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EMPLOYER-SPONSORED RETIREE HEALTH INSURANCE PLANS: BENEFIT ENTITLEMENT, FUNDING AND THE POTENTIAL EFFECTS OF REGULATION

by

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Introduction

Health insurance as a retirement benefit is a major source of private insurance coverage for retirees. For early retirees, not yet eligible for Medicare, the offer of continued health benefits from their employer plan may be a critical factor in the decision to retire. Among Medicare-eligible retirees, these plans provide an important supplement to Medicare coverage.

The importance of retiree health benefits to retirees and the prevalence with which they are promised to workers have raised important public policy issues. Retiree health plan terminations in the course of corporate acquisitions or bankruptcy reorganizations have gained increasing public attention, as many retirees have found themselves suddenly without employer coverage and, because of poor health, uninsurable as individuals.

This paper evaluates the prevalence of retiree health insurance benefit receipt among retirees, and the prevalence with which today's workers are offered health plans that they expect will continue benefits in retirement. The issue of entitlement to retiree health insurance benefits among current retirees and the current funding status of retiree health plans are summarized. The question of ERISA-type regulation of retiree health insurance plans, similar to the federal regulation of private pension plans, is also addressed using results of a microsimulation model that projects retiree health insurance recipiency among future retirees. These results suggest that federal regulation of retiree health insurance plans might substantially raise projected recipiency of retiree health benefits and, therefore, projected plan

costs. In turn, higher costs may lead employers to terminate their retiree health plans or significantly modify benefits for future retirees.

The Prevalence of Retiree Health Benefits

In 1984, at least 3.1 million early retirees (retirees age 45 to 64, and their spouses), and 6.0 million elderly retirees (age 65 or older, and their spouses) had coverage from a private or public-employer retiree health plan.[1] Employer-sponsored retiree health plans provided coverage for percent of older nonworkers (age 45 to 64) in 1984; among the elderly population, 21 percent had coverage from a retiree health plan. Employer-sponsored retiree health plans provide more than one quarter of the elderly's Medigap coverage.

Workers employed in larger establishments commonly anticipate continued health insurance as a retirement benefit. At least 72 percent of employees in medium-size or large establishments with employer-sponsored health insurance have coverage that will continue after early retirement; at least 66 percent have coverage that will continue after retirement at age 65 (Employee Benefit Research Institute, 1986). Workers in these establishments with early or normal retiree health insurance benefits represented approximately 14 percent of the U.S. workforce in 1985. Including workers in smaller establishments, as many as one-quarter of the total U.S. workforce may have employer-based

[1] All data on 1984 retiree health plan coverage are EBRI tabulations of the Survey of Income and Program Participation (SIPP), Waves 2 through 5 (U.S. Department of Commerce, Bureau of the Census).

health insurance benefits that continue after early or normal retirement.

Most retirees with continued health insurance benefits receive an employer contribution to their coverage. In 1984, 80 percent of retirees age 65 or more with coverage from a past employer had an employer contribution covering at least part of the plan cost; 39 percent had the full cost of coverage paid by the plan sponsor. A significant minority--20 percent--of elderly retirees with health insurance from a past employer paid the full cost of the plan themselves with no contribution from the plan sponsor.

Among early retirees with coverage from a past employer, contributions to coverage by the plan sponsor are slightly more common: 84 percent of early retirees with coverage from a past employer received some contribution to coverage from the plan sponsor. For 42 percent, the plan sponsor paid the full cost of coverage. Only 16 percent of early retirees with coverage from a past employer paid the full cost of coverage with no contribution from the plan sponsor.

In most cases, retiree health insurance benefits apparently supplement pension benefits. In 1984, 84 percent of elderly nonworkers with a health insurance plan from a past employer also reported pension income, presumably from a defined-benefit pension plan or in the form of an annuitized defined-contribution plan benefit.[2]

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[2] This figure excludes elderly with retiree coverage only as a dependent of another retiree's plan. It may also exclude pension recipients who received only a lump-sum distribution from their pension plan(s) and reported no pension income beyond the year of distribution.

