-go OASI program were raised from 1.5 percent in 1950 to 5.26 percent in 1994 (P.L. 103-87). Moreover, the full-benefit retirement age will rise incrementally, from 65 today to 67 in 2022, in anticipation of the baby boom cohort's retirement. Nonetheless, OASI expenses are expected to exceed income beginning in 2020, at which time the worker-to-beneficiary ratio will be 2.8. The OASI trust fund will be depleted in 2030, according to the projections of the Social Security board of trustees.

This *Issue Brief* addresses a wide range of retiree

health issues. It begins by reviewing the provisions and impact of FAS 106. It describes how companies have changed their overall retiree health liabilities; discusses Medicare, the primary source of publicly financed retiree health benefits, and the changing relationship between Medicare and employer plans; and analyzes other arrangements for financing retiree health benefits. The *Issue Brief* concludes with a discussion of policy issues that will potentially affect workers, future retirees, and employers.

FAS 106

Retiree health benefits were originally offered in the late 1940s and the 1950s, when business was booming as a result

of economic expansion, and there were very few retirees in relation to the number of active workers. Retiree health benefits were a simple benefit to provide. These benefits emerged as part of collective bargaining agreements, and employers were more than willing to provide them because the cost was such a small proportion of total compensation. With the enactment of Medicare in 1965, the employer obligation became even less significant, with resulting costs even lower as employers were able to integrate their retiree health benefit programs with Medicare. The resulting liabilities were not substantial, and the financing of these benefits was not of concern. However, in more recent years, the changing demographics of the work force, coupled with increasing lifespans and rising health care costs, have left many employers with higher retiree-to-active worker ratios and caused these liabilities to grow.

FAS 106 has dramatically changed the way most private companies account for their retiree health benefits and other postretirement nonpension benefit obligations. FAS 106 requires liabilities for retiree health benefits to be recognized explicitly on balance sheets. It applies many of

In response to FAS 106 and increases in health care costs, the vast majority of companies have made numerous changes in their retiree health benefit programs.

the same principles that were used in accounting for pensions (FAS 87 and FAS 88) to other postretirement benefits (e.g., health coverage, life insurance, long-term care insurance, and housing). It applies to current and future retirees, their beneficiaries, and qualified dependents. The statement generally does not cover *postemployment* benefits such as severance pay or wage continuation for disabled or terminated employees.³

FAS 106 requires that a liability based on the projected unit credit actuarial cost method (which considers future benefits expected to be earned by the employee) be accrued over the period from the first date that the plan grants credits toward these benefits (generally date of hire) to the date that the employee is fully eligible. Under FAS 106, the amount of a company's accumulated postretirement benefit obligation (i.e., the actuarial present value of benefits attributed to employee service rendered to a particular date) that exceeds plan assets will be recorded as a liability on the company's balance sheet.⁴

Even within these guidelines, there are several assumptions that employers must use to estimate postretirement benefit liabilities. Most important is the assumption about health care cost trends. Under FAS 106, employers are required to develop an estimate of the expected future annual change in their health care costs that implicitly considers expected health care cost inflation, changes in utilization and delivery, technological innovation, and changes in the plan participants' health status.

The cost impact of FAS 106 has been widely studied. Initial estimates of the cost of FAS 106 vary depending on the assumptions used. The Employee

Benefit Research Institute (EBRI) estimated that the present value of private employers' liabilities for retiree health insurance obligations

for retired workers was approximately \$241 billion in 1988. Alternatively, the General Accounting Office (GAO) estimated that earned liabilities were \$217 billion and the liabilities expected to be incurred for future retirees were \$175 billion in 1988, resulting in a total of \$402 billion in 1988. The difference between EBRI and GAO for current liabilities was due in part to different assumptions about health care cost inflation.

Employers seriously considered the magnitude of the retiree health liabilities because putting them on financial statements was unappealing to many companies. As a result, many employers offering retiree health benefits began a major overhaul of their retiree health benefits program.

Plan Design and Coverage

In response to FAS 106 and increases in health care costs, some firms have dropped retiree health benefits, while

others still have no plans to change their existing benefit provisions. However, the vast majority of companies have made numerous changes in their retiree health benefit programs. A recent survey found that 51 percent of responding employers have modified or are considering modifications to their postretirement nonpension benefit programs (Buck Consultants, 1995). This survey studied the year-end 1993 and 1994 annual reports of 489 Fortune 1000 companies that adopted FAS 106. Of those companies indicating a modification or considering a modification, the most common modification was a change in cost-sharing provisions (29 percent), followed by caps on company contributions (22 percent), and annual adjustments to retiree contribution amounts (17 percent). Only 4 percent of surveyed employers made

³ Employees who become disabled with a certain minimum period of service may be eligible to receive pension benefits and may, therefore, be considered to be employees deemed to be on disability retirement. In this case, the long-term disability health benefits paid to them would fall under the scope of FAS 106.

⁴ It is not required that this liability be recognized in its entirety immediately on the balance sheet due to some phase-in and amortization provisions.

or are considering making modifications that would entirely phase out retiree health benefits and/or company contributions to retiree health benefit premiums.

A recent study of 50 of the largest companies included in *Forbes* magazine's list of top companies published in May 1995 showed that 31 companies reported changes in retiree cost sharing for medical benefits in 1994 (Watson Wyatt Worldwide, 1995). Retirees were required to increase their cost sharing through some combination of the following: higher contribution rates, higher deductibles, higher coinsurance, and other plan design changes. Only one company did not offer retiree health benefits. This survey also found that over 50 percent of the surveyed employers did not prefund the retiree medical benefits on a tax-preferred basis.

Companies can reduce their FAS 106 liabilities by reducing their health care cost trend rate. A recent survey of 88 companies by Charles D. Spencer & Associates, Inc., found that medical costs trend rate assumptions have continually declined since 1992, when almost all of the surveyed companies had adopted FAS 106 (LaRock, 1995). This study found that the assumption for average medical cost trend rates fell from 12.35 percent in 1992 to 11.4 percent in 1993 and 10.34 percent in 1994. This survey also found that 44 percent of the surveyed companies reported that they had initiated changes in retiree health benefits. A study by William M. Mercer, Inc., also found that the medical cost trend rate has been falling since implementation of FAS 106 (William M. Mercer, Inc., 1995). This study found that the index of medical costs for future retirees fell 29 percent between 1992 and 1995, with the largest decline occurring between 1992 and 1993. It also found that FAS 106 resulted in a large number of employers altering the design of their retiree medical benefit programs, especially for future retirees. Common changes included raising the retirees' share of the premium and imposing higher deductibles and coinsurance rates.

