Demographic and Employment Shifts: Implications for Benefits and Economic Security

- This Issue Brief examines factors affecting the population’s age distribution and composition, such as mortality rates, fertility rates, and immigration. In addition, it examines factors affecting labor force composition, such as immigration, increased labor force participation of women, and retirement trends, and discusses the potential impact of these changes on publicly financed programs: Medicare, Medicaid, Social Security, and federal employee retirement systems. The discussion also highlights the implications of these population and labor force changes on employers, employees, and retirees.

- The elderly population—now 31.8 million, representing 12.6 percent of the population—is projected to experience tremendous growth between 2010 and 2030, when the baby boom generation reaches age 65, rising from 39.7 million, or 13.3 percent of the population, to 69.8 million, or 20.2 percent of the population. Growth in the elderly population has implications for retirement and health care systems.

- Population projections suggest that the traditionally pyramid-shaped work force, with a proportionately greater number of younger workers than older workers, will be replaced with a more even age distribution. Consequently, significant and continued modifications to benefit packages, such as changes in compensation structures in which earnings automatically rise with age, are likely to occur.

- Women’s labor force participation began to accelerate in the mid-1950s, rising to 75 percent among women aged 25–44 in 1991, although there is some indication that this growth may be flattening. With women comprising a greater part of the labor force, employers will be encouraged to develop and implement programs to better accommodate their needs.

- Increased life expectancy, a decreased percentage of entry level workers, changes in Social Security’s normal retirement age from age 65 to age 67, and employer plans to raise the normal age of retirement or provide incentives to delay retirement, could raise the average age of retirement. However, other factors, such as poor health, other sources of retirement income, and individual preferences for retirement, could still dominate the retirement decision.

- The combination of increased average life expectancy guaranteeing more years of retirement to finance and rising dependency ratios increases the future cost of Social Security financing. Medicare financing is also an important policy issue because the program is projected to experience financial difficulties in the short term, resulting from explosive health care costs. In addition, Medicaid expenditures are consuming increasingly shrinking state budget resources—a large portion of which is used to finance nursing home care for a growing elderly population.
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The age distribution in the United States has been undergoing a persistent and fundamental change, mostly attributable to changes in life expectancy and fertility rates. Changes in labor force participation, such as increases in the number of women and a trend toward earlier retirement, have compounded the complexities of the changing age distribution. The combination of these changes has implications for employers, employees, retirees’ economic security, and the savings patterns of individuals preparing to finance their retirement.

Most of the demographic factors examined in this Issue Brief center around the movement of the baby boom generation and the baby bust cohort into the labor market and later into retirement. The baby boom generation is those people born between 1946 and 1964, when birth and fertility rates were abnormally high, and the baby bust cohort is those people born between 1965 and 1976, when birth and fertility rates declined steadily. Because children born today will enter the labor market as the baby boom generation retires, the demographic composition of the future workforce is already determined. It is therefore possible to anticipate some of the changes that will affect employers and public programs in the future. These changes will have an impact on the labor supply and labor compensation, including employee benefits, as well as on publicly financed social insurance and welfare programs. Employer and employee responses to demographic change could lead to a restructuring of labor compensation and employee benefit packages to better accommodate the needs of a changing workforce.

This Issue Brief examines factors affecting the population’s age distribution and composition, such as mortality rates, fertility rates, and immigration. In addition, it examines factors affecting labor force composition, such as immigration, increased labor force participation of women, and the trend toward earlier retirement, and discusses the potential impact of these changes on publicly financed programs: Medicare, Medicaid, Social Security, and federal employee retirement systems. The discussion also highlights the implications of these population and labor force changes on employers, employees, and retirees.

As the baby boom generation ages, it is gradually reshaping the age structure of the U.S. population. In 1991, baby boomers were aged 27–45, and individuals aged 30–34 comprised the largest age cohort, nearly 24 million (chart 1). In 2010, when baby boomers will be aged 46–64, this cohort will account for a population bulge (chart 1). In 2030, when the youngest baby boomers will be 66 years old, the proportion of the population that is aged 65 and over will also grow (chart 1).

Changing Mortality and Fertility Rates

Mortality Rates—Mortality rates and fertility rates affect the population’s age distribution and composition. Mortality rates have declined dramatically since the turn of the century. As a result, between 1900 and 1990, life expectancy at birth increased by 28 years (from age 47 to age 75) and at age 65 by 5 years (from age 77 to age 82) (calculated from chart 2). In 1900, only 25 percent of persons in the United States lived beyond age 65; by 1990, 30 percent lived 80 years or longer. In 1900, median age at death was 55.2 years for men and 58.2 years for women. By
1990, median age at death had increased to 74.7 years for men and to 82.4 years for women. Under the Social Security Administration’s intermediate assumptions, it is estimated that life expectancy for 65-year-olds in 2030 will be 16.7 years for men and 20.6 years for women, up from 15.0 years and 19.1 years, respectively in 1991.

*Fertility Rates—From 1946 to 1957, fertility rates (number of births per 1,000 women) increased dramatically—peaking at 122.9 in 1957. By comparison, the fertility rate was 69.6 in 1991.* (U.S. Department of Health and Human Services, 1992). The boom of children born between 1945 and 1964 added 76 million persons to the population—the equivalent of the entire U.S. population in 1900. The sheer size of this cohort and the resulting change in the population’s age structure have affected the educational system, the labor market, capital formation, the housing market, and the market for all other goods and services.

The return of fertility rates to levels prevailing during most of this century, combined with delayed child-bearing by baby boom women, produced a baby bust between 1965 and 1976. Even though fertility rates have not risen significantly since then, the sheer numbers of baby boom women produced a baby boomlet starting in 1977 (as the number of births gradually rose

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1 Actuaries at the Social Security Administration base projections on various demographic and economic assumptions and present findings under three headings: optimistic (low cost), intermediate (best estimate), and pessimistic (high cost). This discussion will focus on the intermediate and pessimistic assumptions.