Available data on plan provisions among current workers suggest that for future retirees, the proportion with an employer contribution to health benefits may be about the same as today's retirees. For 85 percent of workers in larger establishments participating in health insurance plans that continue coverage after retirement, retiree coverage is financed at least in part by the plan sponsor. However, at least 11 percent of plan participants in medium-size or large establishments anticipate access to continued coverage after normal retirement with no contribution from the plan sponsor (Employee Benefit Research Institute, 1986).

The Distribution of Retiree Health Insurance among Retirees

The relative income of retirees who benefit from retiree health insurance plans illustrates its importance as a source of real income among the elderly. In 1984, more than half of all elderly retirees with health insurance coverage from a past employer (56 percent) reported family income less than $20,000 (see Table 1). If the value of retiree health insurance among these retirees averaged $500 (a conservative estimate), the benefits received by these retirees represented a real income supplement of 5 percent or more, for a married couple. For a married couple with family income less than $10,000 (13 percent of all elderly retiree health plan beneficiaries in 1984), their retiree health benefits may have represented a real income supplement of 10 percent or more. By comparison, Social Security benefits averaged 33 percent of all elderly's income in 1984, and private and public pensions averaged 14 percent (Chollet, 1987).

TABLE 1

Retiree Health Insurance Benefits
Among Current Elderly by Family Income, 1984

	All Elderly		Elderly With Retiree Health Benefits[a]		
	Number (millions)	Cumulative Percent	Number[b] (millions)	Percent Within Income Group	Cumulative Percent of All Recipients
Total	26.1	--	5.4	20.7	--
$0-$9,999	9.2	35.4	0.7	7.6	13.0
$10,000-$19,999	8.8	68.9	2.3	26.1	55.6
$20,000-$29,999	4.3	85.2	1.4	32.6	81.5
$30,000-$39,999	1.9	93.5	0.5	26.3	90.7
$40,000-$49,999	0.8	95.7	0.2	25.0	96.3
$50,000 +	1.1	100.0	0.3	27.3	100.0

Source: EBRI tabulations of the Survey of Income and Program Participation (SIPP), Waves 2 through 5 (U.S. Department of Commerce, Bureau of the Census).

[a] Includes persons age 65 or older with no earnings who at any time during the year reported health insurance coverage from a current or past employer, either as the primary insured or a dependent . The number reported here is probably a somewhat conservative estimate of the true elderly population with retiree health benefits in that (1) people who gave inconsistent responses during the calendar year were assumed to have no retiree health insurance coverage; and (2) workers with employer-related health insurance were assumed to have obtained that coverage from their current employer rather than a past employer.

[b] Figure excludes nonelderly spouses who are covered as dependents and includes elderly covered dependent spouses of nonelderly retirees.

Retiree health insurance plans typically define benefits in terms of covered services; the value of the health insurance benefit, therefore, rises as the cost of covered services rises. Since employer-sponsored retiree health insurance benefits are fully indexed to increases in the cost of health care, the value of benefit relative to the value of pension benefits probably rises over time. This is true with respect to both private employer plans (which rarely automatically index pension benefits) and public employer plans (which typically index pension benefits at the Consumer Price Index, an index that aggregately has risen more slowly than its health care component). Therefore, the value of employer-sponsored retiree health insurance benefits as a share of total real income is likely to be greater for older retirees than for younger retirees, simply because benefits are automatically indexed to health care costs.

Benefit Entitlement

Retiree health insurance benefits have evolved in a largely unregulated environment. Although the Employee Retirement Income Security Act (ERISA) that governs pensions recognizes welfare benefits for workers and retirees, it does not regulate them. The federal tax code also recognizes the deductability of employer trust fund contributions to finance current and projected retiree welfare benefits, but establishes no vesting rules for tax-qualified trusts. As a result, workers who terminate employment prior to retirement commonly retain no right to retiree health insurance benefits from that employer, even if they are vested in the employer's pension plan.