Data from Foster Higgins' annual survey of

employers suggest that some large employers did completely drop retiree health benefits (Foster Higgins, 1993). In 1988, 62 percent of responding firms offered retiree health benefits to individuals under age 65, and 55 percent offered benefits for Medicare eligible retirees. By 1992, 52 percent of responding firms offered retiree health benefits to individuals under age 65, and 46 percent offered benefits for Medicare eligible retirees. At the same time, the survey shows that employees became more responsible for the cost of retiree health benefits. An additional 8 percent of firms required workers under age 65 to share the cost of retiree health benefits between 1988 and 1992, and an additional 6 percent of Medicare eligible retirees were required to share the cost. This survey also found that the percentage of retirees completely financing retiree health benefits decreased by 2 percentage points between 1988 and 1992.

Many state plans have implemented cost management strategies to reduce health care cost inflation. The use of centers of excellence (hospitals that have considerable experience providing specific treatments and exemplary success rates with those treatments), employee assistance programs, midwife benefits, and discounted pharmacy networks have all increased (Yaggy and Jackson, 1995). However, states have shown no pattern of increasing employee contributions toward retiree health benefits.⁵

Impact of FAS 106 on Workers

While there is a lot of information on employer responses to FAS 106, information on the degree to which workers have been affected is still lacking. **Data from the Bureau of Labor Statistics suggest that employees have not experienced a decline in access to retiree health benefits. Between 1988 and 1993, the per-**

⁵ In 1988, 32 percent of states fully financed retiree health benefits; in 1989, 40 percent; in 1990, 42 percent; in 1992, 38 percent; in 1993, 34 percent; in 1994, 36 percent; and in 1995, 36 percent.

centage of full-time workers employed in firms with 100 or more employees with access to retiree health benefits remained fairly constant at 45 percent (U.S. Department of Labor, selected years). The percentage of full-time workers in state and local governments with retiree health benefits declined

between 1990 and 1992 from 58 percent to 50 percent (U.S. Department of Labor, 1991a and 1994a), and the percentage of full-time workers employed in small private establishments with retiree health benefits increased from 15 percent in 1990 to 18 percent in 1992 (U.S. Department of Labor, 1991b and 1994b). Unfortunately, the data on workers in medium and large private establishments are in large part incomparable with earlier surveys and do not allow determination of the effects of FAS 106 on access to retiree health benefits.⁶

Comparisons of the August 1988 and April 1993 Current Population Surveys (CPS) provide insight on the effects of FAS 106 on workers.⁷ **EBRI tabulations of the August 1988 CPS show that 64.4 percent of wage and salary workers aged 46–64 had employment-based health insurance in their own name**

Table 1
Employment-Based Retiree Health Coverage of Wage and Salary Workers Aged 46–64, by Gender, August 1988 and April 1993

	Total	Men	Married Women	Single Women
Total Workers		(millions)		
1988	24.8	13.3	7.7	3.8
1993	25.3	13.1	7.6	4.5
Employer Coverage (All Workers)		(percentage)		
Participates				
1988	64.4%	73.4%	49.1%	63.7%
1993	70.4	77.6	57.0	72.0
Does not participate				
1988	10.0	11.0	5.6	15.3
1993	12.3	7.7	23.2	7.6
Not determinable				
1988	25.6	15.6	45.2	21.0
1993	17.2	14.7	19.8	20.3
Retiree Health Insurance (All Workers)				
Available				
1988	36.8	43.5	26.8	34.0
1993	38.7	46.5	28.0	34.2
Not available				
1988	20.4	21.8	14.7	27.6
1993	41.4	33.9	55.0	40.3
Don't know / no response				
1988	42.7	34.8	58.5	38.5
1993	19.9	19.6	17.0	25.5

Source: Employee Benefit Research Institute tabulations of the August 1988 and April 1993 Current Population Surveys.

(table 1). The survey also shows that for over one-quarter of the sample, health insurance status could not be determined. With regard to retiree health benefits, workers were even more lacking in knowledge about whether they could continue their health insurance after retirement. In 1988, 36.8 percent of wage and salary workers

aged 46–64 expected to have retiree health benefits; however, almost 43 percent did not know if they had retiree health benefits.⁸

When comparing the tabulations from the August 1988 survey with those of the April 1993 survey, it appears that the percentage of wage and salary workers aged 46–64 with employment-based health insurance in their own name increased from 64.4 percent to 70.4 percent. However, further examination of the data reveals that this increase was largely composed of a 8.4 percentage point decrease in the percentage of workers not knowing or not responding to questions on whether or not they were covered by employment-based health insurance. In addition, EBRI tabulations appear to show that there was an increase from 36.8 percent to 38.7 percent of wage and salary workers with retiree health benefits between 1988 and

⁶ Earlier surveys by the Bureau of Labor Statistics limited the sample to full-time workers employed in establishments of at least 250 workers in certain industries. The current survey of medium and large employers expanded the scope of the survey to include establishments with 100 or more workers.

⁷ Employers were required to fully implement FAS 106 in fiscal years starting after December 15, 1992. As a result, the full effect of FAS 106 may not have shown up in the April 1993 Current Population Survey.

⁸ Retirees can almost always continue to be covered under their health insurance plan for at least 18 months under the 1985 Consolidated Omnibus Budget Reconciliation Act (COBRA). However, retirees could be required to pay up to 102 percent of the premium, making it likely that only individuals with the greatest need for health insurance would choose to continue their coverage under COBRA.

Table 2
Employment-Based Retiree Health Insurance Coverage of Wage and Salary Workers Aged 46–64 by Length of Time Provided and Source of Payment, 1993

Total (millions)	9.8	
	Throughout Retirement	Until Age 65
Retiree Health Available	86.2%	13.8%
Employer Pays		
All	11.3	8.1
Part	43.9	29.0
None	31.0	45.3
Not determinable	12.5	17.6

Source: Employee Benefit Research Institute tabulations of the April 1993 Current Population Survey.