2 For an overview, see Russell, 1982.
to baby boom levels)—more than 4 million births a year—since 1989. The baby boomlet peaked in 1990, and the annual number of births is trending downward again. Chart 3 traces total fertility rates per 1,000 women (an estimate of the number of children a woman will have during her entire reproductive cycle) from 1940 to 1991.

Aging Population

The U.S. population is aging. The number of persons aged 65 and over is growing faster than the number of persons under aged 65. In fact, the fastest growing group of people are those aged 85 and over. While both the absolute number and the percentage of the population aged 65 and over have been increasing, the percentage of the population under age 18 has been declining, falling from 40.4 percent in 1900 to 25.8 percent in 1991. In 1900, there were 3.1 million people aged 65 and over (elderly), representing 4.1 percent of the population; by 1980, 11.3 percent (or 25.5 million) were elderly. In 1991, elderly Americans numbered 31.8 million and represented 12.6 percent of the population.

The growth in the number of elderly will precede the retirement of the baby boomers. Although retirement of the baby boom generation is likely to affect retirement income and health care programs, the process will be relatively gradual, evolving over a 25-year period. Under U.S. Census Bureau middle series projections, by 2010, when the oldest baby boomers are nearing age 65, the elderly population is projected to rise to 39.7 million—13.3 percent of the total U.S. population (table 1). Based on highest series projections, the number of individuals aged 65 and over in 2010 will be 41.8 million (13.1 percent); based on the high life expectancy series, it will be 41.2 million (13.7 percent) (table 1). In 2020, when less than one-half of the baby boom generation will have reached age 65, according to the Census Bureau middle series projections, the number of elderly persons will have risen to 53.6 million—an increase of 21.7 million from its current size—and will represent 16.6 percent of the U.S. population. Under the highest series projection there will be 57.9 million (16.1 percent), and under the high life expectancy projection 56.6 million (17.2 percent) (table 1).

When all of the baby boom generation has reached age 65—in 2030—the Census Bureau projects that, under middle series projections, there will be 69.8 million elderly persons, representing 20.2 percent of the population. Under the highest series projection there will be 77.7 million (19.2 percent), and under the high life expectancy projection there will be 76.4 million (18.6 percent).

3 The U.S. Bureau of the Census projects future population growth using 10 alternative projections that are based on projected degrees of change in fertility, life expectancy, and net immigration, assuming low growth, middle growth, and high growth. The middle series assumes middle level growth in all three components. The highest series assumes high level growth in all three components. The high life expectancy series assumes middle level growth in fertility, high level growth in life expectancy, and middle level growth in net immigration. The future size of the elderly population is projected to be smaller under the high life expectancy series projection than under the highest series projection. However, high life expectancy series projections indicate that the elderly will account for a greater percentage of the total population than under the highest series projection because the total population is also projected to be smaller. Other Census Bureau projection series include lowest, low fertility, high fertility, low life expectancy, low net immigration, high net immigration, and zero net immigration.
Table 1  
Projections of the Elderly Population and the Median Age of the Total Population, 1995–2050,  
Based on Alternative Census Bureau Assumptionsa

<table>
<thead>
<tr>
<th>Year</th>
<th>Middle Series Population</th>
<th>Highest Series Population</th>
<th>High Life Expectancy Series Population</th>
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<tbody>
<tr>
<td></td>
<td>(millions)</td>
<td>(millions)</td>
<td>(millions)</td>
</tr>
<tr>
<td></td>
<td>65 and over</td>
<td>75 and over</td>
<td>85 and over</td>
</tr>
<tr>
<td>1995</td>
<td>33.6</td>
<td>14.8</td>
<td>3.6</td>
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<td>2000</td>
<td>34.9</td>
<td>16.6</td>
<td>4.3</td>
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<tr>
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<td>45.9</td>
<td>19.4</td>
<td>6.2</td>
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<tr>
<td>2020</td>
<td>53.6</td>
<td>21.9</td>
<td>6.5</td>
</tr>
<tr>
<td>2025</td>
<td>62.4</td>
<td>26.6</td>
<td>7.0</td>
</tr>
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<td>2030</td>
<td>69.8</td>
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<tr>
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<td>76.7</td>
<td>43.4</td>
<td>15.8</td>
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<tr>
<td>2050</td>
<td>78.9</td>
<td>43.7</td>
<td>17.7</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Year</th>
<th>Middle Series (percentage of total population)</th>
<th>Highest Series (percentage of total population)</th>
<th>High Life Expectancy Series (percentage of total population)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>65 and over</td>
<td>75 and over</td>
<td>85 and over</td>
</tr>
<tr>
<td>1995</td>
<td>12.8%</td>
<td>12.7%</td>
<td>12.7%</td>
</tr>
<tr>
<td>2000</td>
<td>12.7%</td>
<td>12.7%</td>
<td>12.7%</td>
</tr>
<tr>
<td>2005</td>
<td>13.3%</td>
<td>14.8%</td>
<td>16.6%</td>
</tr>
<tr>
<td>2010</td>
<td>14.8%</td>
<td>16.6%</td>
<td>18.7%</td>
</tr>
<tr>
<td>2015</td>
<td>18.7%</td>
<td>20.2%</td>
<td>20.8%</td>
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<tr>
<td>2020</td>
<td>20.2%</td>
<td>20.8%</td>
<td>20.7%</td>
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<td>2025</td>
<td>20.8%</td>
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<tr>
<td>2050</td>
<td>20.7%</td>
<td>20.5%</td>
<td>20.6%</td>
</tr>
</tbody>
</table>


aThe U.S. Bureau of the Census projects future population growth using 10 alternative projections that are based on projected degrees of change in fertility, life expectancy, and net immigration, assuming low growth, middle growth, and high growth. The middle series assumes middle level growth in all three components. The highest series assumes high level growth in all three components. The high life expectancy series assumes middle level growth in fertility, high level growth in life expectancy, and middle level growth in net immigration. The future size of the elderly population is projected to be smaller under the high life expectancy series projection than under the highest series projection. However, high life expectancy series projections indicate that the elderly will account for a greater percentage of the total population than under the highest series projection because the total population is also projected to be smaller. Other Census Bureau projection series include: lowest, low fertility, high fertility, low life expectancy, low net immigration, high net immigration, and zero net immigration.

