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Issue BRIEF

Implications of Health Reform for Retiree Health Benefits

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EXECUTIVE SUMMARY

- This *Issue Brief* examines how current health reform legislation being debated in Congress will impact the future of retiree health benefits. In general, the proposals' provisions will have a mixed impact on retiree health benefits: In the short term, the reinsurance provisions would help shore up early retiree coverage and Medicare Part D coverage would become more valuable to retirees. In the longer term, insurance reform combined with new subsidies for individuals enrolling for coverage through insurance exchanges, the maintenance-of-effort provision affecting early retiree benefits, increases to the cost of providing drug benefits to retirees, and enhanced Medicare Part D coverage, would all create significant incentives for employers to drop coverage for early retirees and drug coverage for Medicare-eligible retirees.

- **REINSURANCE PROGRAM FOR EARLY RETIREES:** Proposed legislation includes a provision to create a temporary reinsurance program for employers providing health benefits to retirees over age 55 and not yet eligible for Medica*re.* Given the temporary nature of the program, it is intended to provide employers an incentive to maintain benefits until the health insurance exchange is fully operational. At that point, employers will have less incentive to provide health benefits to early retirees, and retirees will have less need for former employers to maintain a program.

- **MEDICARE DRUG BENEFITS:** The House-passed bill would initially reduce the coverage gap (the so-called "doughnut hole") for individuals in the Medicare Part D program by $500 and eliminate it altogether by 2019. The bill currently before the Senate would also reduce the coverage gap by $500, but does not call for eliminating it. Both would also provide a 50 percent discount to brand-name drug coverage in the coverage gap. These provisions increase the value of the Medicare Part D drug program to Medicare-eligible beneficiaries relative to drug benefits provided by employers.

- **TAX TREATMENT OF EMPLOYER SUBSIDIES UNDER MMA:** The Medicare Modernization Act provides subsidies to employers that continue to offer prescription drug coverage through a retiree health benefits program. This subsidy is currently not counted as taxable income to the employer receiving it. Both the House and Senate bills would effectively repeal this tax exclusion. This would have two effects: The real cost of providing retiree health benefits to Medicare-eligible retirees would increase, and an employer's FAS 106 liability would increase immediately. The increase in the cost of retiree drug benefits will cause employers to re-evaluate the subsidy, compared with other available options. Moving retirees to Medicare Part D may become even more attractive to employers if the coverage gap is reduced and/or eliminated.

- **POSTRETIREMENT BENEFIT CHANGES:** With some exceptions, the House-passed legislation would prohibit employers from changing the benefits offered to retirees and their beneficiaries once a person has retired. This provision could have a number of different effects: More employers may move toward capping their contributions; employers that want to maintain retiree health benefits may react by cutting the health benefits of active workers; employers may eliminate retiree health benefits altogether to avoid being locked into providing a permanent benefit; or they may drop benefits if they think there is no need to provide them.

Paul Fronstin is director of the Health Research and Education Program at EBRI. This *Issue Brief* was written with assistance from the Institute's research and editorial staffs. Any views expressed in this report are those of the author and should not be ascribed to the officers, trustees, or other sponsors of EBRI, EBRI-ERF, or their staffs. Neither EBRI nor EBRI-ERF lobbies or takes positions on specific policy proposals. EBRI invites comment on this research.

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Introduction

Employment-based retiree health coverage first started appearing in the late 1940s and 1950s, and was considered a "throw-away benefit" as many companies were in "plush" times with growing needs for workers and very few retirees (Feinstein, 1992). When Medicare was passed in 1965, offering retiree health coverage as a supplement to Medicare became even more appealing to employers. However, the coverage was far from universal: Only the largest employers offered retiree health benefits, and only 43 percent of workers ages 40 and older expected to receive retiree health benefits upon retirement in 1988 (Davis, 1991).

The approval of Financial Accounting Statement No. 106 (FAS 106), "Employer's Accounting for Postretirement Benefits Other Than Pensions," in December 1990, an accounting rule change, resulted in many employers dropping or significantly limiting access to retiree health benefits during the 1990s and early 2000s. Employers also increased premiums and cost sharing, and generally made it more difficult for retirees to qualify for the benefit once they retired.

By 2005, 35.8 percent of workers ages 45–64 *expected* to receive retiree health benefits—while, at the time, only 26.4 percent of early retirees and 21.5 percent of Medicare-eligible retirees *had* them (Fronstin, Salisbury, and VanDerhei, 2008). The passage of the Medicare Modernization Act of 2003 (MMA), with its government subsidies for qualified employment-based drug benefits and Medicare Advantage plans, appears to have succeeded in slowing the erosion in employment-based retiree health benefits for retirees who are eligible for Medicare.

Today, Congress is considering legislation that would affect retiree health benefits, as part of the health reform initiative; one bill has passed the House (H.R. 3962, "The Affordable Health Care for America Act), and another is under debate on the Senate floor (H.R. 3590, "The Patient Protection and Affordable Care Act") at this writing.

Both the House and Senate health reform bills include provisions to increase the cost of employment-based drug coverage, and the House bill includes provisions to limit changes in employment-based retiree health benefits. They also contain provisions that could make the Medicare Part D drug benefit more attractive than employment-based plans. Insurance reforms, creating guaranteed issue for early retirees and providing taxpayer-funded subsidies for early retirees who enroll in the new health insurance exchanges called for in the legislation, will also make the individual market more attractive as an alternative to traditional employment-based plans for early retirees. These provisions could affect the availability of health coverage through the workplace for retirees in the future.

This *Issue Brief* examines the impact of current health reform legislation under debate in Congress on the future of retiree health benefits. The next section provides background on the impact of private-sector accounting rule changes on the availability of retiree health benefits since the mid-1990s. The following section examines the more recent impact of public-sector accounting rule changes on retiree health benefits in the public sector. The third section discusses the impact on employment-based retiree health benefits of adding a drug benefit to Medicare. The last section examines the potential impact of current health reform legislation on employment-based health benefits for early retirees and Medicare beneficiaries.