1993. However, there was a dramatic decline in the percentage of workers who did not know they had retiree health benefits or did not respond to the question. While it is not known to what degree workers completely

lost retiree health benefits, it can be concluded that FAS 106 made workers more aware of their retiree health benefits, either as a result of changes made by employers or increased communication about the benefits.

It is important for public policy purposes to know how a proposed policy will affect different individuals. For example, proposals to increase the Medicare eligibility age to 67 would ultimately affect retired individuals and employers. Workers could decide to remain in the labor force until age 67 if they did not have retiree health benefits that would otherwise assist them in bridging the transition into retirement. Employers, in turn, may be forced to cut back on retiree health benefits, pension benefits, and/or jobs in order to account for the increased labor force participation of older individuals.

Individuals can receive retiree health benefits throughout their retirement years. However, some employers choose to provide retiree health benefits only until age 65, when retirees become eligible for Medicare. **In 1993, 9.8 million workers had retiree health insurance available. The vast majority (86.2 percent) expected to receive these benefits throughout their retirement years, while 13.8 percent expected their benefits to be exhausted when they became eligible for Medicare (table 2).**

As mentioned previously, employers have been increasingly passing along the cost of retiree health benefits to retirees, either by increasing the amount that the retiree pays or by capping the amount that the employer contributes. EBRI tabulations of the April 1993 CPS indicate that 11.3 percent of wage and salary workers aged 46–64 with retiree health benefits available throughout their retirement expect their employers

to pay all of the benefits' costs. Thirty-one percent expect to pay for all of the benefit themselves. The vast majority (43.9 percent) expect to share the cost of retiree health benefits with their former employer. Almost 13 percent still

do not know how much they will have to pay for retiree health benefits. Workers with retiree health benefits that will be exhausted when they become eligible for Medicare actually pay more for the benefit. Over 45 percent of these workers will have to fully finance their retiree health benefits if they choose the coverage.

Characteristics of Those Covered by Retiree Health Benefits

Availability of retiree health benefits varies by demographics and work-related variables. Workers aged 55–64 are more likely to have retiree health benefits (39.2 percent) and are less likely to be unaware of their benefits (17.6 percent) than workers aged 46–54 (38.5 percent and 21.2 percent, respectively) (table 3). White individuals appear to have the highest probability of having retiree health benefits available (40.2 percent) and the lowest probability of not knowing about their benefits (19.0 percent) when compared with blacks, Hispanics, and other races. Hispanics are least likely to have retiree health benefits available (23.4 percent).

Retiree health benefits differ by earnings and firm size. Workers with higher annual earnings are more likely to have retiree health benefits, but there is no clear pattern of awareness of the status of these benefits. In general, workers employed in larger firms have a greater chance of having retiree health benefits than workers in smaller firms. The degree of awareness does not present any clear pattern across firm size.

Coverage also varies by industry, union status, hours of work, and job tenure. Workers employed in the communications and utilities industries had a 76.5 percent chance of having retiree health benefits and

Table 3
**Employment-Based Retiree Health Coverage of Wage and Salary Workers Aged 46–64
by Selected Characteristics, 1993**

	Total Workers (All workers)	Participation Rate	Retiree Health Insurance Available	Not Available	Not Determinable
	(millions)		(percentage)		
Total	25.3	70.4%	38.7%	41.4%	19.9%
Age					
46–54	16.1	71.6	38.5	40.3	21.2
55–64	9.2	68.4	39.2	43.3	17.6
Race					
White	20.4	71.6	40.2	40.7	19.0
Black	2.5	68.7	38.7	38.3	23.0
Hispanic	1.6	57.1	23.4	53.2	23.3
Other	0.8	70.8	30.6	43.0	26.4
Region					
Northeast	5.4	70.9	37.0	41.4	21.6
Midwest	5.9	72.6	42.8	39.8	17.4
South	8.8	68.6	38.1	42.1	19.8
West	5.2	70.4	37.1	41.8	21.0
Earnings					
Less than \$5,000	1.0	5.1	1.0	96.4	2.5
\$5,000–\$9,999	2.1	27.0	9.5	80.5	10.1
\$10,000–\$14,999	3.3	55.4	20.7	58.0	21.3
\$15,000–\$19,999	3.1	70.2	32.9	43.1	24.0
\$20,000–\$24,999	3.0	79.8	41.0	33.7	25.3
\$25,000–\$29,999	2.6	81.0	43.6	34.9	21.5
\$30,000–\$49,999	6.0	87.1	55.5	24.6	19.9
\$50,000 or more	3.2	92.4	60.8	18.6	20.6
Not Determinable	1.0	47.5	22.8	60.1	17.1
Firm Size					
1–9 employees	2.7	25.8	9.6	81.2	9.3
10–24 employees	1.7	46.1	16.1	66.5	17.3
25–49 employees	1.4	61.6	20.0	54.2	25.8
50–99 employees	1.3	72.9	29.4	43.9	26.8
100–249 employees	1.9	72.9	35.8	45.2	19.1
250–499 employees	1.2	78.9	46.5	36.7	16.8
500–999 employees	1.6	79.6	42.6	34.8	22.7
1,000 or more employees	11.6	83.9	54.4	25.3	20.2
Unknown	1.9	61.6	19.5	54.1	26.4
Industry					
Federal government	1.2	82.5	63.9	23.3	12.8
State and local government	4.9	83.3	53.5	27.5	19.0
Agriculture, forestry, and fishing	0.2	27.5	9.1	85.8	5.1
Mining	0.1	89.7	54.4	17.5	28.1
Construction	0.8	52.8	22.8	63.3	13.9
Manufacturing-nondurables	2.2	81.6	46.0	30.5	23.5
Manufacturing-durables	3.0	87.9	49.7	25.1	25.2
Transportation	1.2	73.3	38.2	38.3	23.6
Communications and utilities	0.6	94.1	76.5	14.8	8.7
Wholesale trade	1.0	72.5	27.7	43.3	29.1
Retail trade	3.0	50.1	20.9	60.6	18.5
Finance, insurance, and real estate	1.6	69.9	37.9	41.9	20.2
Business, personal, entertainment, and recreation services	1.8	37.7	10.9	72.8	16.3
Professional and related services	3.7	61.2	27.3	52.8	19.9
Union Status					
Union	6.2	87.8	57.1	22.9	20.0
Nonunion	19.1	64.8	32.8	47.3	19.9
Hours of Work					
0–20	1.6	16.4	6.8	88.4	4.8
21–34	1.6	28.2	12.9	78.1	9.0
35 or more	22.1	77.3	42.9	35.3	21.8