life expectancy projection it would be 75.5 (21.3 percent) (table 1).  
There will be a concurrent increase in age of the baby boom generation and the median age of the U.S. population. Under middle series projections, the median age will rise from 34.3 in 1995 to 39.0 in 2030. Under the highest series, the median age is projected to rise to 36.6 in 2030, and under the high life expectancy series it is projected to rise to 39.8 (table 1). Chart 4 depicts the growth of the population aged 65 and over under various Census Bureau projection series.
Chart 4


Chart 5


aData for 1940 and 1941 are for individuals aged 25–54.
Diversifying Population

In addition to an increase in the median age of the U.S. population, the population is also becoming more diverse. A substantial portion of future population growth is likely to consist of new immigrants. Data from the U.S. Immigration and Naturalization Service show that an average of 570,000 individuals per year immigrated to the United States between 1979 and 1988; immigration averaged 657,000 per year between 1989 and 1991.

Asian and Mexican immigrants account for a large portion of these increases. Since the 1950s, the number of immigrants from Europe to the United States has fallen, from 59.3 percent of total immigrants between 1951 and 1960 to 9.2 percent between 1981 and 1991, while the number of Asian immigrants has risen from 6.2 percent to 34.7 percent during the same period. The number of immigrants from Mexico has increased from 12.7 percent between 1951 and 1960 to 28.4 percent between 1981 and 1991 (U.S. Immigration and Naturalization Service, 1992; U.S. Department of Commerce, 1992b; and U.S. Department of Commerce, 1985).

Female Labor Force Participation

Another labor force trend is the increased labor force participation of women. Women’s participation, which grew at a small, relatively constant rate since before the turn of the century, began to accelerate in the mid-1950s. In 1942, the labor force participation rate among women aged 25–44 was 34.0 percent; in 1991, it was 75.0 percent (chart 5).

The largest source of growth in the labor force participation of women has been among married women, rising from 31.9 percent in 1960 to 58.5 percent in 1991. Among married women, the group aged 25–34 experienced the greatest increase in labor force participation, rising 41.3 percentage points between 1960 and 1991, compared with a 33.3 percentage point increase among married women aged 20–24. During this period, the labor force participation rate

Aging Labor Force

The age distribution of the U.S. labor force has traditionally reflected the pyramid shape of the population, with a proportionately greater number of younger workers than older workers. Census data suggest that this structure will change to one in which there is approximately the same number of individuals in the labor force from each age group. Labor force growth in the group aged 18–21 has been flat since it reached a peak of 17.4 million in 1980. Under the Census Bureau middle series projection, the size of this group will decline from 15.2 million in 1991 to 13.8 million in 1994. It is then projected to increase to 15.7 million in 2000 and to 17.8 million in 2010 (U.S. Department of Commerce, 1992c). Although the number of young workers is projected to rise, they will still represent a proportionately smaller share of the labor force. Middle-aged and older workers will account for a larger proportion of the labor force.
among single women grew the most among the group aged 16–19 (20.1 percentage points); the rate fell for single women in all other age groups (i.e., those aged 20–24, 25–34, 35–44, and 65 and over). Among separated, divorced, or widowed women, the labor force participation rate grew the most among the group aged 35–44 (12.1 percentage points) (U.S. Department of Commerce, 1992b). Among married women, the largest increase in the labor force participation rate has been among mothers. In 1960, 18.6 percent of married women with a husband present and children under age 6 were in the labor force; by 1991, 59.9 percent of these women were in the labor force (U.S. Department of Commerce, 1992b). In 1991, 66.8 percent of married women with a husband present and with children under age 18 were in the workforce (U.S. Department of Commerce, 1992a).

Early Retirement Trends

A third labor force trend is the tendency for workers to opt for earlier retirement. While the labor force participation of women has been increasing, successive cohorts of workers have been retiring earlier (Ruhm, 1991). In 1970, 83 percent of all men aged 55–64 were in the labor force; this rate dropped to 66.9 percent in 1991. The participation rate for women aged 55–64 grew during this period—from 43.0 percent to 45.3 percent. Relatively few persons aged 65 and over were labor force participants in 1991—only 15.8 percent of men and 8.6 percent of women. This compares with 26.8 percent of men and 9.7 percent of women in 1970 (U.S. Department of Commerce, 1992b).

It is impossible to predict whether the early retirement trend will continue. Some analysts contend that, given the changes in Social Security’s normal retirement age from age 65 to age 67 (scheduled to rise incrementally through 2027), the average age of retirement will increase, but most feel that the impact of this change will be minimal. If employers, too, begin to raise the normal retirement age or provide incentives to delay retirement, the average age of retirement could increase. But other factors, such as poor health, other sources of retirement income, and individual preferences for retirement, could dominate the decision to retire.6

Immigrants and the Labor Force

An increased representation of immigrants in the labor force is another labor force trend. U.S. Department of Labor (DOL) estimates of the labor force to 2005 show that 4.8 percent of the labor force will be “Asian and Other,” and 11.1 percent will be of Hispanic origin (table 2). The greatest annual growth in the labor force between 1992 and 2005 will be among workers of Hispanic origin (4.0 percent), followed by workers who are “Asian and Other” (3.5 percent) (table 2). This compares with the overall growth in the labor force between 1992 and 2005 of 1.3 percent (table 2).

