The Impact of the Erosion of Retiree Health Benefits on Workers and Retirees
by Paul Fronstin, EBRI

- The percentage of private-sector employers offering health benefits to retirees has been declining in the United States for many years. In 2002, 13 percent of private-sector employers offered retiree health benefits to early retirees (pre-65), down from 22 percent in 1997. Similarly, in 2002, 13 percent of private-sector employers offered retiree health benefits to Medicare-eligible retirees (age 65 or older), down from 20 percent in 1997.

- **Reasons for the Decline:** The Financial Accounting Standards Board triggered most of the changes that private-sector employers have made to retiree health benefits when in 1990 it approved Financial Accounting Statement No. 106 (FAS 106). FAS 106 requires companies to record retiree health benefit liabilities on their financial statements in accordance with generally accepted accounting principles. With the new view of the cost, and the increasing cost of providing retiree health benefits in general, many private-sector employers began to overhaul their retiree health benefit programs in ways that controlled, reduced, or eliminated their costs. Today, the public sector faces similar accounting standards and similar cost pressures.

- **State and Local Governments:** The percentage of local governments offering retiree health benefits has declined, while the percentage of state governments offering it has increased.

- **Workers:** Workers today are less likely to expect to receive retiree health benefits in retirement than they were in the past. In 2002, 47 percent of workers ages 45–64 reported that they expect to receive retiree health benefits in retirement, down from 50 percent in 1997.

- **Retirees:** Both early retirees and Medicare-eligible retirees have experienced a decline in coverage for retiree health benefits. Between 1997 and 2002, the percentage of early retirees with retiree health benefits declined from 39.2 percent to 28.7 percent. Similarly, the percentage of Medicare-eligible retirees with retiree health benefits declined from 28.1 percent to 25.5 percent.

- **Implications:** Despite the fact that workers are more likely to expect retiree health benefits than retirees are actually likely to have those benefits, changes that employers have made to retiree health benefits will likely have a greater impact on today’s workers—which is to say future retirees. The changes that employers have made may not have a noticeable effect on trends in insurance coverage until a few years after the baby boom generation starts to retire and significant numbers of retirees discover the limits on or the costs of whatever retiree coverage they might have. Retirement behavior patterns may also change as employees nearing retirement age postpone their decision to retire upon learning that, without a job, they may not be able to obtain health insurance coverage, or they are unable to afford insurance premiums and/or out-of-pocket expenses. Public policymakers face the difficult task of trying to address these issues.
Paul Fronstin, EBRI senior research associate and director of the Health Research and Education Program, wrote this Issue Brief 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.

This publication is available for purchase online. Visit www.ebri.org/publications or call (202) 659-0570.

Table of Contents

Introduction ....................................................................................................................................3
Recent Trends in Retiree Health Benefits ..................................................................................4
Changes to the Benefits Package and Eligibility ......................................................................6
Impact of Benefit Changes on Employer Liability .....................................................................8
Impact of MMA on Retiree Health Benefits ..............................................................................8
Impact on Retirees ........................................................................................................................12
Overview .......................................................................................................................................12
Demographic Differences: Early Retirees ................................................................................12
Demographic Differences: Medicare-Eligible Retirees .............................................................14
Prior Job Characteristic Differences: Early Retirees .................................................................14
Prior Job Characteristic Differences: Medicare-Eligible Retirees ............................................14
Impact on Workers ......................................................................................................................15
Demographic Differences: Workers’ Expectations of Receiving Retiree Health Benefits ..........15
Job Characteristic Differences: Workers’ Expectations of Receiving Retiree Health Benefits 16
Conclusion.......................................................................................................................................17
References .......................................................................................................................................18
Endnotes .......................................................................................................................................19

Figures

Figure 1, Percentage of Private-Sector Establishments Offering Health Insurance to Retirees, 1997–
2002............................................................................................................................................ 5
Figure 2, Percentage of Local Governments With 250–999 Employees Offering Health Insurance to
Retirees, 1997–2002....................................................................................................................... 5
Figure 3, Percentage of State Governments Offering Health Insurance to Retirees, 1997–2002 ........ 5
Figure 4, Provision of Retiree Health Benefits for Current and All Future Retirees, Employers With
500+ Employees, 1993–2004....................................................................................................... 7
Figure 5, Provision of Retiree Health Benefits by Employers With 1,000+ Employees, 1991–2003 .... 7
Figure 6, Likelihood of Employers Providing Retiree Health Benefits, Sample of Same Employers With
1,000 or More Employees in 1991 and 1998 ............................................................................. 7
Introduction

Numerous studies have examined the erosion of employment-based retiree health benefits and its impact on retirees.\(^1\) These studies have consistently found that fewer employers are offering retiree health benefits. They have also shown that when retiree health benefits are offered, retirees are seeing various combinations of rising premiums, rising out-of-pocket expenses, and more stringent eligibility requirements. It has also been shown that retirees are going to bear an increasing burden of out-of-pocket costs in the future. The burden on retirees may grow as policymakers grapple with a $27.7 trillion dollar unfunded liability in the Medicare program, and an insolvency date of 2019 for the Medicare Part A (hospital insurance) trust fund.

Despite the fact that employers have been cutting back on retiree health benefits, previous studies generally have not found that fewer current retirees are covered by these benefits.\(^2\) Studies also generally have not focused on current workers and how many of them could be expected to have retiree health benefits once they retire. But new data indicate that many current retirees are finally beginning to feel the cutbacks in retiree health benefits they are receiving, that current workers are becoming increasingly pessimistic about ever receiving retiree health coverage, that some public-sector employers (notably local governments) are following the private-sector’s lead in cutting back on retiree health benefits, and that women, minorities, and those without advanced education are likely to be most affected by the decline in retiree health benefits.

About one-third of respondents to the Retirement Confidence Survey left the labor force earlier than expected for health reasons. The survey also found, however, that workers expect to work longer than
retirees actually worked (Helman and Paladino, 2004). Workers often remain in the labor force longer than expected to maintain health insurance. EBRI’s Health Confidence Survey (HCS) has found that 30 percent of workers expecting to retire before becoming eligible for Medicare would not do so if they did not receive retiree health benefits. Findings from the HCS suggest that individuals have a very poor understanding of the cost of health insurance. And, as shown below, workers are more likely to expect to have retiree health benefits than retirees are to actually have it—an expectation that is fairly certain to be dashed, given the erosion in retiree health benefits.