Availability of Retiree Health Benefits After FAS 106

One of the most important factors (if not the single most important) that has led to the decline in the availability of retiree health benefits was a 1990 accounting rule change issued by the Financial Accounting Standards Board (FASB) that required employers to report their retiree health liabilities in the footnotes to their annual financial reports. In the early 1980s, employers were aware that FASB was considering accounting standard changes that would affect the way to account for retiree health benefits on financial statements. There were a number of studies on the earliest FASB guidelines for "Other Post-Employment Benefits" (OPEBs) and broader proposals that were issued in the mid-1980s, such as one done by the Employee Benefit Research Institute (1988). The early 1980s standards and the later draft proposals and subsequent research undoubtedly resulted in some employers making changes to retiree health benefits even before FASB's expanded standards were finalized in 1990.

FASB's issuance of FAS 106 triggered many of the changes that private-sector employers have made to retiree health benefits since the early 1990s. FAS 106 requires companies to record retiree health benefit liabilities on their financial statements in accordance with generally accepted accounting principles. Specifically, it requires private-sector employers to accrue and expense certain future claims' payments as well as actual paid claims. The immediate income statement inclusion and balance sheet footnote recognition of these liabilities dramatically affect a company's reported profits and losses. The impact was greatest on large employers, since small employers typically never offered retiree health benefits and therefore did not have the liability.

As a result of FAS 106, companies now recognize the long-term liability of offering retiree health benefits in the footnotes that accompany their financial statements. With the new view of the cost and the increasing cost of providing retiree health benefits, many private-sector employers have overhauled their retiree health programs in ways that controlled, reduced, or eliminated these costs.[1] Today, 19 years after FAS 106 was issued, these benefit cuts would be expected to have had a major impact on employer FAS 106 liabilities. Recently, the U.S. Government Accountability Office (GAO) examined the financial statements of 50 randomly chosen Fortune 500 companies, and found that more than 90 percent of the employers offering retiree health benefits experienced an increase in their postretirement benefits obligations between 2001 and 2003, with some being 50 percent or more higher (U.S. Government Accountability Office, 2005). While the report did not go into the determinants of the increase in liabilities, they may be due to increases in costs of providing health benefits to the remaining pool of retirees. Were it not for the changes that employers initially made to retiree health benefits in response to FAS 106, those liabilities probably would have been even higher.

As the data show, large establishments are much more likely to offer retiree health benefits than small establishments. In 2008, 36 percent of establishments with 1,000 or more workers offered retiree health benefits to early retirees, compared with 1 percent among establishments with fewer than 10 workers (Figure 1). For the most part, small businesses never offered health insurance as a benefit to retirees.

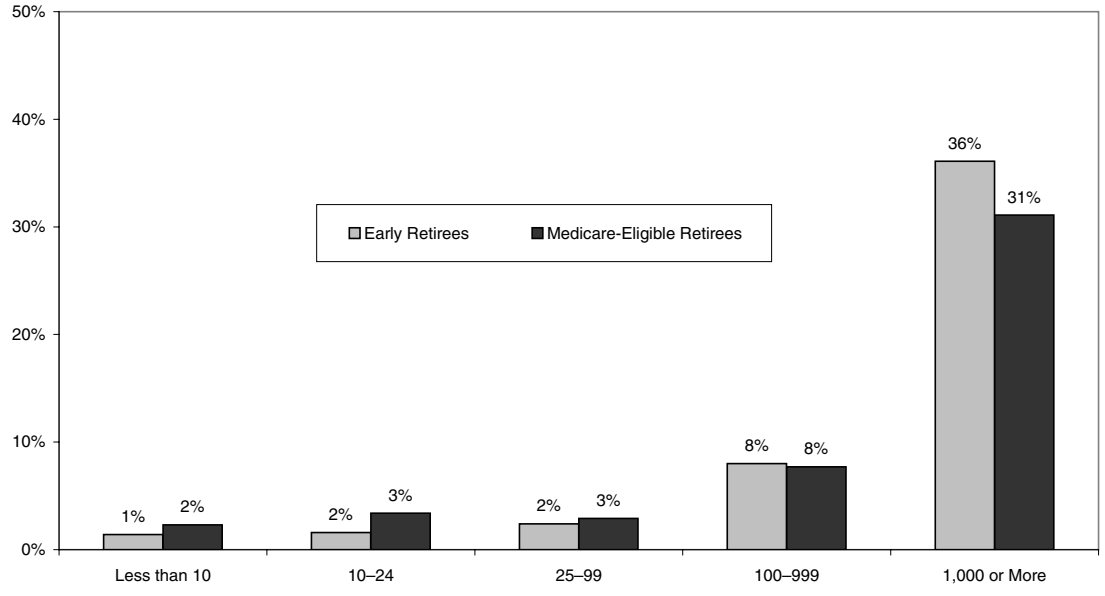
Hence, the trend away from retiree health benefits is mainly a large-firm phenomenon. Among employers with 500 or more employees, 28 percent offered health benefits to early retirees (ages 55–64) and 21 percent to Medicare-eligible retirees (ages 65 and older) in 2009, down from 46 percent and 40 percent in 1993, respectively (Figure 2).

Inevitably, the percentage of workers employed at private establishments offering retiree health benefits also has been falling: In 2008, 22 percent of workers were employed at a private establishment that offered health benefits to early retirees, down from 31 percent in 1997, while 17 percent of workers were employed at a private establishment that offered health benefits to Medicare-eligible retirees, down from 28 percent in 1997 (Figure 3). Because workers in small business were never offered retiree health benefits, and small business accounts for roughly one-half of all jobs in the United States (Fronstin, 2009b), the erosion in the availability of retiree health benefits is not as great as one would expect it to be. Furthermore, these data should not be interpreted as indicating that the 17 percent of workers who work at a firm where the benefit is offered are or actually would be eligible for health benefits once eligible for Medicare should they retire, or that those who do qualify for a retiree medical plan will receive a substantial premium contribution from his or her employer.

Employers have generally made it more difficult for retirees to qualify for health benefits in retirement, so not all of those who work for an employer that offers the benefit will qualify to receive it. They have been tightening eligibility requirements to control spending and reward longer-service employees. This might involve requiring workers to attain a certain age and/or tenure with the company before they qualify for health benefits in retirement. For example, the percentage of employers requiring an age of 55 and a service requirement of at least 10 years for benefit eligibility increased from 30 percent in 1996 to 37 percent in 2009 (Figure 4). The percentage of employers requiring age of 55 and at least 15 years of service nearly doubled between 1996 and 2009, increasing from 5 percent to 9 percent.