Need for Skilled Workers

Another factor that will affect the labor force and employers is the growing need for a pool of employees with specialized training and skills. The average years of formal education has been growing. In 1940, 12.0 percent of the U.S. population completed at least four years of high school, compared with 38.6 percent in 1991. Over the same time period, the percentage of the population completing four or more years of college rose from 3.7 percent to 21.4 percent (U.S. Department of Commerce, 1975; U.S. Department of Commerce, 1992b). Despite this trend, there is growing concern among

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policymakers and employers that the quality of education received is inadequately preparing individuals for the increasing proportion of positions that require technological skills. In 1991, nearly 4 million individuals aged 14–24 were high school dropouts (U.S. Bureau of the Census, 1992b). Employee Benefit Research Institute (EBRI) tabulations of U.S. Bureau of Economic Analysis data show that between 1981 and 1991, the number of manufacturing jobs fell from 19.7 million to 18.0 million, or from 22.5 percent of total positions to 17.4 percent. There has been a concurrent increase in the number of positions requiring specialized training and skills. The need for a workforce with specialized training and skills is particularly important at a time when immigrant populations—who generally have less specialized training—are the fastest growing sector of the workforce.

Impact on Employers

Firms that have traditionally relied on new entrants into the workforce (fast food restaurants and grocery stores) have already experienced rising labor costs as they compete for workers under age 24—the baby bust cohort (Bernstein, et al., 1987). DOL projections indicate that between 1992 and 2005 the labor force will grow at an average rate of 1.3 percent per year (table 2)—less than one-half the average growth rate throughout the 1970s. However, the rapid rise in labor force growth in the 1970s was abnormal, and the slower growth that is currently occurring is more in accordance with historical trends. During the 1970s, the baby boom reached working age at the same time that women’s labor force participation rates rose steeply. Between 1992 and 2005 the number of workers aged 16–24 in the labor force is projected to increase by 17.6 percent, from 20.4 million to 24.0 million (table 2).

The rise in the average age of the labor force has implications for compensation and benefits packages. The labor force has traditionally been pyramid-shaped, with fewer older workers relative to middle-aged and younger workers, but this is changing. Consequently, compensation structures in which earnings automatically rise with age will become less appropriate. A more even population distribution may lead employers to offer benefit packages attractive to a broad range of employees. In the area of retirement benefits, a combination of defined benefit and defined contribution plans may be increasingly used to provide a base level of retirement benefits that will appeal to older workers and provide a more visible accumulation of benefits in a defined contribution account that will appeal to younger workers (Silverman, forthcoming).

### Table 2

<table>
<thead>
<tr>
<th>Group</th>
<th>Level (in thousands)</th>
<th>Percentage Change</th>
<th>Percentage Distribution</th>
<th>Average Annual Growth Rate</th>
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<td></td>
<td></td>
<td>1992</td>
<td>Projected, 2005</td>
<td></td>
</tr>
<tr>
<td>Total, 16 and over</td>
<td>126,982</td>
<td>150,732</td>
<td>18.7%</td>
<td>100.0%</td>
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<td>Gender</td>
<td></td>
<td></td>
<td></td>
<td>100.0%</td>
</tr>
<tr>
<td>men, 16 and over</td>
<td>69,184</td>
<td>79,338</td>
<td>14.7%</td>
<td>54.5%</td>
</tr>
<tr>
<td>women, 16 and over</td>
<td>57,798</td>
<td>71,394</td>
<td>23.5%</td>
<td>45.5%</td>
</tr>
<tr>
<td>Age</td>
<td></td>
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</tr>
<tr>
<td>16–24</td>
<td>20,454</td>
<td>24,048</td>
<td>17.6%</td>
<td>16.1%</td>
</tr>
<tr>
<td>25–54</td>
<td>91,097</td>
<td>104,562</td>
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<td>71.7%</td>
</tr>
<tr>
<td>55 and over</td>
<td>15,432</td>
<td>22,122</td>
<td>43.4%</td>
<td>12.2%</td>
</tr>
<tr>
<td>Race</td>
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<td></td>
</tr>
<tr>
<td>white, 16 and over</td>
<td>108,526</td>
<td>125,785</td>
<td>15.9%</td>
<td>85.5%</td>
</tr>
<tr>
<td>black, 16 and over</td>
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<td>17,766</td>
<td>27.9%</td>
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<td>Asian and other, a</td>
<td>4,565</td>
<td>7,181</td>
<td>57.3%</td>
<td>3.6%</td>
</tr>
<tr>
<td>Hispanic origin, b</td>
<td>10,131</td>
<td>16,790</td>
<td>65.7%</td>
<td>8.0%</td>
</tr>
</tbody>
</table>


a The “Asian and other” group includes Asians, American Indians, Alaskan natives, and Pacific Islanders.

b Persons of Hispanic origin may be of any race.
Implications of Women's Labor Force Participation

Child Care—As more women with children continue entering the labor force, employers will be encouraged to develop and implement programs to accommodate employees' changing needs and offset productivity losses that can result from time lost from work.\(^7\) In 1988, among the nearly 19 million employed women with children under 15 years of age, 4.4 percent reported that they lost time from work in the previous month because of a failure in their child care arrangement.\(^8\) (U.S. Department of Commerce 1992a). The amount of lost time was least when the child was aged 12 and over and greatest when the child was under 2.

Employers have begun offering a restructured work week, termed flextime, to help employees adjust their schedules for child care and work responsibilities. Flextime plans allow employees to vary the times their workdays begin and end. Variations can occur in the number of hours worked each day or in the total number of hours worked each week or pay period.

Another restructured job arrangement offered by some employers is job sharing. Job sharing refers to a structured arrangement that merges the duties of two or more (part-time) workers into one job. Employees involved in the sharing are interchangeable. This arrangement enables two or more workers to balance work and family responsibilities.

An increase in the number of mothers in the work force also encourages employers to offer additional benefits such as child care, adoption assistance, and parental leave. Because members of the baby boom cohort are still in their childbearing years, receiving these benefits is likely to remain an important policy issue.

Elder Care—Women have been the traditional caregivers for the frail elderly. As more women enter the labor force, employers will need to address the needs of employees with caregiving responsibilities. As more workers help to care for their parents or other relatives, productivity on the job is likely to be affected. When employees use sick leave, come in late, leave early, extend their lunch hours, or need to make personal telephone calls because they are trying to juggle two or three roles at once—employee, parent, and caretaker or care coordinator—their work is likely to suffer.