Taken together, this suggests the need for workers and retirees to incorporate the cost of health insurance and health care services into the retirement planning process more fully than in the past. For employers, and especially public policymakers, there are significant potential consequences for employment and retirement patterns from the combined erosion of employment-based retiree health benefits and the possible erosion of Medicare benefits as part of larger reforms to address that program’s unfunded liabilities. This Issue Brief uses recently released data from the U.S. Census Bureau to examine the impact of the erosion of retiree health benefits on workers and retirees. The next section examines recent trends in retiree health benefits. The following section examines the impact of the erosion of retiree health benefits on the percentage of retirees with benefits and how that has changed. The final section discusses the impact of this erosion on the percentage of workers expecting retiree health benefits and how that has changed.

**Recent Trends in Retiree Health Benefits**

Most workers in the United States will never be eligible for health insurance in retirement through an employer. Very few employers offer this benefit, and the number that do has been declining. The Agency for Healthcare Research and Quality (AHRQ) reports that only 13 percent of private-sector establishments offered health benefits to early retirees in 2002, down from 22 percent in 1997 (Figure 1). Furthermore, 13 percent of private-sector establishments offered health benefits to Medicare-eligible retirees in 2002, down from 20 percent in 1997.

The AHRQ survey shows a similar trend for local governments with fewer than 5,000 employees. For example, among local governments with 250–999 employees, 55 percent offered health benefits to retirees under age 65 in 2002, down from 62 percent in 1997, and 35 percent offered health benefits to retirees ages 65 and older, down from 47 percent in 1997 (Figure 2).

Local governments with 5,000 or more employees and state governments were generally more likely to offer retiree health benefits in 2002 than they were in 1997. For example, among state governments, 92 percent offered health benefits to retirees under age 65 in 2002, up from 76 percent in 1997, and 86 percent offered health benefits to retirees ages 65 and older, up from 69 percent in 1997 (Figure 3).

Large private-sector employers, however, are not expanding this benefit like large public-sector employers. According to a number of different surveys, large private-sector employers are less likely to offer retiree health benefits than in the past. An annual national survey of employers with 500 or more employees shows that the percentage that currently expect to continue offering health benefits to future early retirees declined from 46 percent in 1993 to 28 percent in 2004, while the portion expecting to offer such benefits to Medicare-eligible retirees declined from 40 percent in 1993 to 20 percent in 2004 (Figure 4). Another survey of large employers (most with 1,000 or more employees) also showed that the percentage of employers offering retiree health benefits has declined: Within this group, the likelihood of offering retiree health benefits to early retirees declined from 88 percent in 1991 to 68 percent in 2003, while the likelihood of offering retiree health benefits to Medicare-eligible retirees declined from 80 percent to 56 percent (Figure 5).

The decline in the likelihood that a private-sector employer offered retiree health benefits (shown in Figures 4 and 5) is mainly due to two factors: (1) some employers are terminating existing benefits for current and future retirees, and (2) new organizations are choosing not to offer retiree health benefits at all. To some degree, the data presented in Figures 4 and 5 overstate the extent to which employers are dropping retiree health benefits. When broad cross sections of employers have been studied over time,
it appears that employers are dropping retiree health benefits; however, new large employers most likely never offered retiree health benefits at all.\textsuperscript{4}

To understand how employers that offer retiree health benefits are changing their offer rate, it is important to examine a constant sample of employers. McArdle et al. (1999) examined a constant sample of private-sector employers between 1991 and 1998 and found that there had been a decline in the availability of retiree health benefits, but it was not as large as that portrayed in Figure 5. Figure 6 shows the trend for the constant sample of employers and finds that there was a 7 percentage point drop in the likelihood that employers offered retiree health benefits to early retirees between 1991 and 1998 and a 9 percentage point drop in the offer rate for Medicare-eligible retirees over the same period.

**Changes to the Benefits Package and Eligibility**

While many employers have dropped retiree health benefits, especially for future retirees, most that have continued to offer retiree health benefits have raised the premiums that retirees are required to pay, tightened eligibility, limited or reduced benefits, adopted access-only plans, or instituted some combination of these changes. Modifications to premiums are a common change, with employers asking retirees to pay a greater share of the cost of the premium. In 2000, 38 percent of employers with 500 or more employees offering retiree health benefits to early retirees required retirees to pay 100 percent of the premium for coverage, up from 31 percent in 1997 (Figure 7). Similarly, 37 percent of employers offering retiree health benefits to Medicare-eligible retirees required retirees to pay 100 percent of the premium for coverage, up from 27 percent.

Employers are also tightening eligibility requirements to control spending (McCormack et al., 2002). This might involve requiring workers to attain a certain age and/or tenure with the company before they qualify for retiree health benefits. Overall, the percentage of employers requiring an age of 55 and a service requirement of 10 years for benefit eligibility increased from 30 percent in 1996 to 38 percent in 2003 (Figure 8). Concurrently, some employers recently instituted a requirement of age 55 and 20 years service or age 60 and 10 years service.

Employers also have instituted caps or ceilings on the total amount of money they are willing to spend on retiree health benefits. Under a commonly used approach, once an employer reaches the spending cap, the subsidy of the retiree benefit will no longer be increased. These employers often continue to subsidize retiree health benefits, but retirees are responsible for the entire premium in excess of the cap amount each year. Caps erode the level of coverage even for employers continuing to provide retiree health benefits. In 2004, 54 percent of employers offering retiree health benefits reported having a cap on at least one of their plans (Figure 9). Among those with a cap, 84 percent of employers cap their contributions to the largest plan for early retirees, and 89 percent cap their contributions to the largest plan for Medicare-eligible retirees. More than 50 percent have reached the cap for the early retiree plan, and 56 percent have reached it for the Medicare-eligible plan. Another 9 percent expect to reach the cap within one year.

Some employers have reduced the subsidy or eliminated benefits altogether for workers hired (or 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 during either 2001 or 2002; 10 percent reported terminating all subsidized health benefits for future retirees in 2003; and 9 percent reported doing so in 2004 (Figure 10).