Although no nationally representative data describe employer-plan rules for retiree health insurance benefit eligibility, most retiree health plans that accompany pension plans probably define entitlement to plan benefits within the pension plan vesting standard. That is, most retiree health insurance plans probably restrict eligibility for benefits to full-time permanent employees and base benefit entitlement on years of service. While the service requirement may exceed the vesting period for the employer's pension plan, it is probably not shorter than the pension vesting period.[3] By shortening the vesting period for tax-qualified pension plans to 5 years or less for plan years beginning in 1987 or later, the 1986 Tax Reform Act probably widened the disparity between pension vesting periods and service requirements for retiree health insurance benefits.

Some employers additionally restrict eligibility for retiree health insurance benefits to older employees--for example, employees accruing the required years of service after age 40. By comparison, ERISA's pension participation rules (as amended by the 1984 Retirement Equity Act) require that tax-qualified pension plans include full-time regular workers age 21 or older; for the purpose of vesting, service must be accrued from age 18.

In the absence of federal regulation defining vesting standards for

[3] A survey of post-retirement medical benefit plans conducted by the Washington Business Group on Health (1985) indicated that 51 percent of the responding plans continued health insurance after age 65 to all employees meeting requirements for retiree status. Other eligibility criteria separately reported (but potentially included in other respondents' definition of retiree status) include: (1) years of service (16 percent); (2) pension eligibility (13 percent); age and service requirements (9 percent); and participation in the medical plan prior to retirement (6 percent).

tax-qualified retiree health insurance plans, employers have not generally perceived retiree health insurance as a vested benefit. Commonly, plan sponsors believe that the health insurance benefits provided to retirees can be withdrawn or modified freely.[4] However, a series of court cases have challenged the legality of modifying or terminating health insurance benefits for retirees.

Early court cases challenging employer plan terminations brought under contract law generally interpreted retirees' rights conservatively, requiring employers to provide lifetime benefits to retirees beyond plan termination only if that obligation was clearly assumed in the contract.[5] These cases placed the burden of proof on retirees, relying on both the wording of plan documents and verbal statements made preretirement to employees to determine whether a contract existed between the employer and retirees.

In cases of stated or implied contract with retirees, however, the courts typically defined vesting for retiree health insurance broadly. Generally, the courts have found that the right to ongoing health benefits is implicit in

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[4] Of the 131 plans responding to the Washington Business Group on Health (1985) survey of post-retirement medical benefit plans, 81 percent indicated that they felt they had the right to amend or terminate the retiree plan for current retirees.

[5] Such cases include: Odie v. Ross Gear & Tool Co., 305 F. 2d 143 (6th Cir.) cert. denied, 371 U.S. 941 (1962); UAW v. Robertshaw Controls Co., 405 F. 2d 29 (2nd Cir. 1968); Burgess v. Kawneer Co., Memorandum Opinion No. K77-487 CA8 (W.D. Mich. 1977); Turner v. Teamsters Local 302, 604F. 2d 1219 (9th Cir. 1979); Metal Polishers Local 11 v. Kurz-Kasch, Inc., 538 F. Supp. 368, 110 LRRM 3319 (S.D. Ohio 1982); UAW v. New Castle Foundry, 4EBC2455 (S.D. Ind. 1983); UAW v. Roblin Industries, Inc., 561 F. Supp 288 (W.D. Mich 1983); Policy v. Powell Press Steel Co., Case No. C82-24024, slip op. (N.D. Ohio 1984); Bomhold v. Pabst Brewing Co. (No. 83-1327, July 6, 1984). Also see cases identified in subsequent notes.