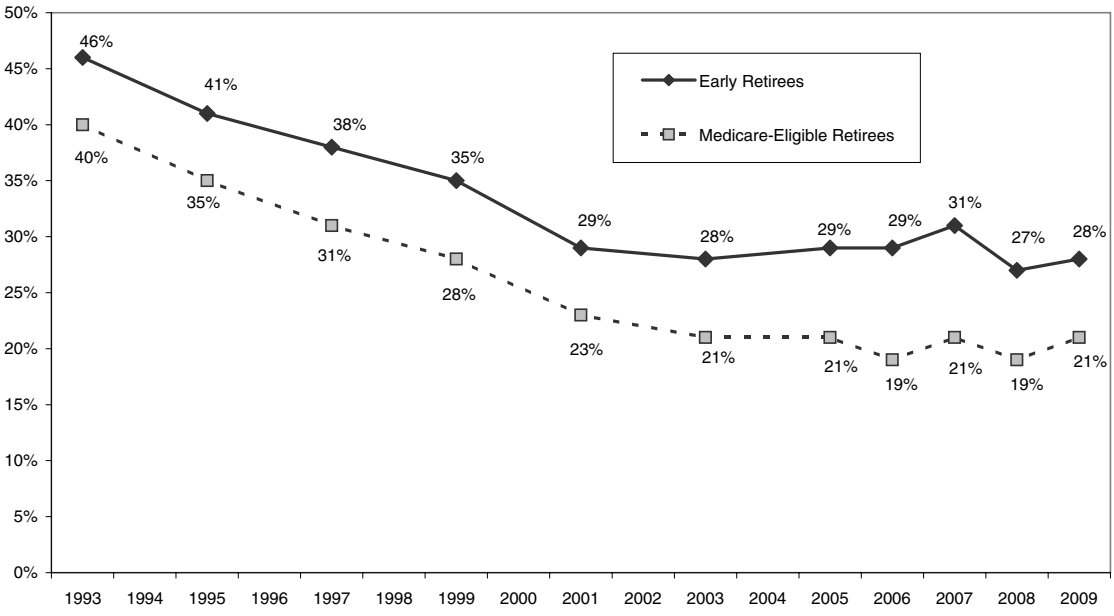
In addition to tightening eligibility for benefits, some employers have simply made the cost of participating in retiree health benefits more expensive for retirees. Employers often used service-based contributions, contributing more for longer-service employees and less for shorter-service ones. Employers have often instituted caps or ceilings on the

Figure 1
Percentage of Private-Sector Establishments That Offer Retiree Health Benefits, by Firm Size, 2008



Source: Online at /www.meps.ahrq.gov/mepsweb/data_stats/summ_tables/insr/national/series_1/2008/tia2e.pdf

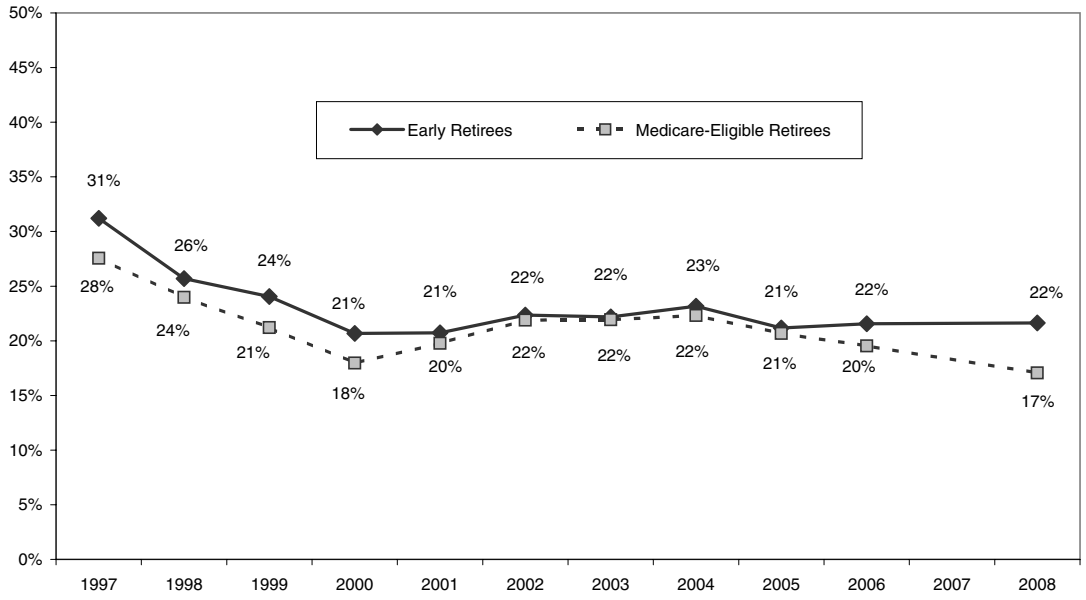
Figure 2
Percentage of Employers With 500 or More Employees Offering Health Insurance to Retirees, 1993–2009



Source: Mercer National Survey of Employer-Sponsored Health Plans.

Figure 3

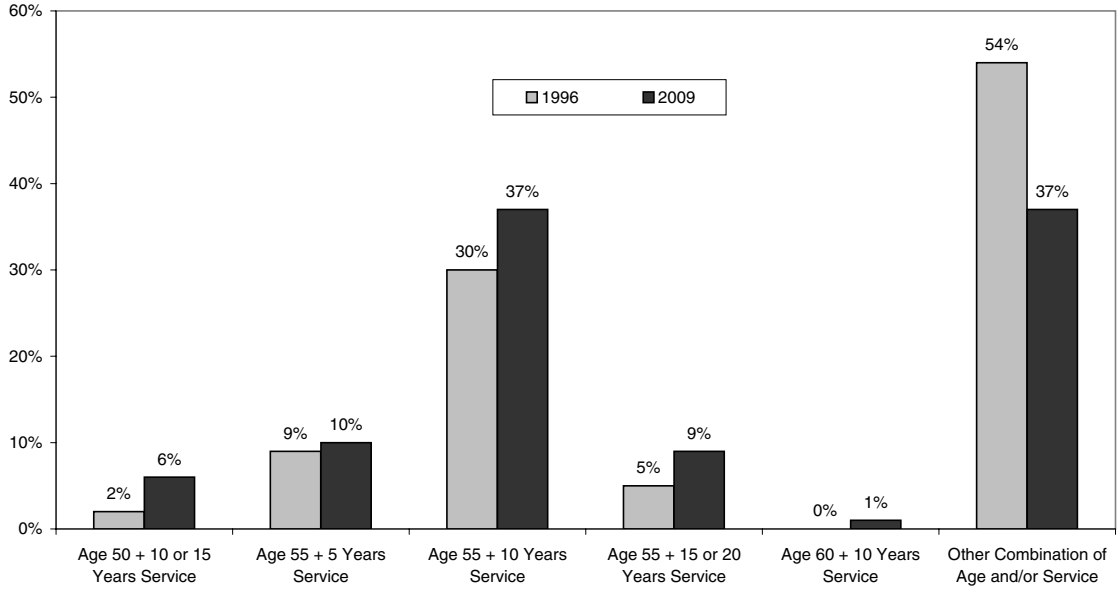
Percentage of Private-Sector Workers Employed at Establishments Offering Health Benefits to Early Retirees, 1997–2008