Some employers have established retiree medical accounts (RMAs) for retirees to use to purchase health benefits during retirement. Employers are interested in RMAs for a number of reasons:

- RMAs could reduce future employer cash costs for retiree health benefits.
- Contributions to the account may earn interest and the value of the contribution could grow over time, or could vary with age or years of service.
- The value of the RMA may not grow as fast as the anticipated cost of providing retiree health benefits, which essentially shifts the risk of unpredictable health benefit cost increases to employees and retirees.
Figure 4
Provision of Retiree Health Benefits for Current and All Future Retirees, Employers With 500+ Employees, 1993–2004


Figure 5
Provision of Retiree Health Benefits by Employers With 1,000+ Employees, 1991–2003


Figure 6
Likelihood of Employers Providing Retiree Health Benefits, Sample of Same Employers With 1,000 or More Employees in 1991 and 1998

RMAs are typically set up as a notional account, which means they are not actually prefunded, but are rather a bookkeeping device that allows employers and employees to keep track of the dollars that will be made available to the worker for health benefits during retirement. Employers make fixed contributions, or bookkeeping entries, to the account over a specific number of years, usually based on age and service requirements. Employees can also make contributions to the account, but those contributions must be made on an after-tax basis. When a worker retires, he or she can then use the money in the account to purchase health insurance, although the money in the account may or may not be enough to pay for health insurance in retirement. A recent study found that 2 percent of large employers have adopted RMAs for current retirees, while 7 percent have adopted them for future retirees and 13 have adopted them for new hires (McDevitt et al., 2002).

While state governments and large local governments have not eliminated coverage for future retirees, public-sector sponsors of retiree health benefits have taken measures similar to that seen in the private sector to cut the benefits package (U.S. Government Accountability Office, 2005).

Impact of Benefit Changes on Employer Liability

The “trigger event” that sparked most of the changes that private-sector employers have made to retiree health benefits can be traced back to December 1990, when the Financial Accounting Standards Board (FASB) approved Financial Accounting Statement No. 106 (FAS 106), “Employers’ Accounting for Postretirement Benefits Other Than Pensions.” FAS 106 markedly changed the way most private-sector companies accounted for retiree health benefits. It requires companies to record retiree health benefit liabilities on their financial statements in accordance with generally accepted accounting principles, beginning with fiscal years after Dec. 15, 1992. It required private-sector employers to accrue and expense certain future claims’ payments as well as actual paid claims. The immediate bookkeeping recognition of these liabilities dramatically impacts a company’s calculation of its profit and losses. It has affected mainly large employers, since small ones typically never offered retiree health benefits.

As a result of FAS 106, companies started to recognize the long-term liability of offering the benefit. With the new view of the cost, and the increasing cost of providing retiree health benefits in general, many private-sector employers began to overhaul their retiree health benefit programs in ways that controlled, reduced, or eliminated their costs, as discussed above. By now, these cuts would be expected to have had a major impact on employer FAS 106 liabilities, but this may not be the case for many employers. The U.S. Government Accountability Office (GAO) examined the financial statements of 50 randomly chosen Fortune 500 employers, and found that more than 90 percent of the employers offering retiree health benefits experienced an increase in their postretirement benefit obligations between 2001 and 2003, with some being 50 percent or higher (U.S. Government Accountability Office, 2005).

Both the GAO and AARP have also speculated about the impact of standards adopted by the Governmental Accounting Standards Board (GASB) on retiree health benefits in the public sector. GASB Statements No. 43 and No. 45 imposed new accounting standards on public-sector sponsors of retiree health benefits that are similar to those required of private-sector employers under FAS 106. 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 AARP study (as cited by GAO), it is unclear what impact GAS 43 and 45 would have on retiree health benefit programs in the public sector. GAS 43 and 45 may simply accelerate changes to benefit programs that are also affecting plan design and retiree premiums.

Impact of MMA on Retiree Health Benefits

On Dec. 8, 2003, President Bush signed into law the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, or MMA (P.L. 108–73). This act creates Medicare Part D, an outpatient prescription drug benefit for Medicare beneficiaries. There was much concern among policymakers and retirees with prescription drug benefits from former employers that the provision of a prescription drug...
**Figure 7**

Percentage of Large Employers Requiring Retiree to Pay Full Cost of Retiree Health Benefits, Employers With 500+ Employees, 1997–2003

<table>
<thead>
<tr>
<th>Year</th>
<th>Early Retirees</th>
<th>Medicare-Eligible Retirees</th>
</tr>
</thead>
<tbody>
<tr>
<td>1997</td>
<td>27%</td>
<td>31%</td>
</tr>
<tr>
<td>1998</td>
<td>35%</td>
<td>36%</td>
</tr>
<tr>
<td>1999</td>
<td>42%</td>
<td>40%</td>
</tr>
<tr>
<td>2000</td>
<td>39%</td>
<td>34%</td>
</tr>
<tr>
<td>2001</td>
<td>35%</td>
<td>31%</td>
</tr>
<tr>
<td>2002</td>
<td>37%</td>
<td>35%</td>
</tr>
<tr>
<td>2003</td>
<td>38%</td>
<td>37%</td>
</tr>
</tbody>
</table>


**Figure 8**

Eligibility Requirements for Retiree Health Benefits, Employers With 1,000 or More Employees, Selected Years, 1996 and 2003

<table>
<thead>
<tr>
<th>Requirement</th>
<th>1996</th>
<th>2003</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age 50 + 10 Years Service</td>
<td>1%</td>
<td>3%</td>
</tr>
<tr>
<td>Age 50 + 15 Years Service</td>
<td>1%</td>
<td>1%</td>
</tr>
<tr>
<td>Age 55 + 5 Years Service</td>
<td>2%</td>
<td>9%</td>
</tr>
<tr>
<td>Age 55 + 10 Years Service</td>
<td>3%</td>
<td>3%</td>
</tr>
<tr>
<td>Age 55 + 15 Years Service</td>
<td>5%</td>
<td>8%</td>
</tr>
<tr>
<td>Age 55 + 20 Years Service</td>
<td>0%</td>
<td>2%</td>
</tr>
<tr>
<td>Age 60 + 10 Years Service</td>
<td>0%</td>
<td>2%</td>
</tr>
<tr>
<td>Based on Age/Service Points</td>
<td>1%</td>
<td>9%</td>
</tr>
<tr>
<td>Based on Age and/or Service Plus Age/Service Points</td>
<td>6%</td>
<td>2%</td>
</tr>
<tr>
<td>Two or More Alternatives</td>
<td>35%</td>
<td>18%</td>
</tr>
<tr>
<td>Other (e.g., Age Only or Service Only)</td>
<td>11%</td>
<td>10%</td>
</tr>
</tbody>
</table>

Source: Hewitt Associates.