retirement status, unless otherwise defined in the labor agreement. As early as 1960, Cantor v. Berkshire Life Insurance Company[6] established that an employer may not withdraw or terminate a retirement program after the employee has complied with all conditions entitling him or her to retirement rights. Furthermore, an employer's contractual obligation to retirees cannot be altered by collective bargaining that fails to represent retiree interests.[7] However, absent a stated or implied contract, the lifetime nature of retiree health insurance benefits may not be presumed or inferred from vesting for other retiree benefits such as pensions.[8]

Recent cases involving retirees' ongoing rights to health insurance benefits have been brought under ERISA rather than contract law (Hansen v. White Farm Equipment Co.[9] and Eardman v. Bethlehem Steel Corp.[10]). However, in Hansen v. White Farm, a subsequent appeals decision returned the determination of employer obligations to contract law.[11] Recent cases

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[6] Cantor v. Berkshire Life Insurance Co., 171 Ohio St. 405, 171 N.E. 2d 518 (1960).

[7] Century Brass Products, Inc. v. UAW, (No. 85-5092, June 30, 1986).

[8] See: UAW v. Houdaiville Industries, Inc., Case No 5-70742 (E.D. Mich.) undated slip op.; UAW v. Cadillac Malleable Iron, 728 F. 2d 807 (6th Cir. 1984); and UAW v. Yard-Man, Inc., 716 F. 2d 1476 (6th Cir. 1983), cert. denied, 104 S. Ct. 100 2 (1984).

[9] In Re White Farm Equipment Co., 42 B.R. 1005, 1015-19 (D.C. 1984), rev'd 788 F.2d 1186 (6th Cir. 1986).

[10] Eardman v. Bethlehem Steel Corp., No. 84-274E, slip op. (W.D. NY Sept. 17, 1984).

[11] The district court decision involving Hansen v. White Farm proposed a "rule of common law" under ERISA, prohibiting employers from invoking any termination clause in plan documents (regardless of how clearly worded or explained) since that right is not otherwise recognized in ERISA's provisions governing pension plans. However, an appeals court subsequently overturned the district court decision (holding that Congress explicitly exempted welfare benefits from ERISA's vesting, participation and funding standards) and returned the question of retirees' ongoing entitlement to benefits to contract law.

challenging employers' right to modify plan benefits for current retirees in an ongoing plan (Eardman v. Bethlehem Steel Corp. and Musto v. American General Corp.[12]--also brought under ERISA) suggest that employers may be unable to modify the scope and provisions of coverage provided to retirees, once they are in receipt of the benefit.[13]

Benefit Funding

Most employers that provide health insurance benefits for their retirees finance the benefits on a current-cost basis. Few employers fund retiree benefits during employees' working careers, although the federal tax code recognizes limited employer trust fund contributions for this purpose.

Estimates of unfunded accrued liability range from just less than $100

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12 Hansen v. White Farm Equipment Co., Nos. 84-3870; 84-3896, slip op. April 21, 1986.

13 In Eardman v. Bethlehem Steel, Bethlehem Steel was constrained from modifying its retiree health insurance plan to parallel the active workers' collectively bargained plan. Per a later appeal settlement, Bethlehem Steel established a substitute "permanent health insurance plan" not subject to later modification or termination. Musto v. American General Corp. (615 F. Supp. 1483, M.D. Tenn. 1985) similarly involved a court injunction restraining American General from modifying the current retirees' plan to parallel that of active workers. The U.S. District Court for the Middle District of Tennessee has asserted that federal common law gives the retirees an enforceable contractual interest in their welfare benefits. The court rejected as "antithetical to ERISA" American General's argument that retirees' medical benefits could be terminated or modified at will as a welfare plan under which no benefits accrued or vested to employees (BNA Pension Reporter, 1985). Musto may not be good law, however, since the district in which it was decided is located in the Sixth Circuit; the Court of Appeals for the Sixth Circuit reversed a similar district court decision regarding the White Farm case.

billion (U.S. Dept. of Labor, 1986) to several times that magnitude. However, even the most conservative estimates suggest that funding accrued liability for retiree health insurance would greatly increase employers' current spending for the benefit. For example, assuming employers amortized an estimated total accrued liability of $98 billion over 20 years, their total cost for retiree health benefits in 1985 would have been 235 percent of their estimated actual plan cost for retirees' coverage--$10.8 billion compared to estimated actual spending of $4.6 billion (U.S. Dept. of Labor, 1986).