Source: Various tables online at www.meps.ahcpr.gov/mepsweb/data_stats/quick_tables.jsp

Figure 4

Eligibility Requirements for Retiree Health Benefits, Employers With 1,000 or More Employees, 1996 and 2009



Source: Hewitt Associates.

total amount of money they are willing to spend on retiree health benefits. Under a commonly used approach, once employer spending reaches the cap, the employer subsidy for the retiree health benefit will no longer be increased. Caps can take the form of a per-person cap or a global cap for all retirees. Employers that have instituted caps often continue to subsidize retiree health benefits, but retirees are responsible for the entire premium in excess of the cap amount each year, and as the cost of coverage increases the retiree cost also increases, while the employer cost does not. In 2009, one-quarter of employers who offered a retiree health benefit continued to provide a plan with no cap on its contributions for either early retirees or Medicare-eligible retirees (Figure 5). In practice, caps erode the level of coverage even for employers continuing to offer retiree health benefits: When employer contributions are capped and retiree premium contributions rise, a significant number of retirees tend to drop their coverage.

Some employers have eliminated their subsidy for retiree health benefits altogether for new hires or workers retiring after a specific date. According to findings from the Kaiser/Hewitt Survey on Retiree Health Benefits, 13 percent of employers that offered retiree health benefits reported that they had terminated all subsidized health benefits for future retirees in either 2001 or 2002; 10 percent reported doing so in 2003; 9 percent reported it in 2004; 12 percent reported it in 2005; and another 9 percent reported that they terminated all subsidized health benefits for future retirees in 2006 (Figure 6).

These employers have not necessarily dropped retiree health benefits altogether. They may be offering a plan, but require certain retirees (not necessarily all retirees) to pay the full cost of the benefit. These plans are known as "access-only" plans. While many retirees will drop or not sign up for coverage under an access-only plan, even without an employer subsidy, many retirees still get significant savings by paying the group-based premiums for health insurance through their former employer, compared with premiums for the same product in the nongroup market. Access-only coverage is available to retirees regardless of health status, and is not rated based on the retiree's individual age or health condition.

Availability of Retiree Health Benefits After GASB

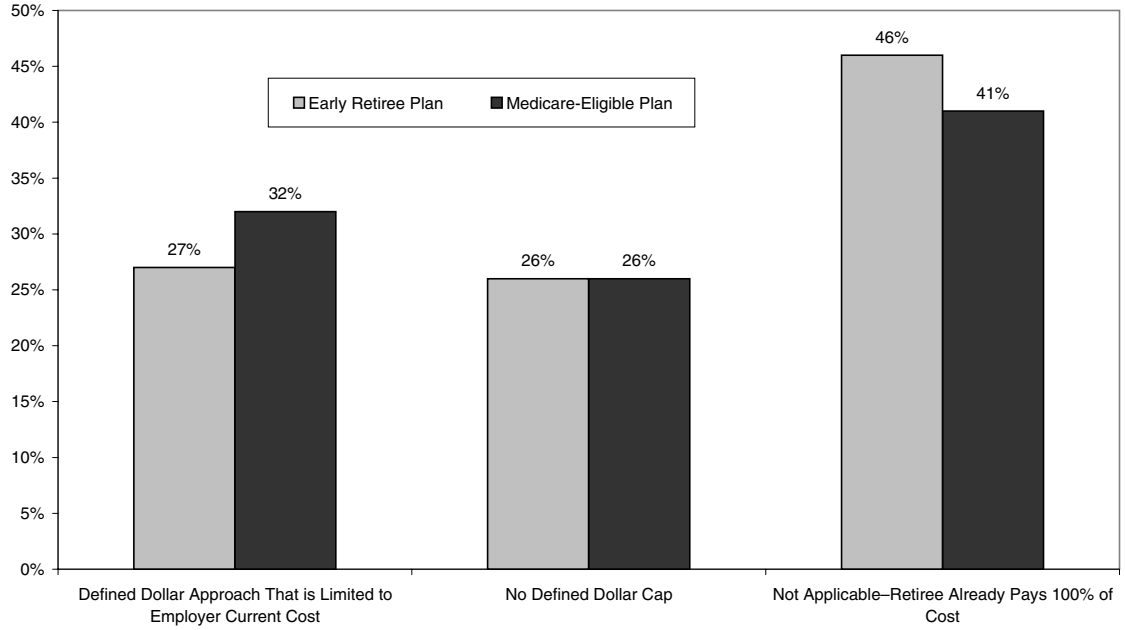
Although it has taken a while, public-sector accounting standards have caught up with private-sector standards on retiree health. Recently, the Governmental Accounting Standards Board (GASB) released Statements No. 43 and 45 (GAS 43 and 45), which impose new accounting standards on public-sector sponsors of retiree health benefits. Under GAS 43 and 45, public-sector sponsors are required to accrue the cost of postretirement health benefits during their covered workers' years of service, as opposed to reporting the cost on a pay-as-you-go basis.