Productivity can also be impaired when an employee refuses to accept a promotion, reduces hours, or quits to care for a chronically ill dependent. Survey results indicate that a substantial percentage of the work force report that their work is affected in some way by long-term caregiving responsibilities. In a 1993 survey conducted by EBRI and the Gallup Organization Inc., 22 percent of employed respondents indicated that a member of their family had received some kind of long-term care during the last five years (Employee Benefit Research Institute/The Gallup Organization, Inc., 1993). Of this 22 percent, 61 percent said that they or someone in their family had provided that care. A 1989 EBRI/Gallup poll found that 31 percent of respondents in families that had provided long-term care claimed that a family caregiver had refused a promotion, reduced working hours, retired early, or stopped working specifically because of long-term caregiving responsibilities (Employee Benefit Research Institute/The Gallup

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\(^8\) The interviewer was instructed to include lost time from work resulting from any disruption that resulted in an alternative child care arrangement. For example, the provider may have been ill or have had an emergency or a prior commitment. Disruption caused when the child's illness prevented care by the usual provider may also have been included.
Organization, Inc., 1989). In addition, in the 1993
survey, 50 percent of all respondents said if they were to
need long-term care assistance, they would expect that
care to be provided by a family member in their or a
family member’s home. A 1989 survey conducted by
Fortune Magazine and John Hancock Financial had
similar findings (Fortune Magazine and John Hancock
Financial Services, 1989). Results indicate that
38 percent of respondents with long-term caregiving
responsibilities needed to take unscheduled leave, and
37 percent reported leaving work early or arriving late.
An estimated 30 percent of female respondents reported
quitting their jobs in order to provide long-term care.

Recognizing that caregiving among their employ-
eses may lower productivity by affecting emotional and
physical well-being, employers or unions may consider
restructuring employee benefits programs. Information
and referral services, counseling, time off to care for a
dependent, and alternative delivery or financing options
such as adult day care are ways employers have begun to
address the problems employees experience as
caregivers.

Employers have also begun offering long-term
care insurance for active workers, retirees, and workers’
parents. The Health Insurance Association of America
(HIAA) reports that by year-end 1991, 288 employers
were sponsoring a long-term care insurance plan, up
from just 2 employers in 1987. Among these employers,
153 had begun sponsoring their plans in 1991). As of
December 1991, 135 companies were selling long-term
care insurance policies, up from 75 in 1987 (Health
Insurance Association of America, 1993).

Implications of Earlier Retirement

The tendency to retire earlier has increased the
significance of retirement to the individual and
society, especially in terms of the cost of support-
ing the retired population. This trend also has
implications for employers. Employers may
choose to raise the normal retirement age to
encourage extended labor force attachment. They
may also choose to assess the current structure of
their retiree health benefit plans (see section on
Retiree Medical Benefits).

Implications of Need for Skilled Workers

In the future, employers will increasingly be
searching for prospective employees with special-
ized skills and training. According to the Department
of Labor, jobs that do not require post-secondary educa-
tion or training, such as manual labor or various service
industry jobs, will at best grow slowly, and may even
decline. At the same time, the number of jobs requiring
more technical skills will expand (Kutscher, 1991). Skills
training designed to help employees adapt to ever-
changing technology will be essential in confronting the
gap between the skill levels of work force entrants and
the demands of available jobs (Ferman et. al, 1990).

Retiree Medical Benefits

Another area in which demographic changes will affect
employers is retiree medical benefits. According to
EBRI tabulations of the March 1992 Current
Population Survey, 10.1 million, or 33.1 percent, of
the 30.6 million elderly received employer-spon-
ored health insurance coverage in 1991;
10.6 million, or 34.7 percent of the elderly, received
other private health insurance coverage in 1991.9
Forty-five percent of active full-time health plan partici-
pants in medium and large establishments were in plans
with a provision for postretirement medical benefits in
199110 (U.S. Department of Labor, 1993). Among those
with this coverage, 4 percent participated in plans that

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9 Other private health insurance coverage is defined as individual or group
coverage not offered through an individual’s current or former employer or
union. This category consists primarily of individually purchased private
insurance.

10 This includes plans financed wholly by employers and plans financed
jointly by employers and employees.
covered only retirees under age 65; 2 percent participated in plans that covered only retirees aged 65 and over; and 38 percent participated in plans that covered all retirees (U.S. Department of Labor, 1993).

The issue of financing retiree health coverage became a focus of policy debate when the Financial Accounting Standards Board (FASB) issued Statement No. 106 (FAS 106) requiring companies with more than 500 retiree plan participants to account for retiree benefits as a liability on their annual balance sheets, effective for fiscal years after December 15, 1992. In other words, employers are required to record retiree benefit liability accruals as an expense against earnings from the date employees are hired until they become eligible for benefits. Each employer must estimate in current dollars the expected postretirement benefits obligation for each employee. The number that represents the liability for retiree benefits that the company has accrued during the previous years—called the accumulated postretirement benefit obligation (APBO)—less plan assets is called the transition obligation. This number is nearly always higher than the company’s current costs for retiree benefits because it includes future cost considerations for active employees or current retirees not included in current costs, and there are seldom any dedicated assets. In response to FAS 106 and escalating health care costs, some employers have already begun to restructure retiree medical plans for current and future retirees.

Findings from an A. Foster Higgins survey show that the number of retiree health plans is falling. However, most surveyed employers are responding to FAS 106 by modifying, not eliminating, their retiree health care plans. Study findings also show that, in 1991, 52 percent of surveyed employers offered retiree health coverage to retirees under 65, and 49 percent offered coverage to retirees aged 65 and over. Between 1990 and 1991, the percentage of surveyed employers requiring retirees to pay the entire premium for family coverage rose from 21 percent to 25 percent among retirees under age 65 and from 19 percent to 21 percent among retirees aged 65 and over (A. Foster Higgins & Co., 1992).

The magnitude of the unfunded liability is directly related to future health care costs and the number of retirees. Financing on a current-cost basis becomes more or less expensive on a per participant basis, depending on the company’s relative growth. For instance, the current cost of postretirement medical benefits per active employee will be relatively smaller if health care costs do not increase and the ratio of active workers to retirees increases. However, if this ratio decreases—which is the situation for most employers—the cost of the postretirement plan per employee will increase. Rising health care costs further accelerate plan costs.