**Figure 9**

Percentage of Large Private-Sector Employers With a Cap on Their Firm's Contributions to Retiree Health Benefits

<table>
<thead>
<tr>
<th>Percentage With a Cap on Any Plan</th>
<th>54%</th>
</tr>
</thead>
</table>

Among Employers With a Cap:

<table>
<thead>
<tr>
<th>Plan Is Capped</th>
<th>Pre-65 Retirees</th>
<th>Medicare-eligible Retirees</th>
</tr>
</thead>
<tbody>
<tr>
<td>Have Already Hit Cap</td>
<td>53%</td>
<td>56%</td>
</tr>
<tr>
<td>Anticipate Hitting Cap Within the Next Year</td>
<td>9%</td>
<td>9%</td>
</tr>
<tr>
<td>Anticipate Hitting Cap Within the Next 3 Years</td>
<td>19%</td>
<td>18%</td>
</tr>
<tr>
<td>Do Not Anticipate Hitting the Cap</td>
<td>19%</td>
<td>18%</td>
</tr>
</tbody>
</table>

Source: [www.kff.org/medicare/med121404pkg.cfm](http://www.kff.org/medicare/med121404pkg.cfm)
benefit under Medicare might cause employers to drop coverage for retirees. Prior to the passage of MMA, researchers provided a range of estimates on the impact of the availability of prescription drug benefits through Medicare. The Congressional Budget Office (CBO) reported that under the Medicare prescription drug legislation, 2.7 million Medicare beneficiaries (or 23 percent of participants in the Medicare prescription drug program with employment-based prescription drug benefits) would no longer have those employment-based benefits. Another study found that of all Part B enrollees (including those who likely would not enroll in the Medicare program) with employment-based drug coverage, 17 percent would lose that coverage as a result of employer decisions to eliminate drug coverage for retirees, due to the Medicare prescription drug benefit (Holtz-Eakin, 2003). Similarly, Thorpe (2003) found that about one-quarter of retirees with prescription drug benefits, or approximately 2.1 million private-sector retirees, would lose their coverage.

However, these estimates reflected expected employer behavior over the 10-year budget-estimating period, and did not take into consideration other factors that may affect employers’ decisions to continue to offer prescription drug coverage. An EBRI analysis found that between 2 percent and 9 percent of current Medicare beneficiaries with employment-based retiree health benefits for prescription drugs would lose those benefits if Medicare provided outpatient prescription drug coverage, solely as a result of that change in the program. Other environmental factors, such as business, accounting, and cost trends, were already causing a decrease in the percentage of employers offering retiree health benefits, regardless of policy changes in the Medicare program (Salisbury and Fronstin, 2003).

Because of the concern that employers would drop retiree prescription drug benefits if Medicare provided it, Congress added a provision in MMA that subsidizes some employer costs for prescription drugs for retirees.7 Since MMA was enacted, there has been much interest in how employers would respond to the subsidy provision: Employers could use the subsidy in MMA to cover some of the cost of drug benefits for retirees, or they could offer drug benefits that would “wrap around” (or supplement) the benefits provided through Medicare Part D. Both options would presumably lower employer costs for drug benefits for retirees. However, employers also could drop benefits altogether and save even more money than they would save under either the subsidy option or the wrap-around option. A recent study8 found that many employers were going to continue offering drug benefits while accepting the 28 percent federal subsidy.

Specifically, the study found that 58 percent of private-sector employers were planning to continue offering drug benefits while accepting the 28 percent subsidy, 17 percent were going to offer a supplemental plan to Medicare, and 8 percent were going to discontinue drug coverage for retirees (Figure 11) (this latter estimate represents about 4 percent of Medicare-eligible retirees enrolled in the employers’ largest retiree plan).

Thirteen percent of employers did not know which strategy their firm would choose. This latter estimate would be expected to be much higher, as the study also found that only 34 percent of employers had evaluated the financial impact of the various options under MMA. The two findings suggest that the estimates in Figure 11 may change, as employers better understand the financial impact of the various options. However, a survey conducted after the release of Centers for Medicare & Medicaid Services proposed rules and other guidance on the employer subsidy was in large part consistent with the findings from the 2004 Kaiser/Hewitt Survey on Retiree Health Benefits. The more recent study found that of the 90 percent of employers planning to continue offering drug benefits, 55 percent have either decided on or are leaning toward accepting the subsidy, 19 percent have either decided on or are leaning toward the wrap-around option, and 23 percent were undecided (Deloitte, 2005). In the recent U.S. GAO study, 12 private-sector employers were interviewed and only two of them had made a decision regarding the strategy they would use to reduce drug spending. The remainder, and the three public-sector employers interviewed, were still considering the available options.

Even before the availability of the Medicare Part D drug benefit, many employers are reflecting the potential savings in their financial statements. The GAO found that 27 of the 39 Fortune 500 employers...
Figure 10
Percentage of Large Private-Sector Employers That Terminated All Subsidized Benefits for Future Retirees, 2002–2004

<table>
<thead>
<tr>
<th>Year</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>2002</td>
<td>13%</td>
</tr>
<tr>
<td>2003</td>
<td>10%</td>
</tr>
<tr>
<td>2004</td>
<td>9%</td>
</tr>
</tbody>
</table>


* In 2002, survey asked employers about changes made to plan during previous two years. In 2003 and 2004, employers were asked about the past year.

Figure 11
Strategies Private-Sector Employers Are Likely to Choose Under Medicare Drug Law

- Offer Drug Benefits To Retirees and Accept 28% Subsidy (58%)
- Other (4%)
- Don't Know (13%)
- Discontinue Drug Benefits (8%)
- Offer Drug Benefits To Retirees as a Supplement to Part D (17%)


Figure 12
Likelihood of Making Selected Changes to Retiree Health Benefits Within the Next Three Years

<table>
<thead>
<tr>
<th>Change to Benefits</th>
<th>Very Likely</th>
<th>Somewhat Likely</th>
<th>Somewhat Unlikely</th>
<th>Very Unlikely</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increase Retiree Contribution to Premiums</td>
<td>56%</td>
<td>29%</td>
<td>7%</td>
<td>8%</td>
</tr>
<tr>
<td>Increase Dependent Contributions to Premiums</td>
<td>49%</td>
<td>26%</td>
<td>11%</td>
<td>14%</td>
</tr>
<tr>
<td>Increase Coinsurance or Copayments</td>
<td>20%</td>
<td>31%</td>
<td>26%</td>
<td>24%</td>
</tr>
<tr>
<td>Increase Deductibles</td>
<td>15%</td>
<td>28%</td>
<td>33%</td>
<td>25%</td>
</tr>
<tr>
<td>Provide Access Only</td>
<td>11%</td>
<td>7%</td>
<td>20%</td>
<td>62%</td>
</tr>
<tr>
<td>Offer Catastrophic Plan Plus Savings Account</td>
<td>6%</td>
<td>13%</td>
<td>28%</td>
<td>52%</td>
</tr>
<tr>
<td>Terminate All Subsidized Benefits for Future Retirees</td>
<td>5%</td>
<td>6%</td>
<td>23%</td>
<td>66%</td>
</tr>
<tr>
<td>Shift to DC Approach</td>
<td>4%</td>
<td>9%</td>
<td>23%</td>
<td>63%</td>
</tr>
<tr>
<td>Add or Improve Coverage or Benefits for Retirees</td>
<td>4%</td>
<td>7%</td>
<td>24%</td>
<td>65%</td>
</tr>
<tr>
<td>Eliminate Prescription Drug Coverage</td>
<td>1%</td>
<td>4%</td>
<td>20%</td>
<td>75%</td>
</tr>
<tr>
<td>Terminate All Subsidies for Current Retirees</td>
<td>0%</td>
<td>1%</td>
<td>16%</td>
<td>84%</td>
</tr>
</tbody>
</table>