According to the GAO, studies have estimated that state and local government unfunded liabilities for retiree health benefits are between $600 billion and $1.6 trillion,[2] and governments have typically paid for these benefits on a pay-as-you-go basis instead of setting aside money for postretirement health benefits as they have for pensions (U.S. Government Accountability Office, 2008a). A more recent study examined state liabilities for retiree health benefits, and found that many (but not all) states face substantial future liabilities.[3] Because these estimates raise concerns about the fiscal challenge that public-sector employers will face in the future, the estimates also raise concern over the impact that the GASB statements ultimately will have on the future of retiree health benefits in the public sector. GAS 43 and 45 may simply trigger changes to retiree health benefits in the public sector that the private sector has been experiencing since the mid-1990s. For instance, Michigan has adopted pre-funded retiree health care accounts that other states may adopt.[4] But in general, the likely result is that public-sector employers will also begin to restrict or eliminate retiree health benefits to public-sector workers. Because a higher percentage of public-sector workers are covered by collective bargaining agreements, it is also likely that public-sector employers will face greater challenges in modifying labor agreements to address the liability, including a greater threat of work stoppages and strikes.

Public-sector employers are certainly aware of GAS 43 and 45. By 2009, one-half of local governments had completed calculation of the OPEB liability while another 11 percent had the calculation in progress.[5] In response to GAS 43 and 45, a number of public-sector employers are planning to change eligibility requirements. Four percent have closed their plans to new hires recently, and another 2 percent plan to do so in the next two years (Figure 7). Similarly, 3 percent

Figure 5

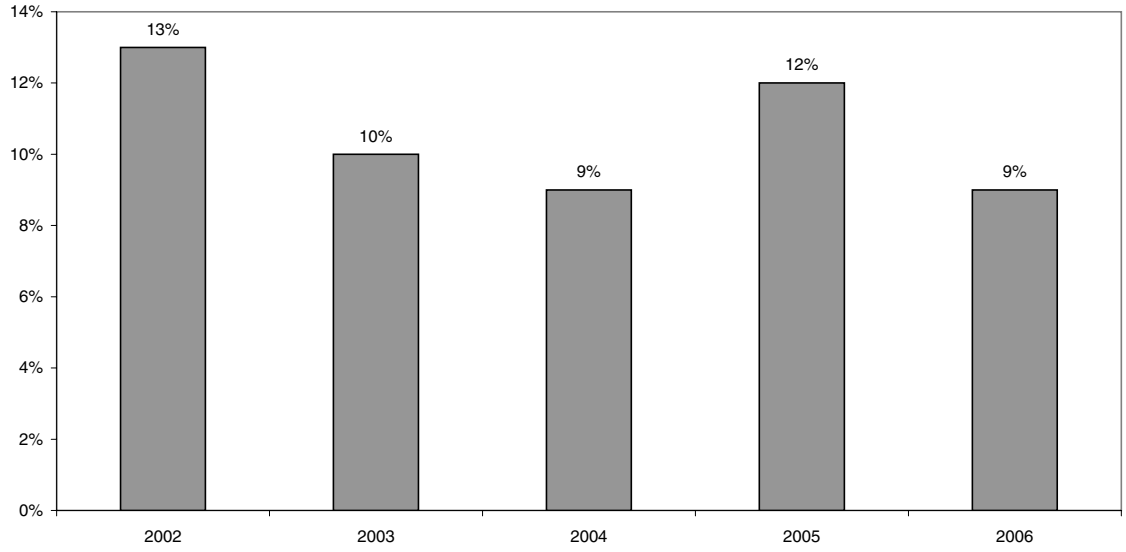
Prevalence of Defined Dollar Approach to Cap Employer Contribution to Retiree Health Benefits, 2009



Source: Hewitt Associates.

Figure 6

Percentage of Large Private-Sector Employers That Terminated All Subsidized Benefits for Future Retirees, 2002–2006[a]

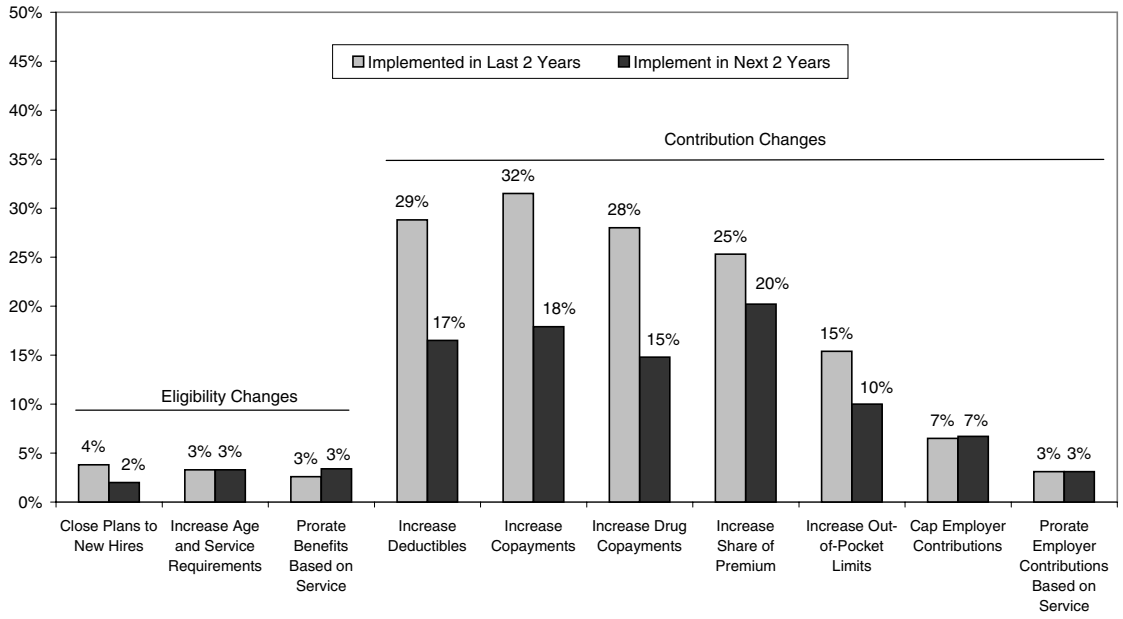


Source: The Henry J. Kaiser Family Foundation and Hewitt Associates, *Findings From the Kaiser/HewittSurvey on Retiree Health Benefits, 2002–2006.*

[a] In 2002, survey asked employers about changes made to plan during previous two years. In 2003–2006, employers were asked about the past year.