Longer life expectancies will increase the cost of retiree health insurance plans. The propensity of workers to retire earlier also raises plan costs, as the funding period is shortened and the benefit period is lengthened. Although the Census Bureau’s middle series projections currently estimate that the elderly population will number 78.9 million by 2050, alternative census projections point to even greater growth among this population. The number of persons aged 65 and over is projected to rise to 97.9 million under the highest series projection and to 91.4 million under the high life expectancy projection.
The Medicare, Medicaid, and Social Security programs and federal worker retirement systems—civil service and military retirement programs—are important sources of retirement income security for the elderly. The financial health of these programs is likely to affect employers, employees, and retirees. Medicare provides protection against the high cost of acute and ambulatory health care. Medicaid, the means-tested health care program for poor persons in specific categories, pays for health care for low-income individuals and elderly and disabled persons whose Social Security income is sufficiently low that they receive Supplemental Security Income and many whose health care costs exceed their income. Workers who qualify for Social Security can obtain benefits at age 65 or at an actuarially reduced rate beginning at age 62. In the event of major health care reform, it is likely that the Medicare and Medicaid programs will be restructured to fit into a new health care system. Therefore, cost projections for these two programs should be considered in this light.

Medicare

Medicare, which is generally available to Social Security recipients aged 65 and over, pays for acute health care expenditures (hospital care and skilled nursing care) under Part A and ambulatory physician services under the optional Part B program. Part A of Medicare is financed from current payroll taxes paid by employers and employees into the Hospital Insurance (HI) trust fund essentially on a pay-as-you-go basis. That is, current workers finance current benefits. One-quarter of Medicare Part B is financed through the premiums paid by beneficiaries, and three-quarters is financed from general revenues. In 1992, 35.4 million persons were Medicare beneficiaries, and total expenditures for the program were $119.0 billion (table 3).

Medicare does not pay for many services needed by chronically disabled elderly persons. Most of this care is provided informally by family members or is paid for directly out-of-pocket, resulting in expenses that can easily exceed a family’s resources. Medicaid has become an important source of coverage for these services and especially for nursing home care. EBRI tabulations of the March 1992 CPS show that 9.5 percent of the elderly were covered by Medicaid in 1991. Personal health care expenditures for nursing home care totaled $59.9 billion in 1991. The largest share came from Medicaid (47.4 percent), followed by out-of-pocket payments (43.1 percent), Medicare (4.4 percent), and private insurance (1.1 percent).

Technological advances in medicine, coupled with a growing number and proportion of persons aged 65 and over, are likely to increase Medicare program costs per beneficiary. Expenditures per Medicare enrollee are projected to rise—in nominal terms—from $3,361 in 1992 to $5,937 in 1998 (table 3). Consequently, the financial problems experienced by the Social Security program in the early 1980s are expected to arise in the Medicare program within the next few years. The HI trust fund ratio peaked at 136 percent in 1992. The intermediate assumptions indicate that the ratio will decline steadily to 42 percent in 1998, and the trust fund will be depleted in 1999. Under pessimistic assumptions, the trust fund ratio is projected to fall to 53 percent in 1997, with depletion of the trust fund projected to occur in 1998.

11 This age is scheduled to rise incrementally in the next century to 67.

12 Assets at the beginning of the year expressed as a percentage of the outgo during the year.
Excluding interest earnings, the HI trust fund is projected to begin showing a negative balance in 1993 under all three sets of assumptions. Estimates included in the fiscal year 1994 Clinton administration budget show that total outlays from the program rose to $119.0 billion in 1992 and are projected to rise to $233.1 billion in 1998 (Table 3). Proposals to reduce the age limit for Medicare from 65 to 60, offered during the 102nd Congress, would further increase these costs. Without changes to the current system, the HI trust fund will be insolvent about one decade before the oldest baby boomers become eligible to receive benefits—the beginning of rapid expansion in the Medicare-eligible population.

Medicaid

The Medicaid program is administered by the states, which are entitled to federal funding of between 50 percent and 83 percent of their expenses for medical services provided in accordance with federal Medicaid guidelines. States have a great deal of latitude in establishing specific eligibility rules and provider reimbursement methods and rates and in determining the scope of covered services. They are also free to cover groups of persons and services not eligible for federal matching funds. Consequently, each state’s Medicaid program is different. Individuals eligible in one state might not be eligible in another. Medicaid eligibility is not conferred automatically on persons whose income falls below federal poverty standards. In fact, EBRI tabulations of the March 1992 CPS show that 68.6 percent of elderly individuals with family incomes below the poverty level were not covered by Medicaid in 1991.13

Medicaid eligibility is not conferred automatically on persons whose income falls below federal poverty standards. In fact, EBRI tabulations of the March 1992 CPS show that 68.6 percent of elderly individuals with family incomes below the poverty level were not covered by Medicaid in 1991.13

One of Medicaid’s major expenses is financing nursing home care. Thus, projected growth in the population most likely to need nursing home care services will directly affect program expenditures. Over the next 25 years—before most of the baby boom is aged 65—the demand for institutional long-term care services is projected to increase 73 percent, and the demand for noninstitutional care is projected to increase 66 percent over the amount of care now provided (Manton and Liu, 1984). Shortages of services in light of this growing demand will continue to put upward pressures on the cost of these services.14

Table 3

<table>
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<tr>
<th>Year</th>
<th>Number (in thousands of enrollees)</th>
<th>Outlays ($ billions)</th>
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13 Employee Benefit Research Institute tabulations.