Employers' accrual of liability for retiree health insurance benefits is likely to accelerate over the next few decades. The aging of the workforce as the baby boom moves toward retirement may substantially raise corporate liability for retiree health insurance in the absence of plan changes to reduce coverage and/or plan cost. The continued growth of real health care costs, expected to exceed 15 percent of GNP by the turn of the century, will further accelerate liability accrual. Although funding retiree benefits on a current basis may be feasible (even in an inflationary environment) when the workforce is young and growing, it may become financially burdensome as the workforce ages and the number of retirees per active worker rises.

In part, the reluctance of employers to prefund benefits may be attributed to their concern that prefunding could fuel the presumption of vesting among employees and retirees.[14] Employers may also be reluctant to prefund in an era of hostile corporate takeovers, since the fund may be unprotected: because no minimum funding rules apply to retiree health insurance benefits, the fund may be attractive as a cash asset unrelated to liability accrual.

Probably also important in employers' decisions not to prefund is the current, relatively unfavorable tax treatment of employer contributions for retiree health insurance benefits.

Tax Code Restrictions on Retiree Health Plan Funding

Employers' principal options for funding accruing liability for retiree health insurance benefits include contributions to Internal Revenue Code section 501(c)(9) trusts (called voluntary employee benefit associations, or VEBAs) and section 401(h) trusts. Although both are tax-favored, various tax code provisions seriously limit their usefulness for adequately funding retiree health benefits. As a result, employers may find contributions to these trusts unattractive relative to other tax-favored uses of corporate funds.

The federal Deficit Reduction Act of 1984 (DEFRA) sharply restricted the use of VEBAs for the purpose of funding liability for retiree health insurance benefits, prohibiting deductions except as they are justified by current plan costs without adjustment for future inflation. Earnings on funds held in a VEBA for the purpose of financing retiree health benefits are taxable as unrelated business income, and disqualified VEBA distributions (including

[14] Policy v. Powell Pressed Steel Co. 770 F.2d 609 (6th Cir. Aug. 20, 1985) addressed the inverse question. In this case, the Circuit Court rejected the lower court's reasoning that, by not funding retiree health insurance benefits, employers meant them not to be permanent.

asset reversions to the plan sponsor are subject to a 100-percent penalty tax. Furthermore, contributions to a VEBA for retiree health insurance benefits are included in the section 415 limits on pension and profit-sharing plan contributions for highly compensated employees.

Federal tax-code restrictions on employer contributions to 401(h) accounts may similarly discourage employers from using them. Under current law, employer contributions to 401(h) trusts that exceed accrued liability cannot be recaptured by the employer and cannot be used to cover unfunded liabilities in the employer's pension plan.

Due to DEFRA's taxation of VEBA earnings and limits on qualified contributions for rank-and-file workers, employers who use VEBAs may not accumulate sufficient reserves to finance health benefits throughout workers' retirement. By one estimate, currently allowable VEBA contributions to finance the retiree health benefits of a hypothetical 50-year-old worker would produce peak VEBA assets equal to about half that which would have accumulated pre-DEFRA. If this worker retired at age 65, starting plan distributions that year, VEBA assets would be exhausted by age 73. However, under pre-DEFRA law, substantial excess assets may have persisted beyond age 80 (Buck Consultants, 1985). Limits on tax-qualified contributions to 401(h) plans (in practice, not more than 25 percent of annual total contributions to all retiree benefits, including pensions) may also be too low to adequately fund accruing health liabilities, given the other benefits (death and disability) that may be funded through the same plan.