Figure 7

Implemented or Planned Initiatives to Reduce Health Care Costs and Liabilities, 2009



Source: Published and unpublished data from the Cobalt Community Research: Health and OPEB Funding Strategies: 2009 National Survey of Local Governments, www.ncpers.org/files/OPEB_2009.pdf

Figure 8

Prescription Drug Coverage Costs, Per Retiree, 2011

Current Law	Employer Provides Retiree Health Benefit	Employer Purchases Part D Plan[a]	Difference
Employer Costs			
Retiree drug expense	$2,701	$420	
Government subsidy[b]	665	0	
Tax deduction of employer cost as business expense[c]	945	105	
Total after-tax cost	1,090	315	-$775
Government Cost	665	1,209	544
Proposed Law			
Employer Costs			
Retiree drug expense	2701	420	
Government subsidy[b]	665	0	
Tax deduction of employer cost as business expense[c]	945	105	
Tax paid on government subsidy[c]	233	0	
Total after-tax cost	1,323	315	-1,008
Government Cost	665	1,209	544
Change in Employer Costs	-233		233

Source: Employee Benefit Research Institute.

[a] See Table V.C2 in www.cms.hhs.gov/ReportsTrustFunds/downloads/tr2009.pdf for projected average Part D monthly premium in 2011.

[b] Employer subsidy per enrollee in 2011. See Table IV.B10 in www.cms.hhs.gov/ReportsTrustFunds/downloads/tr2009.pdf

[c] Assumes average corporate tax rate of 35 percent.

plan to increase age and service requirements and 3 percent plan to prorate benefits based on service.

Some public-sector employers are planning to change the benefits package, and some already have. For example, 29 percent have increased deductibles, and 17 percent plan to do so in the next two years. One-quarter have increased premiums and 20 percent plan to do so. Note that employers that plan to increase cost sharing or premiums during the next two years may have already increased them and are planning on additional increases. While public-sector employers' benefit cost increases have mirrored those in the private sector, they have generally not eliminated coverage for future retirees (U.S. Government Accountability Office, 2005).

Retiree Health Benefits After MMA

As noted above, prior to the passage of MMA, the percentage of employers offering retiree health benefits had been declining, and even when those benefits were offered, retirees were increasingly being required to pay higher premiums and cost sharing, and were also increasingly less likely to qualify for any subsidized coverage. A major concern at the time of debate over adding a benefit for outpatient prescription drugs in the Medicare program was that employers would drop drug coverage that they provided to Medicare beneficiaries (Salisbury and Fronstin, 2003). This concern developed from Congressional Budget Office (CBO) estimates indicating that between 31 percent and 37 percent of Medicare beneficiaries with employment-based drug coverage would lose it under the various House and Senate bills as a result of employer decisions to drop coverage. As a result of this concern, when the outpatient prescription drug program was created under Medicare Part D, MMA also established various options and incentives to encourage employers and other plan sponsors of health benefits for retirees to continue offering prescription drug benefits to Medicare-eligible retirees.

For instance, MMA provides subsidies to employers that continue to offer qualified prescription drug coverage through a retiree health benefits program. The coverage offered must be actuarially equivalent to that offered through Medicare Part D. The subsidy is equal to 28 percent of the allowable gross retiree prescription drug costs, which was initially set between $250 and $5,000 annually, for a maximum of $1,330 per beneficiary in 2006. The thresholds for the subsidy are indexed such that, in 2009, allowable gross retiree prescription drug costs were set between $295 and $6,000, for a maximum of $1,597 per beneficiary. The thresholds are increasing to $310 and $6,300 in 2010, for a maximum of $1,677 per beneficiary. The subsidy is also provided on a tax-free basis, which provides both an earnings benefit and a cash tax benefit to employers that avail themselves of the subsidy. Subsidies are only available for retirees who do not enroll in Medicare Part D, which is an incentive to employers to keep retirees off the Part D program.

Prior to enactment of MMA, employers were experiencing increases in their FAS 106 liabilities. A U.S. Government Accountability Office study (2005) examined financial statements filed with the SEC for 50 randomly selected Fortune 500 employers. It found that more than 90 percent of the 38 employers reporting postretirement benefit obligations had an increase in these obligations from 2001–2003. Thirteen of the 38 employers (one-third) experienced an increase of between 25 percent and 50 percent, while eight employers (20 percent) experienced an increase above 50 percent. As a comparison, the Consumer Price Index (CPI) increased 5.3 percent during this period.

The GAO found that, according to financial statements filed with the SEC as of November 2004, 27 of the 39 Fortune 500 employers that were reviewed stated the effect of the MMA options on their postretirement benefit liabilities. Thirteen of the 27 reported that they would be choosing the subsidy option, while the other 14 had not made a clear decision regarding Medicare-eligible retirees. Three of the 13 employers that reported they would choose the subsidy option reported reductions in accumulated obligations of more than $100 million.

While the 2005 GAO study is informative, a more recent GAO study interviewed a number of plan sponsors and was told that they did not make further changes to the retiree health programs in direct response to the MMA (U.S. Government Accountability Office, 2007). These findings are reinforced by the data in Figure 2, which show that since the passage of MMA, the percentage of employers offering health benefits to Medicare-eligible retirees has been flat. This should not imply that the subsidy to employers is the *only* reason why there has been no change in offer rates, as the trend in availability of retiree health benefits for early retirees is also unchanged. Early retiree benefits would not

be directly affected by the subsidy for drug expenses for Medicare-eligible retirees. Also, Salisbury and Fronstin (2003) found that 63 percent of retirees at that time had retired from either a public-sector or unionized job and concluded that because of politics and collective bargaining they were not vulnerable to short-term changes in availability of retiree health coverage. Similarly, in 2005, 72 percent of employers with 500 or more workers reported that the MMA options would have no effect on their ability to provide retiree health coverage.[6]

The GAO report also found that, in response to MMA, employers took the subsidy instead of other options because of other factors. Employers considered as part of their decision-making process the possible negative media coverage, the potential for lawsuits, relations and communications with retirees, future union negotiations, hiring and retention of workers, and marketplace conditions. These same factors may explain why employers have not cut back on the availability of retiree health benefits for early retirees. The leveling of the trend in coverage for early retirees may be simply due to the fact that retirees are paying higher premiums for coverage and higher out-of-pocket expenses for health care services.