Source: www.kff.org/medicare/med121404pkg.cfm
filed with the SEC had reported reductions in their FAS 106 liability, some in excess of $100 million. This should not be interpreted as suggesting that employers will stop making other changes to retiree health benefit programs: More than 50 percent of employers say they are very likely to increase retiree contributions to premiums over the next three years, 49 percent are very likely to increase premiums for dependents, 20 percent are very likely to increase co-payments or coinsurance, and 15 percent are very likely to increase deductibles (Figure 12).

**Impact on Retirees**

In order to understand the impact that the erosion of retiree health benefits has had on retirees, data from the Survey of Income and Program Participation (SIPP) are examined. Data for this article come from the 1996 and 2001 SIPP panels. In Wave 5 of each panel, questions were asked regarding health benefits in the workplace, health benefits in retirement, and job characteristics associated with the job from which an individual retired. These topical questions were asked in 1997 and 2002. Early retirees (persons ages 55–64) are examined separately from Medicare-eligible retirees (persons ages 65 and older) because employers are generally more likely to offer retiree health benefits to early retirees than to Medicare-eligible retirees.

**Overview**

The sample of data used from SIPP for this article represents 6 million retirees ages 55–64 in 1997 and 8.5 million in 2002 (Figure 13). The sample also includes 19.7 million retirees ages 65 and older in 1997 and 22.3 million in 2002.

Among retirees ages 55–64, the percentage with retiree health benefits declined between 1997 (39.2 percent) and 2002 (28.7 percent) (Figure 14). This represents a decline of 26.8 percent.

Among Medicare-eligible retirees (ages 65 and older), the percentage with retiree health benefits also declined, from 28.1 percent in 1997 to 25.5 percent by 2002, a drop of 9.1 percent.

**Demographic Differences: Early Retirees**

Overall, the percentage of early retirees with retiree health benefits has declined 26.8 percent. The decline of retiree health benefits appears to have affected younger retirees, women, and those without advanced education more than their counterpart groups. Retirees of all ages have experienced a decline in retiree health coverage, with younger retirees (those ages 55–59) experiencing a 28.6 percent decline in coverage, and older early retirees (those ages 60–64) experiencing a 24.3 percent decline (Figure 14). Both males and females have experienced a decline in coverage, but females were more than twice as likely to experience a decline in retiree health coverage than males. Males ages 55–64 were nearly 16 percent less likely to have retiree health benefits in 2002 than in 1997, while females were nearly 36 percent less likely.

Among early retirees, whites were less likely to have retiree health benefits in 2002 than in 1997, but there were no statistically significant differences for persons of other races. There were some statistically significant differences for some regions, but it is not quite clear what these data mean, as they refer to where retirees currently reside, not where they were living when they retired.

With respect to education, all early retirees except those with post-college degrees experienced a decline in the likelihood of having retiree health benefits between 1997 and 2002. Retirees without a college degree experienced a 34 percent decline in the likelihood of having retiree health benefits, while those with a college degree experienced a 28 percent decline.

The age of retirement also appears to be a factor in the decline in retiree health benefits for early retirees. Retirees who left their job before age 55 experienced a 43 percent decline in the likelihood of having retiree health benefits, compared with a 22 percent decline for retirees ages 55–64. As discussed above, when employers changed eligibility requirements for retiree health benefits, the changes were often not effective immediately. Most of the people affected by these changes had not yet retired. The data from SIPP appear to indicate that the changes employers have made in the availability of the benefit on retirement are finally having more of an effect on recent retirees than on older retirees.
**Figure 13**

**Overview of SIPP® Data**

<table>
<thead>
<tr>
<th>Data Set</th>
<th>1996 Panel Wave 5</th>
<th>2001 Panel Wave 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of Individuals Age 45 and Older</td>
<td>(millions)</td>
<td>(percentage)</td>
</tr>
<tr>
<td>Wage and salary workers ages 45–64</td>
<td>87.3</td>
<td>102.4</td>
</tr>
<tr>
<td>Wage and salary workers ages 45–64 expecting retiree health benefits upon retirement</td>
<td>16.9</td>
<td>50.2%</td>
</tr>
<tr>
<td>Retirees(^b)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>55–64</td>
<td>6.0</td>
<td>8.5</td>
</tr>
<tr>
<td>with retiree health benefits in own name</td>
<td>2.3</td>
<td>39.2</td>
</tr>
<tr>
<td>65 and older</td>
<td>19.7</td>
<td>22.3</td>
</tr>
<tr>
<td>with retiree health benefits in own name</td>
<td>5.5</td>
<td>28.1</td>
</tr>
</tbody>
</table>

Source: Employee Benefit Research Institute.


\(^b\) Defined as persons reporting having left a job after age 45.