Projected Retiree Health Benefit Recipiency

The estimates presented in this section are based on a microsimulation of pension and retiree health insurance recipiency among future retirees. For the purpose of projecting retiree health recipiency among future retirees, the Pension and Retirement Income Simulation Model (PRISM)[15] was, under contract to the Employee Benefit Research Institute, updated to reflect current law and enhanced to include the simulation of worker qualification for retiree health benefits.

The accuracy of microsimulation projections depends on predictable behavior in response to anticipated events. The unstable legislative and regulatory environment for corporate pension and retiree health insurance benefits is potentially a major source of error in any projection of benefit recipiency.

However, several assumptions built into our simulation of worker qualification for retiree health benefits probably make the projections generally conservative and may also reduce the potential error associated with unanticipated, exogenous events. First, workers may qualify for retiree health insurance benefits only if (1) they retire from a job which offers retiree health benefits and (2) they vest in a defined benefit pension plan

[15] The Pension and Retirement Income Simulation Model (PRISM) was first developed for the 1979 President's Commission on Pension Policy by ICF, Inc. Under contract to EBRI and others, PRISM has been periodically updated for legislative changes affecting pension eligibility and vesting. Kennell and Sheils (1986) provides a full description of this version of PRISM.

while at that job. Our estimates of 1984 survey data indicate that a significant minority of retirees over age 65 with health insurance benefits from a past employer (16 percent) report no pension income. Thus, our projections may understate total recipiency by ignoring recipiency among retirees without pension income or with pension income only from a defined-contribution plans. However, these plans--freestanding (without an accompanying pension plan) or associated with a primary defined contribution plan (and, therefore, potentially offered predominantly by smaller employers)--may be most likely to terminate in response to relatively minor changes in public policy toward retiree health plans.

Other reasons that our estimates of retiree health benefit recipiency may be conservative include the assumption that pension coverage rates show no growth during the simulation period. Since only workers that retire having vested in a defined-benefit pension plan on their last job qualify for retiree health benefits, the assumed growth of defined-benefit pension coverage is critical to the simulated growth of health benefit recipiency among future retirees. Our model assumes that the rate of defined benefit pension coverage within industry groups remains at the level observed in 1983 throughout the simulation period. Changes in both pension and health benefit recipiency among future retirees nevertheless occur as a result of changes in the distribution of employment among industries, the longer tenure of workers in a post-ERISA workforce, and real wage growth (assumed to occur at the Social Security alternative III level: 1 percent).

For employers who maintain parallel retiree health benefit service

requirements and pension vesting rules, the reduction of pension vesting periods to 5 years as required by the 1986 Tax Reform Act could entail a revision of their service requirement for the retiree health plan. Our projections, however, assume that employers retain the pre-1987 ERISA pension vesting standard to qualify retirees for health insurance benefits. For most employers, the assumed service requirement for retiree health plan eligibility is 10 years.[16]

Using the assumptions described above, the projected rate of health insurance recipiency among future retiree cohorts is nearly constant at the approximate level among recent retirees observed in survey data: 24 percent. This estimate provides some validation for the model's near-term projections, and reflects the model's assumption that industry-level defined-benefit pension coverage rates do not change during the 40-year simulation period. The number of workers projected to retire with health benefits, however, rises substantially, reflecting the likely acceleration of accruing employer liability for retiree health benefits as the baby boom moves toward retirement.