(continued)

Table 3 (continued)

	Total Workers (All workers)	Participation Rate	Retiree Health Insurance Available	Not Available	Not Determinable
	(millions)		(percentage)		
Job tenure					
Less than 1 year	2.1	32.7%	10.7%	75.3%	14.0%
1–4 years	5.2	51.8	17.7	59.9	22.3
5–9 years	4.6	65.5	29.7	48.3	21.9
10–14 years	3.3	78.5	39.5	37.7	22.7
15 or more years	9.6	88.7	60.7	21.6	17.7
No response	0.5	61.2	30.4	44.9	24.7

Source: Employee Benefit Research Institute tabulations of the April 1993 Current Population Survey.

a 8.7 percent chance of not knowing the status of these benefits. Workers in the public sector, mining, and manufacturing also had an above average chance of having retiree health benefits and a below average chance of not knowing the status of these benefits. Not surprisingly, union workers, full-time workers, and workers with more than 15 years of job tenure were most likely to have retiree health benefits.

Retiree health benefits are expected to continue in the future; however, workers should expect modifications in their retiree health programs, and some workers may not have retiree health benefits available by the time they retire.

Funding Options

Companies maintaining retiree health benefits have a number of concerns, such as reducing costs and cost volatility and

managing the effects of the funding on corporate and retiree taxes. As a result, decisions on how to fund these obligations are concerned with both tax-advantaged vehicles and investment strategies. Generally, the choice of vehicle may be largely based on tax ramifications. The investment strategy used within that vehicle may be mainly intended to exploit tax benefits or to achieve an optimal cash flow.⁹

Figuring a retiree medical health liability is not as simple as calculating the present value of known costs. The unknowns of medical inflation, technological innovation, and utilization patterns complicate the estimation. In addition, the government may change aspects of Medicare, thereby affecting employer plans.

There are several vehicles for funding retiree health benefits, each with some tax advantage and limitations. Funds must be segregated and restricted (usually in a trust) to be used as an asset against FAS 106 liability. These vehicles

include 501(c)(9) trusts, or voluntary employee benefit associations (VEBAs), and 401(h) plans. Alternatively, some plans are used to help employers and employees set aside monies to help plan for the purchase of retiree health insurance, although these funds are not specifically reserved for this purpose. Such plans are 401(k) plans, corporate-owned life insurance (COLI), and employee stock ownership plans (ESOPs). Not all are tax deductible means of funding or setting money aside, and each has specific limits. The following summary outlines these differences.¹⁰

501(c)(9) Trusts or VEBAs

VEBAs were originally established for use by multi-employer plans through the Internal Revenue Code (IRC) and the Labor Management Relations Act of 1947 (Taft-Hartley Act). As a result of increasing health care costs and increasing inflation, ERISA extended these trusts to single-employer plans. VEBAs must be based on voluntary membership, and qualifications for membership eligibility must be defined by objective standards of an employment-related "common bond." The employer can make tax-deductible contributions; however, these are limited to essentially only the cost necessary to pay current welfare benefits plus a contribution to a qualified asset account.¹¹ While the contribution to the asset account is intended to fund the liability over the employees' working lives, neither health inflation nor increased utilization can be taken into account when figuring that

⁹ An optimal cash flow in this situation would match cash inflows with cash outflows. In retiree health funding, this means having investments mature when benefits need to be paid.

¹⁰ See Davis (1991) for more detail on funding options.

¹¹ The formula is: benefits actually paid during any year (direct costs), plus a reserve for estimated claims incurred in the year but not yet paid (which must be determined as reasonable to the Internal Revenue Service and cannot exceed 35 percent of the qualified direct costs), minus the fund's after-tax income for the year.

contribution. Investment income is not exempt from tax for most plans (it is taxable as unrelated business income unless invested in tax-exempt instruments), although for VEBAs established under a collective bargaining agreement, the contributions are unlimited and earnings accumulate tax free. Expenses for disability, medical benefits, and group-term life insurance purchases are also tax free to the recipient, although other benefits are taxable on receipt.¹²

Nondiscrimination regulations were added by the Deficit Reduction Act of 1984 (DEFRA) and state that each plan benefit is subject to Internal Revenue Service (IRS) oversight to prohibit discrimination in both design and operations.¹³ DEFRA disallowed accounting for future inflation in funding VEBAs and changed the law to subject earnings to federal income tax.¹⁴ DEFRA also imposed a 100 percent excise tax on employers whose welfare benefit fund provides any type of disqualified benefit.

401(h) Plans

Another vehicle for funding retiree health benefits is a 401(h) plan in which contributions are put into a separate account within a defined benefit pension plan. Medical benefits must be subordinate to retirement benefits. This means that the contributions made to cover medical benefits cannot exceed 25 percent of aggregate employer contributions for both medical and retirement contributions after the plan first provides medical benefits.¹⁵ Therefore, some plans may not be able to make such a contribution if the pension plan has been restricted by the full-funding limits. Investment earnings of a 401(h) plan are not taxable to the em-

ployer. If the pension plan or the medical benefit plan is discriminatory, neither plan will be tax qualified.

Within this separate account, individual accounts, known as individual medical benefit accounts (IMBAs), must be kept for each employee who is (or was during the past five years) a 5 percent owner of the company. However, separate accounts are only for recordkeeping purposes, and the money in the investments can be commingled. IMBA contributions are treated as an annual addition to a defined contribution plan for purposes of IRC sec. 415(c). The plan must allow the employer to take a reversion of any excess amount remaining in the separate medical benefit accounts after all liabilities have been satisfied.

401(k) Plans

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

These plans can include both elective and nonelective contributions. While they can be financed wholly through elective deferrals, employers may not use nonelective deferrals in order to ensure that money is set aside for retiree medical payments for all their employees.