**Figure 14**

**Retiree Health Benefits, by Demographics, 1997 and 2002**

<table>
<thead>
<tr>
<th></th>
<th>Early Retirees (Age 55–64)</th>
<th>Medicare-Eligible Retirees (Age 65 and Older)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1997 (millions)</td>
<td>2002 (millions)</td>
</tr>
<tr>
<td>Total</td>
<td>39.2</td>
<td>28.7</td>
</tr>
<tr>
<td>Age</td>
<td></td>
<td></td>
</tr>
<tr>
<td>55–59</td>
<td>35.4</td>
<td>25.3</td>
</tr>
<tr>
<td>60–64</td>
<td>41.2</td>
<td>31.2</td>
</tr>
<tr>
<td>65–69</td>
<td></td>
<td></td>
</tr>
<tr>
<td>70–74</td>
<td></td>
<td></td>
</tr>
<tr>
<td>75–79</td>
<td></td>
<td></td>
</tr>
<tr>
<td>80 or older</td>
<td>21.8</td>
<td>22.3</td>
</tr>
<tr>
<td>Gender</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>48.5</td>
<td>40.6</td>
</tr>
<tr>
<td>Female</td>
<td>29.0</td>
<td>18.5</td>
</tr>
<tr>
<td>Race/Ethnicity</td>
<td></td>
<td></td>
</tr>
<tr>
<td>White</td>
<td>41.8</td>
<td>30.5</td>
</tr>
<tr>
<td>Black</td>
<td>34.0</td>
<td>28.5</td>
</tr>
<tr>
<td>Hispanic</td>
<td>14.1</td>
<td>9.5</td>
</tr>
<tr>
<td>Other</td>
<td>24.1</td>
<td>17.8</td>
</tr>
<tr>
<td>Region</td>
<td></td>
<td></td>
</tr>
<tr>
<td>New England</td>
<td>35.7</td>
<td>28.8</td>
</tr>
<tr>
<td>Middle Atlantic</td>
<td>40.0</td>
<td>29.5</td>
</tr>
<tr>
<td>East North Central</td>
<td>49.3</td>
<td>36.4</td>
</tr>
<tr>
<td>West North Central</td>
<td>32.5</td>
<td>25.7</td>
</tr>
<tr>
<td>South Atlantic</td>
<td>43.3</td>
<td>27.4</td>
</tr>
<tr>
<td>East South Central</td>
<td>36.0</td>
<td>26.0</td>
</tr>
<tr>
<td>West South Central</td>
<td>34.3</td>
<td>25.9</td>
</tr>
<tr>
<td>Mountain</td>
<td>28.0</td>
<td>27.3</td>
</tr>
<tr>
<td>Pacific</td>
<td>33.6</td>
<td>26.5</td>
</tr>
<tr>
<td>Education</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Less than high school</td>
<td>18.3</td>
<td>12.1</td>
</tr>
<tr>
<td>High school or some college</td>
<td>42.0</td>
<td>28.0</td>
</tr>
<tr>
<td>College</td>
<td>49.4</td>
<td>35.4</td>
</tr>
<tr>
<td>Post-college</td>
<td>63.1</td>
<td>53.6</td>
</tr>
<tr>
<td>Age Retired</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Under age 55</td>
<td>38.0</td>
<td>21.6</td>
</tr>
<tr>
<td>55–64</td>
<td>42.6</td>
<td>33.1</td>
</tr>
<tr>
<td>65 or older</td>
<td>18.1</td>
<td>19.7</td>
</tr>
</tbody>
</table>


**Change in percentage of retirees with retiree health benefits is statistically significant at the 100% confidence level.**

**Change in percentage of retirees with retiree health benefits is statistically significant at the 95% confidence level.**

* Change in percentage of retirees with retiree health benefits is statistically significant at the 90% confidence level.
Demographic Differences: Medicare-Eligible Retirees

While the likelihood that early retirees have retiree health benefits declined 26.8 percent between 1997 and 2002, it declined only 9.1 percent for Medicare-eligible retirees. The impact on Medicare-eligible retirees may be lower because they were more likely to have been “grandfathered” into a plan when their former employer (or soon-to-be former employer at the time) changed eligibility requirements for retiree health benefits. As with early retirees, age, gender and education tend to be major factors affecting retiree health benefits, with race also showing up as a statistically significant factor as well.

Like early retirees, changes in the likelihood of having retiree health benefits vary by age for Medicare-eligible retirees. Retirees ages 70–74 experienced a 17.6 percent decline in retiree health benefits (Figure 14). While retirees in other age groups also experienced a decline, the changes were not statistically significant. Also, females experienced a statistically significant decline of 14.7 percent in the likelihood of having retiree health benefits, while males did not experience a statistically significant change.

Medicare-eligible retirees who are white experienced a modest decline in the likelihood of having retiree health benefits, but those who are Hispanic experienced a 67.6 percent increase. With respect to education, all Medicare-eligible retirees except those with post-college degrees experienced a decline in the likelihood of having retiree health benefits between 1997 and 2002. And, finally, Medicare-eligible retirees who retired before age 55 were less likely to have retiree health benefits in 2002 than in 1997.

Prior Job Characteristic Differences: Early Retirees

While both retirees from union and nonunion jobs have experienced a decline in retiree health benefits, union retirees have fared much better than nonunion retirees. Specifically, union retirees experienced a 12.5 percent decline in the likelihood of having retiree health benefits, while nonunion retirees experienced a 32.1 percent decline (Figure 15). With respect to industry, retirees from the public sector had the highest probability of having retiree health benefits and experienced the smallest declined between 1997 and 2002, 15.1 percent. Workers in all other industries experienced declines in retiree health benefits, with manufacturing workers experiencing less erosion in coverage than other private-sector industries. This may be due to the fact that the manufacturing sector is more likely to be unionized than other private-sector industries.

Private-sector retirees generally experienced a larger erosion in retiree health benefits than public-sector retirees, but retirees from the federal government appear to have experienced a statistically significant erosion of 26.1 percent between 1997 and 2002. Retirees with lower income in their last job were generally more likely to experience a decline in the likelihood of having retiree health benefits, and workers in large firms were less likely than workers in small firms to experience a decline. This may be because very few small employers ever offered retiree health benefits.

Prior Job Characteristic Differences: Medicare-Eligible Retirees

Unlike the experience of retirees ages 55–64, union Medicare-eligible retirees were more likely to experience a reduction in the likelihood of having retiree health benefits than nonunion retirees. Union retirees experienced a statistically significant 11.1 percent reduction in the probability of having retiree health benefits, compared with a statistically insignificant reduction of 6.1 percent among nonunion retirees (Figure 15). Even after the decline, union retirees were still nearly twice as likely as nonunion retirees (37.9 percent and 21.4 percent, respectively) to have retiree health benefits.

Also unlike the experience of retirees 55–64, Medicare-eligible retirees in the public sector have been most likely to experience a decline in retiree health benefits. The probability of having retiree health benefits declined 17.7 percent between 1997 and 2002 for persons retired from the public sector. State and local government retirees experienced a greater decline in coverage than federal government retirees. This compared with 9.4 percent of retirees from manufacturing. Similar to the experience of union retirees, public-sector retirees are still most likely to have retiree health benefits. Nearly 40 per-
percent of public-sector retirees had retiree health benefits in 2002, compared with 30.7 percent of retirees from manufacturing jobs, 19.2 percent of retirees from service-sector and other jobs, and 11 percent of retirees from the trade industry.