Among workers now retiring (age 55-64 in 1979), 24 percent are projected

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[16] The 1986 Tax Reform Act requires faster vesting standards for private-sector single-employer plans: (1) 100-percent vesting after five years of service; or (2) 20-percent vesting after three years of service with an additional 20 percent for each subsequent year, and 100-percent vesting after seven years. The actual effect of this legislation on defined-benefit pension recipiency and, therefore, retiree health benefit recipiency among future retirees is difficult to anticipate. The greater pension plan costs imposed on employers (and ultimately the greater wage deferral required of workers) may reduce pension coverage while raising the percent of covered workers who are vested. This pattern could, in turn, leave unchanged the rate of retiree health benefit recipiency among workers retiring.

to retire with continued health benefits (see Table 2). The projected rate among the youngest cohort (workers age 25-34 in 1979) is approximately the same. However, the projected number of new retirees (and their spouses) receiving retiree health benefits rises more than 46 percent over the 40-year simulation period--raising recipiency and employers' real liability for retiree health benefits by nearly one percent per year.

Alternative Vesting Rules for Retiree Health Insurance Benefits

This section describes the impact of potential alternative vesting rules on retiree health insurance recipiency among future retirees, based on the microsimulation model described earlier. Our projections suggest that the adoption of vesting standards in federal law to parallel current pension vesting standards could substantially increase future benefit recipiency and, consequently, employer liability for retiree health benefits.

Vesting with benefit deferral. One important way that retiree health plans commonly differ from pension plans is in participants' ability to terminate employment preretirement but still retain a right to eventual benefits. In general, workers who terminate employment preretirement retain no vested right to retiree health benefits, even if they are vested in the pension plan.

A retiree health plan vesting rule that would allow benefit deferral could present difficult administrative problems for most plans. Since most plans

TABLE 2

Retirees at Age 67 with Health Insurance Benefits Continued from an Employer Plan: Projections by 1979 Age Cohort

	1979 Age Cohort			
	55-64	45-54	35-44	25-34
	(Persons in millions)			
Retirees with coverage	5.2	5.6	5.6	7.6
Benefits from own plan	3.8	4.0	4.0	5.5
Benefits only as a dependent	1.5	1.6	1.7	2.2
Retirees without coverage	16.9	15.7	16.8	23.6
	(Percents)			
Retirees with coverage	23.7%	26.4%	25.1%	24.5%
Benefits from own plan	17.1	19.0	17.7	17.5
Benefits only as a dependent	6.7	7.5	7.4	7.0
Retirees without coverage	76.3	73.6	74.9	75.5

SOURCE: Preliminary results from the Pension and Retirement Income Simulation Model (PRISM) (The Employee Benefit Research Institute, 1986).

NOTE: Detail may not add to totals because of rounding.

define plan benefits as service coverage rather than cash, coordination of benefits among retirees' multiple plans from different past employers would be an immediate issue. This problem notwithstanding, benefit deferral could significantly raise the ultimate rate of benefit recipiency among retirees.

Assuming a health plan vesting standard equal to the actual defined benefit pension vesting standards used by employers in 1985 (before tax reform), the rate of health benefit recipiency among workers even now retiring (age 55-64 in 1979) might rise modestly, had benefit deferral been in place since January 1985--from 23.7 percent to 24.5 percent (see Table 3). Among younger cohorts with greater opportunity to change jobs before retirement, benefit deferral could substantially raise ultimate benefit recipiency. The projected rate of retiree health insurance recipiency among workers age 25 to 34 in 1979 would rise by 58 percent--from a rate of 24 percent without benefit deferral to 39 percent if all plans allowed benefit deferral. The projected number of new retirees with health insurance from a past employer would increase by nearly 224 percent over 40 years, equal to an average annual increase of more than 2 percent.