Total contributions to a 401(k) plan, including employer and employee contributions, are limited to the

¹² Disability and medical expenses are tax free to the extent provided in Internal Revenue Code (IRC) secs. 104 and 105, which list the nonincludable expenses specifically.

¹³ This holds only for contributions for postretirement medical and death benefits in 501(c)(9) trusts, or voluntary employee beneficiary associations (VEBAs). Also, nondiscrimination rules do not apply to plans maintained through a collective bargaining agreement. VEBA nondiscrimination rules are in IRC sec. 505.

¹⁴ This does not apply to VEBAs covering groups that are at least 90 percent collectively bargained. Assets held before enactment of the Deficit Reduction Act of 1984 are grandfathered. Also, the taxability of earnings holds only for postretirement medical benefits, as these may not be taken into account when figuring reserve limits. Earnings on reserves for other benefits are not taxed as long as the reserves for these benefits do not exceed the new funding limits.

¹⁵ However, this does not include contributions made to the pension plan to fund the plan's past service credits.

lesser of \$30,000 (or 25 percent of the defined benefit plan dollar limit, if greater) or 25 percent of compensation. Contrary to the rules governing other 401(k) contributions, nonelective or matching employer contributions can be distributed only in the event of death, disability, or separation of service. There are some provisions for hardship withdrawals; but these withdrawals, except for those made for medical expenses, are subject to a 10 percent excise tax.

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

Corporate-Owned Life Insurance

A company could use corporate-owned life insurance (COLI) to set aside money for retiree health liabilities. In this method, the employer purchases life insurance on the active work force (and sometimes on retirees). Later, the company can collect the life insurance proceeds tax free and/or borrow the maximum cash surrender value to derive positive cash flow in later years. COLI does not fund postretirement benefits in either a traditional sense or in accordance with FAS 106, but it does create a cash flow stream to meet all or part of the benefit costs.

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

COLI can be nonleveraged; i.e., no loans are taken out on a policy or its cash value. In nonleveraged COLI, the assets build up and the policies are held to term. Direct corporate ownership of the assets eliminates trust expenses, nondiscrimination requirements, the

limitations on funding, and the irrevocable dedication of funds to benefits. Benefits paid to the employer are tax free.

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

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

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

ESOPs

Employee stock ownership plans (ESOPs) have recently become another vehicle for funding retiree health benefits. Again, the assets of a stand-alone ESOP cannot be used against the FAS 106 liability, and the distribu-

Table 4
**Estimated Total and Per Capita Personal
 Health Care Spending among the Elderly,
 Selected Years, 1977–1991**

Year	Total (\$ billions) Aged 65 and over	Per Capita Aged 65 and over
1977	\$ 45.2	\$1,856
1987	120.4	4,040
1991	216.6	7,016
Total Growth 1977–1991	379.2%	278.0%

Source: Employee Benefit Research Institute (EBRI) estimates of data from the National Medical Expenditure Survey (NMES); and Waldo, et al., 1989.

tions are taxable to the retiree. Similar to the method used for 401(k) plans, this method of funding focuses more on the employer's ability to communicate the intended use of the funds when received by the employee than on direct funding for retiree health benefits. However, according to a 1989 EBRI/Gallup survey, 69 percent of those aged 18 and over would rather receive employer-paid health insurance benefits after retirement than a share in the ownership of the company that could be cashed out at retirement (Employee Benefit Research Institute/The Gallup Organization Inc., 1989).

An added advantage of ESOPs is that the fund could be leveraged to provide more tax benefits to the employer. In a leveraged ESOP, the plan borrows money to pay for the company stock, which is then held in a trust. The company makes the necessary contributions to the ESOP, which the ESOP then uses to pay down the loan. The stock is then allocated to the employees' accounts. In this loan, the interest may be tax deductible for the organization making the loan, so that the organization can often offer a lower rate on the loan.¹⁶

Combinations

Some companies have created combinations of these previously discussed plans. One combination is known as an "HSOP" because it combines a 401(h) and an ESOP. Others combine aspects of 501(c)(9) trust and COLI. In a 501(c)(9) trust, as long as the policies are held until death, the trust will pay no income tax.¹⁷ However, there is no leveraging possible with this product.

¹⁶ The law sets out certain criteria for those organizations that can use this deduction and limits its use to employee stock ownership plans that own 50 percent of the company's stock.

¹⁷ If set up in a 501(c)(9) trust, none of the investment earnings on the life insurance contracts are subject to the tax normally assessed on these trusts, since the inside insurance cash value buildup is tax deferred, and the policies will be held until death.

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

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

Medicare

While the elderly represent approximately 13 percent of the U.S. population, they account for approximately

32 percent of every personal health care dollar spent in the United States. In addition, these expenditures have grown rapidly over the last decade. Between 1977 and 1991, the total cost of health care for the elderly increased 379 percent in current dollars (table 4).

Medicare is by far the largest public health care financing program for the elderly. In 1993, Medicare financed \$151.1 billion in health care, mostly for the elderly. Total Medicare benefit payments (for the elderly and disabled) were \$7.3 billion in 1970, increasing to \$36.4 billion in 1980, and \$109.6 billion in 1990 (Levit, et al., 1994). As a percentage of national health care spending, Medicare has increased from 11.3 percent in 1970 to 19.3 percent in 1993 (Levit, et al., 1994).

Medicare is divided into two parts. Medicare Part A is financed through the mandatory Hospital Insurance (HI) payroll tax and pays for most inpatient hospital care, limited nursing home care, home health agency visits, and hospice care for terminally ill patients. It requires cost sharing in the form of deductibles and coinsurance. Part B is voluntary and is financed with

Employers have discovered that Medicare HMOs, especially risk HMOs, offer employers and retirees a “win-win” alternative to the traditional fee-for-service Medicare program and traditional retiree health benefits.

participant premiums and general federal revenues through the Supplementary Medical Insurance (SMI) trust fund. Part B provides payments for physicians' services, outpatient hospital services, rural health clinic office visits, and related physician supplies.