Retiree Health Benefit Provisions in Current Legislative Proposals

On Nov. 7, 2009, the U.S. House of Representatives passed the *Affordable Health Care for America Act* (H.R. 3962). On Nov. 18, 2009, the Senate voted to allow debate to begin on the *Patient Protection and Affordable Care Act* (H.R. 3590). Both proposals include provisions that would affect the future of retiree health benefits in the workplace. In general, the provisions will have a mixed impact on retiree health benefits:

- Early retiree benefits may temporarily become less costly due to the short-term government-funded reinsurance program, while government-sponsored drug benefits for Medicare-eligible retirees will become more attractive relative to employment-based group plans in terms of coverage.
- Underwriting reform, combined with subsidies for qualified individuals who enroll for coverage in the new health insurance exchanges to be created by the bills, will also undermine employment-based coverage for retirees.
- Changes in the tax treatment of government subsidies for qualified employment-based drug plans will also undermine employment-based coverage.

On balance, the provisions in both the House and Senate proposals are likely to substantially undermine employment-based retiree health benefits; however, early retirees would see improved access to coverage through health insurance exchanges, and Medicare-eligible retirees would see enhanced Medicare Part D drug coverage.

Reinsurance Program for Early Retirees

Both the House and Senate bills include a provision to create a temporary reinsurance program for employers providing retiree health benefits to retirees over age 55 and not yet eligible for the Medicare program. In both cases, the program would provide an 80 percent subsidy on retiree claims of between $15,000 and $90,000. The House bill would provide about $10 billion over 10 years to pay for this provision. In contrast, the Senate would provide about $5 billion through Jan. 1, 2014. In both cases, the program would be effective starting 90 days after enactment of the bill.

The goal of the reinsurance program is to provide an incentive to employers to maintain retiree health benefits and assist retirees with their costs for health coverage, since the reinsurance funds would be required to be used primarily for lowering retiree expenses for coverage. Given the temporary nature of the reinsurance, it is intended to provide employers an incentive to maintain benefits until the health insurance exchange is fully operational.

Once the health insurance exchange is fully operational, employers would have less incentive to provide health benefits to early retirees, and retirees would have less need for former employers to maintain a program.[7] Under the health insurance exchange, retirees could not be denied coverage because of pre-existing conditions and they could not be charged a higher premium because of their health status. Limited age rating would be allowed. Furthermore, in both the House and Senate bills, subsidies would be available to individuals in families with income below 400 percent of the

federal poverty level who purchase health insurance through the exchange. In the short term, the reinsurance provisions would help shore up early retiree coverage, but in the longer term, the underwriting reform combined with new subsidies for individuals enrolling for coverage through the exchange would create significant incentives for employers to drop coverage for early retirees.

Medicare Drug Benefits

The bill passed by the House would initially reduce the coverage gap (the so-called doughnut hole) in the Medicare Part D program by $500 and eliminate it altogether by 2019. The bill up for debate in the Senate would also reduce the coverage gap by $500, but does not call for eliminating it, although recent reports indicate the Senate would agree to eliminate it in the House-Senate conference. Both would also provide a 50 percent discount for brand-name drug coverage in the coverage gap. These provisions increase the value of the Part D drug program to Medicare-eligible beneficiaries relative to drug benefits provided by employers, which typically do not have coverage gaps for prescription drugs or other benefits.

Tax Treatment of Employer Subsidies Under MMA

As mentioned above, the MMA provides subsidies equal to 28 percent of allowable gross retiree prescription drug costs to employers that continue to offer prescription drug coverage through a retiree health benefits program. This subsidy is currently not counted as taxable income to the employer receiving it. Sec. 534 of the House bill and Sec. 9012 of the Senate bill would effectively repeal this tax exclusion.

This proposed legislative change would have two effects. First, the real cost to employers of providing retiree health benefits to Medicare-eligible retirees would increase. Second, and concurrently, an employer's FAS 106 liability would increase. This tax law change would apply to taxable years beginning after Dec. 31, 2010, in the Senate bill and tax years beginning after Dec. 31, 2012, in the House measure. However, the impact on an employer's FAS 106 liability and income statement would take effect immediately.

In 2011, overall gross costs for prescription drug benefits are expected to be $2,701 on average per Medicare-eligible retiree with employment-based retiree health benefits (Figure 8). After factoring out the $665 MMA subsidy provided by the federal government and tax deduction that employers receive on the cost of retiree benefits as a business expense, the net cost to employers would be $1,090. If the proposed tax change takes effect, employers would pay an additional $233 in U.S. federal income taxes per retiree, resulting in a total cost of $1,323 per Medicare-eligible retiree after the impact of the proposed tax law were taken into account.

This increase in the cost of retiree drug benefits is certain to cause employers to re-evaluate taking the subsidy over other options available to them. Employers may choose to drop drug coverage for retirees and instead pay for Medicare Part D benefits. The average premium for Medicare Part D is expected to be $420 in 2011. After factoring out the tax deductibility of this expense, the real cost to employers would be $315. Moving from offering and paying for retiree drug coverage to simply paying for Medicare Part D premiums would save employers $775 per beneficiary under current law, and $1,008 under proposed law. Moving to Medicare Part D may become even more attractive to employers if the coverage gap is reduced and/or eliminated.

Figure 8 also compares the projected cost to the government of subsidizing employment-based retiree drug coverage and Medicare Part D costs. In 2011, the government is expected to provide a per-retiree subsidy of $665 (on average) to employers that provide drug benefits to retirees. In contrast, each Medicare beneficiary enrolled in Part D costs the government $1,209 on average. For each retiree who loses drug coverage through an employer and gains it through Medicare Part D, the additional cost to the government would amount to $544.

For employers, the immediate impact of the proposed tax law change limiting the deductibility of retiree prescription drug expenses would be shown on the employer's income statement. FASB Statement No. 109, "Accounting for Income Taxes," requires employers to account for changes in the tax law that affect the value of deferred tax assets and liabilities. Despite the fact that the out-of-pocket expenses associated with the tax law change would not take

effect until 2011 under the Senate legislation, and 2013 under the House legislation, FAS 109 requires employers to immediately take a charge against current earnings to reflect the higher anticipated tax costs and higher FAS 106 liability. This will cause employers to re-evaluate whether they should continue providing retiree health benefits—much as they did after FAS 106 was announced.