Five year vesting without benefit deferral. A five year vesting standard paralleling current pension vesting standards (but without benefit deferral) might raise recipiency rates among future retirees even more. Among younger workers (age 25-34 in 1979), the projected rate of retiree health benefit recipiency would rise nearly 72 percent--from 24 percent (under assumed current service requirements) to 42 percent (with a uniform 5-year service requirement) (see Table 3). In both cases, the projections assume that

TABLE 3

Retirees at Age 67 with Health Insurance Benefits Continued from an Employer Plan under Alternative Vesting Rules: Projections by 1979 Age Cohort

	1979 Age Cohort			
	55-64	45-54	35-44	25-34
	(number in millions)			
Current Practice[a]	5.2	5.6	5.6	7.6
Vested benefit deferral[a]	5.4	6.3	8.1	12.1
Five-year vesting rule[b]	5.4	6.6	8.8	13.1
	(percent of retirees in cohort)			
Current Practice[a]	23.7%	26.4%	25.1%	24.5%
Vested benefit deferral[a]	24.5	29.6	36.2	38.8
Five-year vesting rule[b]	24.5	30.8	39.0	42.1

SOURCE: Preliminary results from the Pension and Retirement Income Simulation Model (Employee Benefit Research Institute, 1986).

[a] Assumes defined-benefit pension vesting standard used in 1985, before tax reform.

[b] Assumes no reduction in pension or retiree health plan coverage in response to shorter mandatory vesting periods.

retirees would receive benefits only if they qualified for immediate benefits upon termination of employment with the plan sponsor. The number of new retirees projected to receive health insurance benefits would rise by 243 percent over the 40-year period. In the near-term (among workers age 55-64 in 1979), either a benefit-deferral rule or a five-year vesting rule might have about the same effect on benefit recipiency.

The vesting standards discussed above parallel the vesting rules ERISA imposes on private pension plans and were selected for the purpose of illustration. The projected effect of either vesting standard on ultimate benefit recipiency--and, therefore, plan cost--is substantial, especially as the baby boom moves toward retirement. The magnitude of the effect suggests that substantial pressure employers may face to terminate or modify plan benefits for future retirees. Employers who may have used their pension vesting standard to establish service requirements for retiree health benefits before 1987 certainly confront strong incentives to establish separate, more stringent rules for health benefit eligibility.

Modification of the retiree health plans provided by employers might take several forms, including (1) reduction in the share of plan cost that employers pay; (2) reduction of the service coverage provided by the plan; or (3) conversion of service benefits to a cash benefit with access to a group insurance plan. In the last case, the cash benefit may (or may not) be gauged to the insurance plan premium. No data indicate that any employer now offers a cash-denominated health benefit distinct from their pension plans, nor is it clear that present tax law would recognize such a benefit. Nevertheless, the

Treasury has shown interest in allowing cash-denominated retiree health benefits (Ross, 1985), an option that may be increasingly attractive to employers as they seek to limit out-year liability for retiree health benefits.

Concluding Remarks

The difficult problems reported by retirees whose health insurance benefits have been terminated (commonly in a corporate merger or bankruptcy reorganization) have dramatically illustrated the importance of these benefits to retirees, both as a source of insurance coverage and as a real income supplement. Among early retirees, not yet Medicare-eligible, a retiree health plan may be the only available source of coverage. The prevalence with which early retirees cite poor health as a reason for retirement suggests that many may be individually uninsurable. For these people, participation in a retiree health plan may have been critical to their decision to retire and may be essential to their continued ability to finance retirement.

The public attention drawn to plan terminations and the subsequent dilemma faced by many retirees has drawn the attention of the Congress. Seeking to fund accruing liabilities that might better safeguard benefits for current and future retirees, some employers have urged Congressional reconsideration of the tax code amendments included in the 1984 Deficit Reduction Act. These amendments severely limited tax-qualified employer contributions to 501(c)(9) accounts to fund retiree health benefits. However, if Congressional reconsideration of the DEFRA restrictions generates new rules for tax

qualification paralleling current pension vesting rules, retiree health plans are likely to confront substantial new costs. Such rules might, at minimum, double ultimate benefit recipiency among future retirees, substantially raising employers' liability accrual for retiree health benefits. The magnitude of these projected changes suggest the pressure that employers may confront to terminate or reorganize their plans, or to reduce benefits for future, if not current, retirees.

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