Not only are higher income Medicare-eligible retirees more likely to have retiree health benefits, but they are also less likely to have lost those benefits between 1997 and 2002. In contrast, Medicare-eligible retirees who retired from a large firm were most likely to have retiree health benefits in 2002, but they were significantly less likely to have those benefits in 2002 compared with 1997.

Impact on Workers

Data from the Survey of Income and Program Participation (SIPP) are also used to examine the impact of the erosion of retiree health benefits on workers. The sample of data used from SIPP for this article represents 33.5 million wage and salary workers ages 45–64 in 1997 and 40.9 million in 2002 (Figure 13).

Just over 50 percent of wage and salary workers ages 45–64 (or 16.9 million of all wage and salary workers that age), expected to receive retiree health benefits at retirement in 1997, and by 2002 this had declined to 47.4 percent (or 19.4 million).

Demographic Differences: Workers’ Expectations of Receiving Retiree Health Benefits

In 2002, 47 percent of workers ages 45–64 expected to receive retiree health benefits once retired, down from 50 percent in 1997 (Figure 16). This is a decline of 5.6 percent. Workers ages 45–64 were significantly less likely to expect to have retiree health benefits between 1997 and 2002. Workers at older ages were not significantly less likely to expect benefits in retirement. While men were more
likely than women to expect to have retiree health benefits in retirement (51 percent and 43 percent, respectively), only men were significantly less likely to expect to receive those benefits between 1997 and 2002. Similarly, white and black workers were more likely than Hispanic and workers of other races to receive retiree health benefits in retirement, but the expectation of receiving those benefits in retirement declined significantly for whites and blacks, although not for Hispanics or workers of other races.

**Job Characteristic Differences: Workers’ Expectations of Receiving Retiree Health Benefits**

Union workers are much more likely than nonunion workers to expect to receive retiree health benefits upon retirement. In 2002, 66 percent of union workers and 43 percent on nonunion workers expected to receive these benefits (Figure 17). Both union workers and nonunion workers were less likely to report that they expected to receive these benefits in 2002 than in 1997. Between 1997 and 2002, the expectations of receiving retiree health benefits dropped 5.8 percent among union workers and 4.6 percent among nonunion workers.

Public-sector workers were much more likely than workers in other industries to expect to receive retiree health benefits. Nearly three-quarters of public-sector workers reported in 2002 that they...
expected to receive retiree health benefits, compared with (in the private sector) 53 percent of manufacturing workers, 46 percent of service-sector workers, 40 percent of workers in the trade industries, and 32 percent of workers in other industries. Only workers in the manufacturing sector and the service sector were less likely to report that they expected to receive retiree health benefits in 2002 compared with their expectation in 1997. However, when examining public-sector workers more closely, workers employed by the federal government were significantly less likely to expect retiree health benefits in 2002 than in 1997, while there was no change for state or local government workers.

Low-income workers were generally less likely than higher-income workers to expect to receive retiree health benefits. About one-quarter of workers earning less than $10,000 expected to receive retiree health benefits, compared with 61 percent of workers earning $50,000 or more. However, between 1997 and 2002, the percentage of workers earning less than $10,000 expecting to receive retiree health benefits increased by 24.2 percent. In contrast, the percentage of workers earning $20,000 or more who reported that they expected to receive retiree health benefits declined significantly between 1997 and 2002.

Workers employed part-time were less likely than full-time workers to expect retiree health benefits in 2002. About 50 percent of full-time workers expected retiree health benefits, while 29 percent of workers employed 20–34 hours per week expected it, and 20 percent of workers employed less than 20 hours per week expected it. The percentage of full-time workers expecting retiree health benefits declined from 56 percent to 51 percent between 1997 and 2002. In contrast, the percentage of part-time workers employed less than 20 hours expecting retiree health benefits increased by 63.3 percent (from 12 percent in 1997 to 20 percent in 2002), while the percentage of workers employed 20–34 hours per week expecting retiree health benefits increased by 20.8 percent (from 24 percent in 1997 to 29 percent in 2002).

Generally, workers in large firms are more likely than workers in small firms to expect retiree health benefits. In 2002, 55 percent of workers employed in firms with 100 or more employees expected retiree health benefits, compared with 36 percent of workers in firms with 25–99 employees, and 26 percent of workers in firms with fewer than 25 employees. Between 1997 and 2002, the percentage of workers employed in firms with 100 or more employees expecting retiree health benefits declined by 9.3 percent, while it increased by 17.8 percent among workers employed in firms with fewer than 25 employees.

**Conclusion**

FAS 106 triggered substantial changes to retiree health benefits starting more than a decade ago. Some employers capped their spending on retiree health benefits. Some required employees to meet age and service requirements before becoming eligible for retiree health benefits. Others moved to access-only plans, defined contribution plans, or completely eliminated retiree health benefits for either current retirees or future retirees.

New data reveal the changes that employers have made to retiree health benefits are finally having an impact on the percentage of *retirees* with retiree health benefits and the percentage of workers expecting to have those benefits in the future. Between 1997 and 2002, the portion of workers expecting retiree health benefits dropped from 50.2 percent to 47.4 percent, the portion of early retirees with health benefits dropped from 39.2 percent to 28.7 percent, and the portion of Medicare-eligible retirees with retiree health benefits dropped from 28.1 percent to 25.5 percent.

Despite the fact that *workers* are more likely to *expect* retiree health benefits than *retirees* are actually *likely to have* those benefits, changes that employers have made to retiree health benefits will likely have a greater impact on today’s workers—which is to say future retirees. The changes that employers have made may not have a noticeable effect on trends in insurance coverage until a few years after the baby boom generation starts to retire and significant numbers of retirees discover the limits on or the costs of whatever retiree coverage they might have. Retirement behavior patterns may also change as employees nearing retirement age postpone their decision to retire upon learning that, without a job,
they may not be able to obtain health insurance coverage—or as EBRI has shown in previous work, they
are unable to afford insurance premiums and/or out-of-pocket expenses.10

Public policymakers face the difficult task of trying to provide solutions to the problems of a system
that is largely voluntary. The availability of subsidies to employers for drug benefits under
employment-based retiree programs is one step in this direction. However, because employers are
under no obligation to provide retiree health benefits, except to current retirees who can prove that they
were promised a specific benefit, it is likely that employers will continue to make changes to retiree
health benefits (especially for future retirees) in response to predicted future medical costs, unfavorable
court rulings involving the Age Discrimination in Employment Act, and potential federal legislative
initiatives.