During the past decade, changes have been made in both Medicare Part A and Part B in an effort to control rising health expenditures. These reforms have resulted in major changes in the hospital industry and in the way physicians and Medicare beneficiaries utilize health care services. Medicare's prospective payment system (PPS), implemented in 1983, provides incentives designed to lead to more efficient production of services within the hospital. Medicare's reimbursement methodology changed in two distinct ways. First, the change from a reimbursement rate based on the individual hospitals' historic costs meant that hospitals could no longer influence future reimbursement rates by incurring higher costs in the present. PPS thus removed one disincentive for hospitals to restrain their costs. The second way in which PPS changed hospital incentives was the bundling of the service provided a patient during a single admission. Historically, cost-based, per diem reimbursement provided hospitals with a financial incentive to increase Medicare patients' length of stay and provide more services per stay. Conversely, under PPS, hospitals have an incentive to reduce the length of stay and provide the minimum services necessary for care. As a result of these incentives, changes have occurred in both inpatient and outpatient care.¹⁸

In 1989, a resource based relative value scale (RBRVS) and volume performance standards (VPS) were adopted by Medicare. RBRVS is an index of the resources necessary to provide a given medical service. Like PPS for hospitals, RBRVS makes physician reimbursement

prospectively determined. It removes incentives for physicians to charge higher fees in one year in the hope of achieving higher reimbursement levels the next, along with increasing payments to primary care physicians. These incentives were necessary because of the shift from

the inpatient setting to outpatient departments that occurred after the implementation of PPS. But unlike PPS, the new physician reimbursement methodology does not bundle services. Physicians are still reimbursed on a piecemeal basis, and the upcoding of procedures may continue. The financial incentive to provide as many services as possible for each episode of care remains.

VPS was implemented to reduce the incentive to increase service volume by tying increases in physician reimbursement rates to an annual volume target that is determined through congressional action or, if Congress does not act, through a default formula. The difference between the target and actual volume partly determines future physician payment rate updates, with low growth rewarded by higher updates.

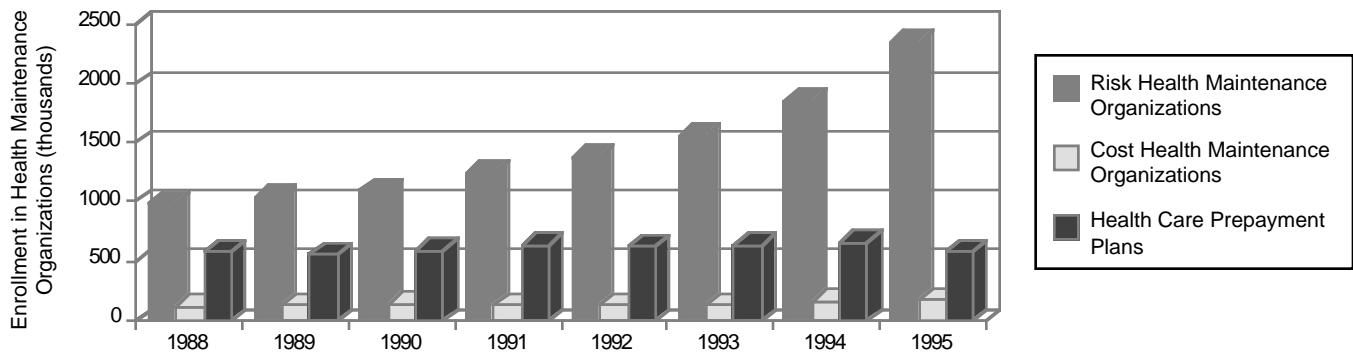
Medicare and Managed Care

With FAS 106 requirements, employers may not only see their current costs increase but also experience additional costs, as the traditional Medicare program covers less of the elderly's health care bill. As a result, many employers have turned to the Medicare HMO program to reduce their FAS 106 liabilities.

The Medicare managed care program was created by Congress in 1982, under the Tax Equity and Fiscal Responsibility Act, and became operational during 1985. This program allows Medicare beneficiaries to enroll in one of three types of managed care contracts: risk HMOs, cost HMOs, and health care prepayment plans (HCPPs). Employers have discovered that Medicare HMOs, especially risk HMOs, offer employers and

¹⁸ See Fronstin (1995) for a list of the major changes the prospective payment system has made in physician practice patterns.

Chart 1
Medicare Managed Care Enrollment, 1988–1995



Source: Employee Benefit Research Institute.

retirees a “win-win” alternative to the traditional fee-for-service Medicare program and traditional retiree health benefits (Marlowe and Childress, 1995). For employers, every retiree enrolled in a Medicare HMO represents a decrease in the FAS 106 postretirement medical liability.

Risk HMOs assume all of the financial risk of caring for Medicare beneficiaries. In other words, risk HMOs completely replace Medicare Part A and Part B. Also known as competitive medical plans, these plans are reimbursed on a capitated basis. All of the Medicare-covered services are included as well as benefits that are not typically covered by Medicare, such as routine physicals, prescription drugs, and vision care. Members of the risk HMO must receive all of their medical care through the HMO’s network of providers, except in the case of emergency care and out-of-area urgent care.

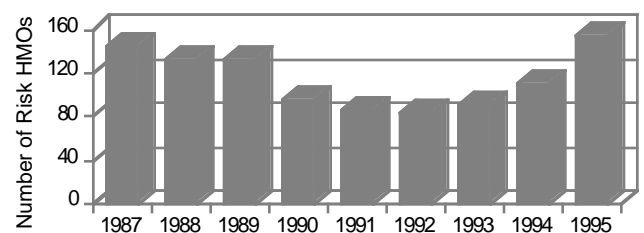
Medicare pays cost HMOs a predetermined per capita monthly amount that is based on a total estimated budget. However, these plans do not face financial risks. Payment adjustments are made at the end of the year to account for any variations from the budget. Cost HMOs more closely resemble point-of-service plans, as opposed to closed-ended HMOs. These plans allow Medicare enrollees to use out-of-network providers. If Medicare enrollees choose out-of-network providers, they become responsible for all Medicare Part A and Part B deductibles and coinsurance as if they were receiving care under the traditional Medicare fee-for-service program, and they are also subject to Medicare’s coverage restrictions.

HCPPs are similar to cost HMOs in the way that they are paid by Medicare and in the way they provide benefits. These plans cover all or part of Medicare Part B services but do not cover Medicare Part A services. Union trusts and Taft-Hartley funds often sponsor HCPPs.