14 The average cost of a year’s stay in a nursing home has risen steadily from $13,000 in 1980 to $31,000 in 1990 (Anzick, 1992).
Table 4

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a As of December 31.
b Employee Benefit Research Institute tabulations.
c Actual data.

by the Health Care Financing Administration (HCFA) indicate that Medicaid expenditures on personal health care will rise from $59.2 billion in 1989 to $234.9 billion in 2000, with hospital care expenditures accounting for 38.7 percent in 1989 and 42.4 percent in 2000. Nursing home expenditures are projected to rise from $20.6 billion in 1989 to $59.9 billion in 2000. However, nursing home care expenditures as a percentage of Medicaid spending on personal health care are projected to fall from 34.8 percent in 1989 to 25.5 percent in 2000. Recent estimates through 1998 included in the fiscal year 1994 Clinton administration budget show that Medicaid expenditures are projected to rise from $67.8 billion in 1992 to $150.2 billion in 1998 (U.S. Office of Management and Budget, 1993).

States have tried to control their Medicaid costs in large part by reducing access to health care services. Access can be denied either by lowering income or asset eligibility standards for potential recipients or by restricting the availability of services. Availability of long-term care services can either be restricted directly by denying approval for the construction or license of the service or by providing a reimbursement rate that does not allow for a normal or market rate of return.

Unless there are substantial improvements in the elderly’s health status, increased numbers of very old persons are likely to demand services and bid up the cost for long-term care services, beginning long before the baby boom generation becomes elderly. In the absence of major reform of the Medicaid program, higher costs for these services are likely to increase Medicaid expenditures for those currently eligible for this program and also to increase the possibility of more persons becoming impoverished and joining the program. State legislators may find themselves in a situation in which access to long-term care requires either assigning a larger portion of the state’s budget to the Medicaid program or increasing the state’s overall budget by raising taxes. Long-term care financing may also be included in national health care reform.
Social Security

In 1975, Social Security benefit payments were greater than revenues received from payroll taxes. Reserves established for contingencies under the program were eroding, and it appeared that the program would be bankrupt in the early 1980s. Despite legislation enacted in 1977 to secure the trust fund for 75 years, other measures were soon needed. The 1981 Amendments to the Social Security Act permitted, as an interim measure, interfund borrowing from the Disability Insurance fund and the HI trust fund. The 1983 Amendments to the Social Security Act raised taxes and cut benefits, which staved off immediate bankruptcy. According to intermediate assumptions, the combined Old-Age, Survivors, and Disability Insurance (OASDI) trust fund ratio (income to disbursements) will peak at 298 percent (enough to cover expenses for nearly three years) in 2015 and fall to 33 percent in 2035, leading to exhaustion of the trust fund in 2036. Under pessimistic assumptions, the combined OASDI trust fund is projected to be exhausted in 2017. A growing portion of the growth in the Social Security trust funds in the 21st century will be derived from interest earnings on special issue Treasury securities. Excluding interest income to the combined OASDI trust fund, the funds are projected to show a negative balance in 2020 under intermediate assumptions and in 1997 under pessimistic assumptions.

Longer periods of retirement and more retirees are likely to keep a persistent upward pressure on average Social Security program costs per beneficiary. According to Social Security intermediate assumptions, the average annual cost per beneficiary will increase—in nominal terms—

According to Social Security intermediate assumptions, the average annual cost per beneficiary will increase—in nominal terms—51.7 percent over the next 10 years, from $7,153 in 1993 to $10,849 in 2003. Based on pessimistic assumptions, it is projected to rise from $7,161 to $12,254—an increase of 71.1 percent (table 4). Under current law, the OASDI payroll tax rate is not scheduled to rise above the current combined employer-employee contribution of 12.4 percent. However, according to pessimistic assumptions, the cost rate—the ratio of program costs to the taxable payroll for the year—is projected to rise from 11.7 percent of taxable payroll in 1993 to 19.8 percent in 2030.

Federal Employee Systems

The civil service and military retirement programs represent a sizable liability to the federal government, which will grow steadily with growth in the aged population. The Civil Service Retirement System (CSRS) covers those hired as federal employees prior to 1984, and the Federal Employee Retirement System (FERS) covers those hired after 1984. These two programs had an unfunded liability of $864 billion in 1991, compared with $831 billion in 1990 (Salisbury, 1993).

Budgeted outlays (inclusive of interest paid on bonds held as assets by the plans) for these employee pensions grew from $21 billion in 1975 to $73 billion in 1991 and are projected to grow to $92 billion in 1997 (Salisbury, 1993).

The Military Retirement System (MRS) presents a future financial challenge as well. MRS had an unfunded liability of $701.6 billion at the end of fiscal year 1991, compared with $864 billion in 1991, compared with $831 billion in 1990 (Salisbury, 1993).


16 The addition of interest income is projected to increase income to the trust funds from a projected 12.64 percent of taxable payroll in 1993 to 13.12 percent of payroll in 2030, according to intermediate assumptions.

17 Civil Service Retirement System participants were given the option of switching to the Federal Employee Retirement System in 1984.
Employers and employees participate in the financing of Medicare, Medicaid, and Social Security programs and federal retirement systems. Payroll taxes from employers and employees finance current Social Security recipients and Part A of Medicare. Federal income taxes finance three-quarters of Part B of Medicare and the federal portion of Medicaid expenditures. The state portion of Medicaid funding comes from general revenues, mostly property, sales, and income taxes. Therefore, the ratio of beneficiaries to active workers can directly affect the cost per worker or taxpayer. Unless the average age of retirement increases, public programs financed by active workers on a pay-as-you-go basis will continually require either greater contributions from employers and active employees, contributions from beneficiaries, or a combination of both.

The potential consequences of a growing number of elderly persons on the financing of pay-as-you go programs can be seen in the ratio of persons who are not of prime working age to those of prime working age (age 18 to 64). Over the next 30 years, the proportion of dependents (children under age 18 and adults aged 65 and over) to the number of people of primary working age is expected to decrease gradually as the last members of the baby boom generation enter their working years (chart 6). The ratio of potential dependents to the working age population is projected to decline from 63.7 percent in 1995 to 60.0 percent in 2010—a level similar to the decade prior to 1945. As the baby boomers begin to retire, this proportion is projected to increase rapidly, reaching 78.6 percent in 2035 (chart 6).