Postretirement Benefit Changes

The proposed House legislation contains language not contained in the Senate legislation that would also affect retiree health benefits. Sec. 110 of the House bill would prohibit employers from changing the benefits offered to retirees and their beneficiaries once a person has retired. In effect, this provision would prohibit an employer from increasing premiums or increasing cost sharing. Any change to the plan that either increased premiums by more than 5 percent or decreased the actuarial value of the plan by more than 5 percent would be deemed in violation of the provision. This provision of the proposed legislation would take effect as soon as the president signs the bill into law.

There are three exceptions to this provision:

- First, changes are allowed if they are also made to active-worker benefits. In other words, employers could increase retiree premiums and/or increase cost sharing if the same change is made to active-worker benefits.
- Second, caps on employer contributions in place at the time of retirement can remain in place. For instance, if an employer has placed a cap on its contributions and the cost of providing health benefits to retirees increases 10 percent, the employer can pass along the entire 10 percent cost increase to the retiree.
- Third, an employer may apply to the Secretary of Labor for a waiver from this provision if the employer can reasonably demonstrate that meeting the requirements of this section would impose an undue hardship.

This provision could have a number of different effects. Because of the exception of caps on employer contributions, more employers may move toward capping their contributions. In fact, according to Figure 5, most employers have already capped their contribution to retiree health benefits. With respect to early retirees, 27 percent provide a capped subsidy, and another 46 percent provide a plan with no employer subsidy. Similarly, among Medicare-eligible plans, 32 percent provide a capped subsidy, and another 41 percent provide a plan with no employer subsidy. Whether for early retirees or Medicare-beneficiaries, only one-quarter continue to provide an uncapped subsidy.

Employers that want to maintain retiree health benefits may react to the provision by changing the health benefits of active workers in order to change the health benefits of retirees—with the result that benefits would be reduced for all. For example, an employer may increase deductibles for both actives and retirees. Cost sharing has already been increasing for active workers for a number of years. Employers may keep cost-sharing increases small enough to be below the 5 percent actuarial equivalent threshold. Finally, employers may eliminate retiree health benefits altogether (to the degree they can) to avoid being locked into providing a benefit permanently, or they may drop benefits if they think there is no need to provide them, as discussed above relative to the availability of the health insurance exchange for early retirees and enhanced benefits in the Part D program for Medicare-eligible retirees.

Finally, this maintenance-of-effort provision would have a chilling effect on the expansion of employment-based retiree benefits. It is far less likely that employers will offer new retiree health benefits when they no longer have the discretion to change those benefits once in place.

Excise Tax on High-Cost Health Plans

The Senate legislation would impose an excise tax on employment-based health plans with an aggregate annual value of at least $8,500 for employee-only coverage and $23,000 for family coverage. Benefits would be taxed at 40 percent of the difference between the aggregate value of the plan and the threshold levels. The threshold is higher for retirees ages 55 and older who are not yet eligible for Medicare: Instead of using the $8,500 and $23,000 thresholds, retiree benefits would be subject to the excise tax if they exceeded $9,850 for retiree-only coverage, and $26,000 for family

coverage. Although only in the Senate legislation, this provision recognizes that the cost of providing retiree health benefits is higher on average than the cost of coverage for active workers, and therefore attempts to minimize the impact of the excise tax on retiree health benefits. Were retiree health benefits subject to the same excise tax that active workers are subject to, the real cost of providing retiree health benefits would increase, further causing employers to re-evaluate whether to continue offering those benefits. To the degree employers can pool early retirees and Medicare-eligible retirees in calculating the aggregate value of coverage for purposes of determining whether the plan is subject to the excise tax, the likelihood of being subject to the tax will be lower, as coverage for Medicare-eligible retirees is less costly than coverage for early retirees because Medicare-eligible retirees are generally provided coverage that wraps around Medicare benefits.

Medicare Buy-In for Early Retirees

As of this writing (mid-December 2009), the Senate appears to have dropped efforts to add a Medicare buy-in program for persons ages 55–64. In 2007, 4 million (or 12 percent of the population ages 55–64) were uninsured (Fronstin, 2009a). While details of the provision were unknown, the availability of such a program raised a number of issues for employment-based programs. Sponsors of such programs would want to know if they can enroll their participants in the Medicare program by paying the premium. And similar to underwriting reform combined with new subsidies for individuals enrolling for coverage through the insurance exchange, the availability of a Medicare buy-in program means retirees will have less need for former employers to offer coverage, creating significant incentives for employers to drop such coverage for early retirees.

Conclusion

Since the mid-1990s, there has been erosion in retiree health benefits. This has been driven by the excessive cost of offering this benefit due to new accounting rules and the increasing cost associated with providing the benefit. Fewer private-sector employers offer the benefits, both private- and public-sector employers have been increasing retiree premiums and cost sharing, and workers are finding it harder to qualify for a subsidized benefit. MMA provided a subsidy to employers since 2003 to maintain drug benefits for Medicare-eligible retirees, which appears to have contributed to slowing the trend.

However, current legislative proposals will increase the cost to employers of offering retiree health benefits. If these proposals pass—such as insurance market reforms that will benefit early retirees, enhancements in Medicare Part D benefits that will benefit Medicare-eligible retirees, and taxation of the federal subsidy for offering retiree health prescription drugs—private-sector employment-based retiree health benefits are practically certain to decline: They will be less valuable to retirees in the future, and employers will find they are not as necessary to offer in the future, dramatically reducing the number of retirees enrolled in employment-based plans.

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Endnotes

[1] In order to avoid court challenges over benefit changes affecting current and future retirees, generally, employers explicitly reserve the right in plan documents to modify those benefits. According to the U.S. General Accounting Office (1998), virtually all employers have such language in their plan documents.

[2] According to the GAO report, estimates presented in these studies are limited by their methodologies and are not generated from a nationally representative sample of public-sector employers. For more information, see U.S. Government Accountability Office (2008).

[3] www.slge.org/vertical/Sites/{A260E1DF-5AEE-459D-84C4-876EFE1E4032}/uploads/{DA8CD136-5814-4AEA-AF21-067EF733C619}.PDF

[4] www.mersofmich.com/index.php?option=com_content&task=view&id=150&Itemid=196

[5] www.ncpers.org/files/OPEB_2009.pdf

[6] Mercer National Survey of Employer-Sponsored Health Plans: 2005 Survey Tables, pg. 48.

[7] Employers may also drop access-only retiree health plans if proposed language in the House bill passes as it relates to the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). The House bill would allow COBRA–eligible individuals to stay on COBRA until the health insurance exchange is established.

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