It is clear from the research that workers are far more likely to expect to receive retiree health benefits
than retirees are to receive them. As current trends continue, and workers come to understand to true
availability and cost of retiree health benefits, baby boomers may find themselves unpleasantly
surprised by what awaits them in retirement.

References
Brief no. 175 (Employee Benefit Research Institute, July 1996).
__________. “Retiree Health Benefits: Trends and Outlook.” EBRI Issue Brief no. 236 (Employee
Benefit Research Institute, August 2001).
Fronstin, Paul, and Dallas Salisbury. “Retiree Health Benefits: Savings Needed to Fund Health Care in
Retirement.” EBRI Issue Brief no. 254 (Employee Benefit Research Institute, February 2003).
__________. “Health Care Expenses in Retirement and the Use of Health Savings Accounts.” EBRI
Issue Brief no. 271 (Employee Benefit Research Institute, July 2004).
Gabel, Jon. Erosion of Private Health Insurance Coverage for Retirees, The Commonwealth Fund
Helman, Ruth, and Variny Paladino, “Will Americans Ever Become Savers? The 14th Annual
Retirement Confidence Survey.” EBRI Issue Brief no. 268 (Employee Benefit Research Institute, April
2004).
Henry J. Kaiser Family Foundation and Hewitt Associates, Findings From the Kaiser/Hewitt Survey on
McDevitt, Roland D., Janemarie Mulvey, and Sylvester J. Schieber. Retiree Health Benefits: Time to
Salisbury, Dallas, and Paul Fronstin. “How Many Medicare Beneficiaries Will Lose Employment-Based
Retiree Health Benefits if Medicare Covers Outpatient Prescription Drugs?” EBRI Special Report SR-43


________. *Kansas Future Retirement Income Assessment Project of the EBRI Education and Research Fund and Milbank Memorial Fund* (Employee Benefit Research Institute, March 31, 2002a).

________. *Massachusetts Future Retirement Income Assessment Project of the EBRI Education and Research Fund and Milbank Memorial Fund* (Employee Benefit Research Institute, Dec. 1, 2002b).

________. “Can Americans Afford Tomorrow’s Retirees: Results From the EBRI-ERF Retirement Security Projection Model.” *EBRI Issue Brief* no. 263 (Employee Benefit Research Institute, November 2003).

**Endnotes**


2 Fronstin (2001) found no change in the percentage of early retirees with retiree health benefits between 1994 and 1999, and subsequent unpublished research indicates that this trend has continued. The U.S. Government Accountability Office (2005) has also found that the overall percentage of Medicare-eligible retirees and their insured dependents obtaining health benefits through a former employers remained relatively constant between 1995 and 2003, but did find a modest decline in coverage among persons ages 65–79.

3 See www.ebri.org/hcs/2003/03hcspq.pdf

4 Cross sections that include these new employers cannot be used to examine individual employer behavior over time. Instead, they provide snapshots of the availability of retiree health benefits at a point in time to population groups across many employers.

5 FASB is the professional organization that establishes standards of financial accounting and reporting. As early as the mid-1980s, employers were aware that FASB was considering accounting standard changes that would affect the way they would be required to account for retiree health benefits on financial statements. This led to a number of studies on early FASB draft proposals, and presumably resulted in some employers making changes to retiree health benefits even before FAS 106 was finalized. For example, see Employee Benefit Research Institute (1988) for a study that analyzed an early FASB draft proposal that formed the basis of FAS 106. The study illustrated a range of liabilities for three hypothetical companies and indicated the annual expenditures required to finance the benefits during the covered workers’ terms of employment.


7 MMA provides a 28 percent subsidy for employer expenses incurred between $250 and $5,000.

8 See www.kff.org/medicare/med121404pkg.cfm (last reviewed February 2005).

9 SIPP provides comprehensive information about the income of individuals and households in the United States. It also provides information on participation in public programs. SIPP is a nationally representative longitudinal survey of the civilian noninstitutionalized U.S. population. People selected into the SIPP sample are interviewed once every four months over the life of the panel. In addition to the core set of questions asked of participants each four months, a rotating set of topical questions supplement the core questions.

The Employee Benefit Research Institute (EBRI) was founded in 1978. Its mission is to contribute to, to encourage, and to enhance the development of sound employee benefit programs and sound public policy through objective research and education. EBRI is the only private, nonprofit, nonpartisan, Washington, DC-based organization committed exclusively to public policy research and education on economic security and employee benefit issues. EBRI’s membership includes a cross-section of pension funds; businesses; trade associations; labor unions; health care providers and insurers; government organizations; and service firms.

EBRI’s work advances knowledge and understanding of employee benefits and their importance to the nation’s economy among policymakers, the news media, and the public. It does this by conducting and publishing policy research, analysis, and special reports on employee benefits issues; holding educational briefings for EBRI members, congressional and federal agency staff, and the news media; and sponsoring public opinion surveys on employee benefit issues. EBRI’s Education and Research Fund (EBRI-ERF) performs the charitable, educational, and scientific functions of the Institute. EBRI-ERF is a tax-exempt organization supported by contributions and grants.

EBRI Issue Briefs are periodicals providing expert evaluations of employee benefit issues and trends, as well as critical analyses of employee benefit policies and proposals. EBRI Notes is a monthly periodical providing current information on a variety of employee benefit topics. EBRI’s Pension Investment Report provides detailed financial information on the universe of defined benefit, defined contribution, and 401(k) plans. EBRI Fundamentals of Employee Benefit Programs offers a straightforward, basic explanation of employee benefit programs in the private and public sectors. EBRI Databook on Employee Benefits is a statistical reference volume on employee benefit programs and work force related issues.

Contact EBRI Publications, (202) 659-0670; fax publication orders to (202) 775-6312. Subscriptions to EBRI Issue Briefs are included as part of EBRI membership, or as part of a $199 annual subscription to EBRI Notes and EBRI Issue Briefs. Individual copies are available with prepayment for $25 each (for printed copies) or for $7.50 (as an e-mailed electronic file) by calling EBRI or from www.ebri.org. Change of Address: EBRI, 2121 K Street, NW, Suite 600, Washington, DC 20037, (202) 659-0670; fax number, (202) 775-6312; e-mail: Publications Subscriptions@ebri.org. Membership Information: Inquiries regarding EBRI membership and/or contributions to EBRI-ERF should be directed to EBRI President/AEC Chairman Dallas Salisbury at the above address, (202) 659-0670; e-mail: salisbury@ebri.org