Although referred to as a dependency ratio, the ratio actually exaggerates the extent of dependency across generations. In particular, it does not adjust for the number of employed dependents. Nor does it adjust for the lifetime accumulation of assets, including funded pensions, held by individuals aged 65 and over or for differences in individual health. On the other hand, a dependent parent is potentially likely to require more assistance for a much longer time than a dependent child.

Some of the shortfalls in this measurement may be compensated by other measures of dependency. For example, the Social Security actuaries estimate the ratio of workers paying Social Security payroll taxes to beneficiaries. From 1960 to 1992, the ratio dropped from 5.1 to 3.2. Based on their intermediate assumptions through 2070, the ratio is projected to remain above 3.0 through 2005 and then decline to 2.1 by 2030, when all members of the baby boom generation will be at least aged 65 (U.S. Department of Health and Human Services, 1993).

Demographic changes and employer and public policy responses to them will directly affect employees and retirees. Higher labor market costs that lead to new methods of producing goods and services could result in the displacement of workers with inadequate or obsolete skills. Employees will also be affected by increases in taxes that become necessary to support public expenditures, while retirees are likely to be affected by any changes in public program benefits. Moreover,
more persons will be affected by the issues surrounding dependent and long-term care.

Providing long-term care for aging family members particularly affects women. As daughters or daughters-in-law, they may have fewer disincentives to leave the labor market (because their wages are likely to be lower than their husbands’) to care for an elderly parent. As younger spouses, women are also more likely to become caregivers of their ailing husbands. As spouses and as widows, women are more likely to bear the financial burden of uncovered expenses incurred by a husband’s illness. Women tend to marry men older than themselves, and, because of their longer life expectancy, will continue to comprise a disproportionate share of the single elderly. According to EBRI tabulations of the March 1992 CPS, among persons aged 65–74 living in the community, the ratio of women to men in 1991 was 1.2, and among persons aged 85 and over, it was 2.2.

Women who reduce their work hours, change jobs, or leave the labor force to become caregivers may be less likely during their retirement years to afford health care that is not covered by Medicare. In addition, such women are more likely to need long-term care, because they tend to report lower health status and more chronic conditions than men of the same age (Verbrugge, 1982).

Growth in the aged population, increased labor force participation of women, a growing immigrant population, and the propensity for workers to retire earlier are the primary demographic trends likely to affect employers, and, consequently, employees and retirees. Longer life expectancies and earlier retirement increase the duration of retirement, while reduced mortality without commensurate declines in illness means that more retired persons will need assistance with activities essential for independent living.

As the number of elderly persons grows relative to the number of nonelderly, the financing of public programs such as Social Security, Medicare, and Medicaid becomes an increasingly important public policy issue. Social Security benefits have already been reduced and taxes increased by the 1977 and the 1983 Social Security Amendments to avoid imminent insolvency in the OASDI trust funds resulting from high rates of inflation and unemployment and a faulty benefit indexation formula (later corrected) that was generating unexpectantly generous replacement rates. Medicare is projected to experience financial difficulties in the short term, and Medicaid, despite the growing number of persons likely to need assistance, is expected to continue to manage program expenditures by restricting access to health care.

The insolvency of the Medicare program and actions by states to manage Medicaid expenditures will precede the retirement of the baby boom generation that is now between age 29 and age 47. Population projections indicate that, in 2030, the retirement of this cohort will increase the elderly population by 113.2 percent, from 32.8 million in 1993 to 69.8 million in 2030; increase the portion of population aged 65 and over to 20.2 percent; and increase the proportion of persons aged 85 and over to 2.4 percent of the population.

Smaller family size will also slow the growth rate of the labor force and therefore of potential taxpayers and consumers. Relatively tighter labor markets are likely to raise the cost of labor to employers. Employer responses to these increases are likely to vary—depending partly on the products produced—but for most employers the cost of production is likely to rise.

Concern about the quality of future workers has
prompted some larger employers to focus attention and money on the public school system. More than 64 percent of 130 major corporations surveyed in 1988 ranked primary and secondary education as their major concern, an increase from 42 percent two years earlier (The Conference Board, 1988). Even if wages are not driven up, training costs (including remedial education) may raise the unit cost of labor.

As the composition of the labor force changes, employers are likely to experience new pressures from employees to consider a different mix of employee benefits. Some expected changes include the changing structure of the work force from a pyramid shape to one that is relatively flat, the larger number of working mothers, and the increased number of adults with a chronically ill parent or family member. Most of the growth in the labor market has been among women in general and women with children in particular.

Smaller families not only reduce the number of new employees and new taxpayers but also mean that there will be fewer adults to assist parents and family members with chronic disabilities. Longer life expectancies without commensurate reductions in illness ensure that more persons will need long-term care. On average, a man retiring at age 65 in 1990 will need to finance 14.8 years of retirement; a woman will need to finance 18.8 years. This time period will lengthen to 16.7 years for men and 20.7 years for women retiring in 2030. The need for increased retirement income should be considered within the context of current pension design, the future solvency of the Social Security program, and health care costs. Will an individual who has participated in a defined contribution pension plan have the necessary resources to adequately finance an extended period of retirement? In addition, will individuals be able to finance the growing share of retiree health costs that will become their responsibility as employers restructure current plans to curtail the growing costs of health care and address the requirements of FAS 106?

Concern over retirement income security for a growing elderly population and the employee benefit needs of a diversifying work force has prompted employers and policymakers to focus on these issues. For example, women’s growing labor force participation has led policymakers to focus on changing employee needs. On February 5, 1993, President Clinton signed the Family and Medical Leave Act (H.R. 1) into law. Effective August 5, 1993, the law provides up to 12 weeks of unpaid, job-protected leave each year (with continued health insurance coverage) to employees for the birth or adoption of a child or for the serious illness of the...
employee or the employee's child, parent, or spouse.18 It is likely that policymakers and employers will take additional actions as the American population begins to adjust to major demographic shifts that are permanently reshaping and restructuring the U.S. population and work force.

References


18Small employers (with fewer than 50 employees) are exempted from the legislation.


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