Between 1987 and 1995, enrollment in Medicare HMOs increased from 1.6 million to 3.1 million, a 93 percent increase, with the greatest growth occurring in risk HMOs (chart 1). However, only 9 percent of the Medicare population is currently enrolled in a Medicare HMO. Medicare beneficiaries residing in California, Florida, Arizona, Oregon, and Nevada accounted for over 50 percent of Medicare managed care enrollment (U.S. Department of Health and Human Services, 1995). Growth in the number of risk HMO plans has only recently increased, after stagnation and declines in the early 1990s that were due to poorly defined reimbursement rates (chart 2). In fact, between 1989 and 1990 the number of risk HMOs decreased 28 percent, and they decreased another 11 percent between 1990 and 1991. It was not until 1993 that the number of risk HMOs started increasing. By 1995, the number of risk HMOs surpassed the 1987 level, and they are expected to continue to grow.

Medicare HMOs offer both employers and retirees advantages over traditional retiree health benefits and the traditional fee-for-service Medi-

Chart 2
Number of Medicare Risk Health Maintenance Organizations (HMOs), 1987–1995



Source: Employee Benefit Research Institute.

care program. Employer advantages include significant savings on retiree health care costs (including a reduction in FAS 106 liabilities), expanded benefit coverage, increased value of the organization's health care dollars, improved long-term predictability of health care expenses, and reduced staff time devoted to retiree coverage and claims questions (table 5). Retiree advantages include low or no monthly premiums; expanded benefit coverage; reduced out-of-pocket expenses; predictable health care expenditures; reduced or no claims hassle; and quality assurance such as provider credentialing, quality of care, and care management.

Medicare risk HMOs are attractive to both employers and retirees because of the low premium costs of these plans. In 1995, premiums in the Medicare risk program ranged from zero to \$110 per month, with one-half of the plans offering health care coverage with no monthly premium (chart 3). Medicare risk HMO enrollees are even more likely to choose a plan with no monthly premium (chart 4). They cover the Medicare deductibles and coinsurance for which a beneficiary is responsible. Premiums are allowed to be charged for items not provided by the traditional fee-for-service Medicare program. Expanded benefit protection is an advantage of Medicare risk HMOs over the traditional Medicare program. Medicare beneficiaries enrolled in these HMOs are also likely to have coverage for routine physicals, eye exams, immunizations, ear exams, and outpatient drugs (chart 5).

Issues for Plan Sponsors

A coalition of congressional Republicans and Democrats has agreed to

reduce Medicare spending by \$168 billion by the year 2002. However, Republicans would begin the spending

Table 5
Medicare HMO Advantages to Employers and Retirees

Employer Advantages

- Significant savings on retiree health care costs
- Expanded benefit coverage
- Increased value of the organization's health care dollars
- Improved long-term predictability of health care expenses
- Reduced staff time devoted to retiree coverage and claims experience

Retiree Advantages

- Low or no monthly premiums
- Expanded benefit coverage
- Reduced out-of-pocket expenses
- Predictable health care expenditures
- Reduced or no claims hassles
- Senior focused quality assurance

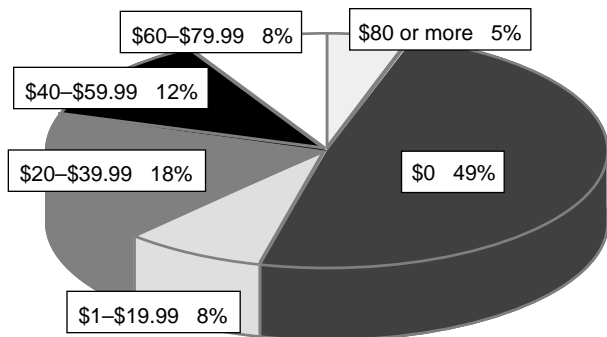
Source: Joseph F. Marlowe and H. Kathleen Childress, "Medicare Risk HMOs: Careful Consideration Can Yield Rewards," *Employee Benefits Journal* (September 1995).

reductions in FY 1997, while the Democrats propose to start the spending reductions in FY 1996. Nevertheless, both congressional Republicans and Democrats have been paying extra attention to the role that Medicare risk HMOs will play as part of the future of Medicare. One goal is to reduce Medicare spending by increasing the percentage of Medicare beneficiaries enrolled in risk HMOs. This move would be a natural extension of the current trend of private-sector employers increasing participation of workers and their families in managed care arrangements. As a result, retiree health plan sponsors are likely to increase access to Medicare risk HMOs for their retirees. There are several issues that employers should consider when redesigning their retiree health plans.

Plan sponsors can benefit significantly from increased enrollment among retirees in the Medicare risk program. Consider the following example provided by Godwins, Booke, and Dickenson. Prior to the adoption of Medicare risk HMOs as part of an employer's retiree health plan, the annual per capita cost of retiree health benefits was \$1,200 for the employer. A plan sponsor with 500 Medicare eligible retirees would spend \$600,000 per year on retiree health benefits. Alternatively, the plan sponsor could offer a Medicare risk HMO as part of its retiree health benefits package. The annual cost of the risk HMO would be \$200 per enrollee and would include unlimited prescription drug benefits. If 30 percent of all Medicare eligible retirees enrolled in the Medicare risk HMO, the plan sponsor would achieve current annual cash savings of \$150,000.¹⁹

¹⁹ This figure does not include the deduction in service costs or recurring interest costs or FAS 106 deductions due to increased enrollment in Medicare risk health maintenance organizations by future retirees, and it has not been amortized for purposes of listing the liability on the balance sheet.

Chart 3
Percentage of Medicare Risk Health Maintenance
Organization Contracts, by Premium Range, 1995

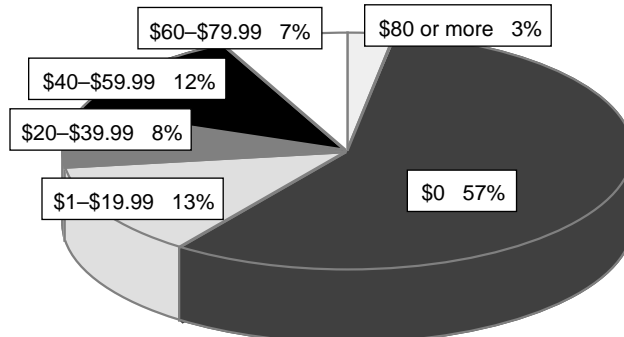


Source: Employee Benefit Research Institute.

In the past, plan sponsors typically offered active workers and retirees the same options for health insurance. However, increasing health care cost inflation has led many plan sponsors to reevaluate their health insurance benefits. Many plan sponsors have redesigned their health benefit programs for active workers to give managed care a dominant role, but employers have been hesitant to make changes in their retiree health benefit programs because they fear litigation promulgated by former employees. Rising retiree health care costs (and FAS 106) have made it more important to reevaluate their retiree health benefits. As a result, plan sponsors are starting to look toward managed care (and Medicare risk HMOs) as a way to control their retiree health benefit costs.

Medicare risk HMOs are an attractive benefit because these programs often include benefits that are not provided in the Medicare program and typically may not be provided in traditional retiree health benefits. These additional benefits may include prescription drugs and coverage for routine physicals. They may also include reduced premiums and the waiver of charges such as the Medicare deductible and coinsurance. In addition, plan sponsors can negotiate with the Medicare risk HMO for additional benefits for retirees that would not ordinarily be included in the Medicare risk HMOs' plan design. These benefits would be paid for by some combination of cost sharing between plan sponsors and employees and would make the Medicare risk HMO option more attractive to Medicare eligible retirees. Currently, risk HMOs are reimbursed at 95 percent of Medicare's actuarial estimate of the average cost of treating the patient in the traditional fee-for-service Medicare program, calculated by county. Research suggests that this methodology does not maximize the potential cost savings of the Medicare managed care

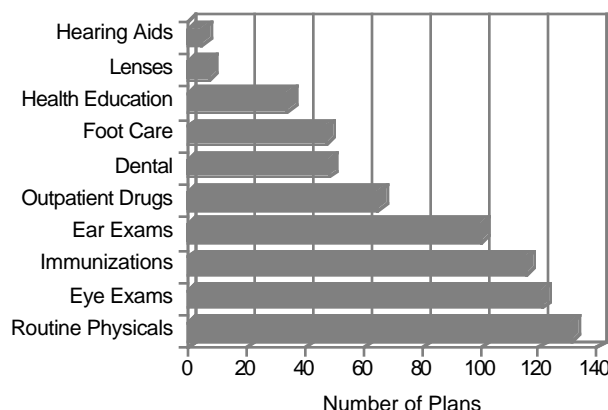
Chart 4
Enrollment in Medicare Risk Health Maintenance
Organizations, by Premium Range, 1995



Source: Employee Benefit Research Institute.

program. There are three inherent problems with this reimbursement scheme. First, there is conflicting evidence that risk HMOs are overpaid. A study by Brown, et al., (1993) found that the Medicare managed care population benefits from favorable risk selection—meaning that healthier individuals typically enroll in risk HMOs rather than in the traditional Medicare program. As a result, HMOs' costs for providing health care to Medicare beneficiaries are 11.2 percent less than the cost of treating this population in the traditional fee-for-service Medicare program. However, a recent study by Rodgers and Smith (1996) suggests that the Brown, et al., (1993) study may overstate the degree of favorable selection because the risk HMO population has matured, their health status may have declined over time, and the population has almost doubled since 1990, reducing the potential for favorable selection. Rodgers and Smith

Chart 5
Additional Benefits Offered by Medicare Risk Health
Maintenance Organizations



Source: Employee Benefit Research Institute.

This *Issue Brief* was written by Paul Fronstin of EBRI, with assistance from the Institute's research and editorial staffs. Any views expressed in this article are those of the author and should not be ascribed to the officers, trustees, members, or other sponsor of EBRI, EBRI-ERF, or their staffs. Neither EBRI nor EBRI-ERF lobbies or takes positions on specific policy proposals.

(1996) show that risk HMOs do not exclusively attract less costly Medicare beneficiaries, and overall risk HMO costs are similar to costs in the traditional Medicare program, resulting in a 5 percent savings to the Medicare program for each risk HMO enrollee. Second, the Medicare managed care program has largely ignored the ability of competitive markets that could be used to reduce reimbursement rates (U.S. General Accounting Office, 1995). Third, reimbursement rates may have been set too low in some geographic regions, resulting in fewer health plans participating in the risk HMO program.

Plan sponsors and current and future participants in the Medicare risk HMO program should realize that future changes in the financing of this program could result in fewer HMOs offering risk contracts to Medicare beneficiaries and increased costs to enrollees and other third party payers of premiums. Currently, Medicare risk HMOs can achieve "savings" if the HMO's adjusted community rate for services to enrolled Medicare beneficiaries is less than the average of the per capita payments made to the HMO by Medicare (Landan and Martingale, 1995). Savings must be passed back to enrollees by reducing premiums, reducing other charges such as deductibles and coinsurance, or providing additional benefits. Alternatively, HMOs can elect to receive lower payments from Medicare in order to reduce savings. Most HMOs use the savings to offer benefits with no or low premiums and to offer additional benefits. If risk HMOs were forced to return savings to Medicare or reimbursement rates were reduced to reduce savings, premium rates might increase and additional benefits might not be available.

Conclusion

expected in Medicare as the federal government at-

The percentage of the U.S. population aged 65 and over is expected to continue to increase. At the same time, future cuts can be

tempts to balance the U.S. budget and keep the Medicare trust fund from going bankrupt and in retiree health benefits as private companies increasingly shift the cost of retiree health benefits onto retirees. However, previous trends suggest that it is unlikely that many employers will completely drop retiree health benefits.

The issues of longevity, mortality, and morbidity have, in large part, been absent from discussions of the future of retiree health benefits. Technological innovation in the health care industry will allow individuals to live longer, healthier lives. Mortality rates have been declining, and the elderly are already reaping the benefits of advanced medical technologies. Current and future advances in medical technology can be expected to contribute to additional gains in mortality and morbidity in the near future. Future increases in medical technology could, in fact, exceed the pace of past increases at a far greater rate than that previously experienced. As a result, it will become more difficult to plan for retirement security. Future changes in mortality and morbidity can have large financial effects on the elderly, the nonelderly, private companies, and the federal government. Society must start preparing for technological advances in the medical industry that will place increasing strains on our resources for financing and delivering health care to the aged population.

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Issue Brief

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