Chapter 26

Retiree Health Benefits

Introduction

Retiree health benefits were originally offered on a very limited basis in the late 1940s and 1950s. The number of employers offering these benefits expanded in the late 1960s in conjunction with the creation of the Medicare program. The benefits were provided as part of the health plan for active workers, generally without a separate premium structure or separate accounting. In subsequent years, the changing demographics of the work force, coupled with increasing life spans and rising health care costs, left many employers with higher retiree-to-active-worker ratios, increasing the costs and liabilities of retiree medical benefits.

In 1989, the Financial Accounting Standards Board (FASB) issued Statement No. 106 (FAS 106), "Employers' Accounting for Postretirement Benefits Other Than Pensions," which required companies to account for these benefits and report liabilities for the future value of all promised benefits on their corporate balance sheets, beginning with fiscal years after Dec. 15, 1992. For the first time, the true cost of the benefits was understood (Employee Benefit Research Institute, 1988, 1989). Prior to FAS 106, companies were only required to disclose information on the existence of plans and amounts of benefit outflows. Governmental Accounting Standards Board (GASB) Statements No. 43 and No. 45 imposed new accounting standards upon 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 the years of service as opposed to reporting the cost on a pay-as-you-go-basis.

As a result of FAS 106, and the increasing cost of providing retiree health benefits in general, many employers began a major overhaul of their retiree health benefit programs. Some employers placed caps on what they were willing to spend on retiree health benefits. Others added age and service requirements; moved to some type of "defined contribution" health benefit; completely dropped retiree health benefits for future retirees; or dropped benefits for current retirees, although this happened less frequently than other changes. While these changes do not appear to be having much impact on current retirees, they are likely to be felt most by future retirees who are not yet or may never become eligible for retiree health benefits, especially since an employer plan sponsor has an unqualified right to termi-

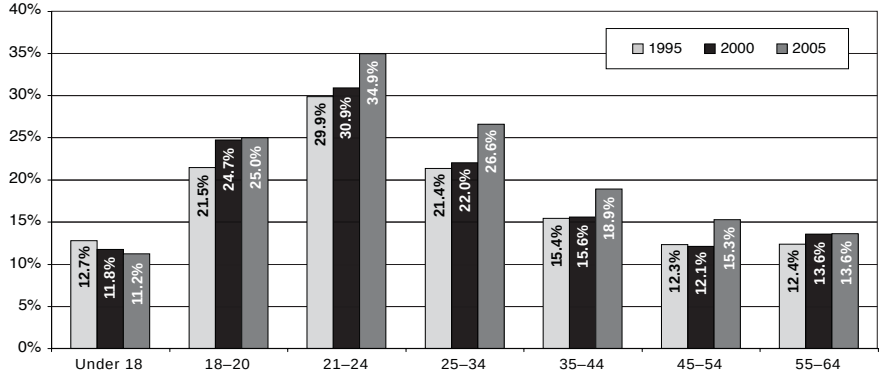
nate, modify, or amend unvested retiree health benefits if no commitment has been made to provide the benefit (Davis, 1991).

Retiree Health Participation and Cost

Since 1994, the percentage of persons ages 55–64 without health insurance generally has been fluctuating. Between 1994 and 1999, the percentage of the population ages 55–64 who were uninsured increased from 12.8 percent to 13.5 percent (EBRI estimates from the Current Population Survey). Since 1999, the percentage of Americans ages 55–64 without health insurance coverage remained rather stable, reaching 13.6 percent in 2005 (Figure 26.1). Recently, the percentage of persons ages 55–64 with employ-

Figure 26.1

Percentage of Uninsured Americans, by Age, 1995, 2000, and 2005



Source: Employee Benefit Research Institute estimates from the Current Population Survey, March 1996, 2001, and 2006 Supplements; *EBRI Notes,* January 2007.

ment-based health benefits decreased, from 68.1 percent in 2003 to 66.7 percent in 2005.

Coverage overall has been stable for workers. The percentage of workers ages 55–64 with no health insurance increased, from 11 percent in 1994 to 12.3 percent in 1999 (Fronstin, 2001), but decreased slightly to 11.9 percent in 2005. As the percentage of workers 55–64 with employment-based health insurance increases, the percentage with either coverage purchased in the individual market or public coverage declines. The percentage of workers ages 55–64 with employment-based health benefits increased, from 77.1 percent in 1994 to 79.1 percent in 2003. Since 2003, the percentage of workers 55–64 with employment-based health insurance has declined, reaching 77.6 percent in 2005. The percentage with insurance purchased directly

from an insurer declined from 9.4 percent in 1994 to 6.8 percent in 2005, and the percentage with public coverage declined from 8.6 percent in 1994 to 6.6 percent in 2003. After 2003, the percentage of workers ages 55–64 with public coverage increased to 8.5 percent in 2005.

Similar patterns can be seen in sources of coverage for retirees, although the trends are more pronounced. For example, the likelihood of a retiree age 55–64 being uninsured increased from 15.1 percent in 1994 to 17.8 percent in 2001, but declined to 16.6 percent in 2003. After 2003, the percentage of retirees ages 55–64 increased to 17.3 percent in 2005. In contrast, the percentage of retirees ages 55–64 with employment-based health benefits increased from 56.1 percent in 1994 to 57.2 percent in 2003. After 2003, the percentage of retirees ages 55–64 with employment-based health insurance declined to 54.4 percent in 2005. As the likelihood of a retiree having employment-based health insurance coverage declined from 2003–2005, the likelihood of having health insurance purchased in the individual market increased from 11.1 percent in 2003 to 13.0 percent in 2005.

The experience of the ill and disabled (persons not working for health reasons) is much different from that of workers and retirees. In general, the likelihood of an ill or disabled person being uninsured has been declining. In 1994, 14.1 percent of the ill and disabled were uninsured, compared with 6.5 percent in 2003. However, since 2003, the likelihood of an ill or disabled person ages 55–64 being uninsured increased sharply to 9.7 percent in 2005. The ill and disabled experienced an increase in the likelihood of being covered by either Medicare or Medicaid between 1994 and 2005. The variation in coverage from one year to the next among the ill and disabled is much greater than it is for workers and retirees. This may be the result of actual changes taking place, such as moving from one health insurance status to another. It also may be because this group is smaller than other groups.

Medicare

There are two basic designs for retiree health benefit plans: one for plans covering retirees under age 65 and one covering retirees age 65 and older. The reason for this age distinction is that eligibility for the Medicare program begins at age 65. For retirees under age 65, the benefit plan is usually based on the coverage they received while working, although, in recent years, the premium-sharing feature in programs for early retirees has increasingly differed from that in programs for active employees. For retirees age 65 and older, the benefit plan is coordinated with Medicare.

Medicare Basics—The Medicare program is the critical component of any employment-based retiree health benefit plan for Medicare-eligible retirees. Medicare is the primary payer of medical services for most Medicare

enrollees, except for active workers age 65 and older with employment-based health benefits. Most employer plans that extend health insurance coverage to retirees age 65 and older are coordinated with Medicare.

Medicare is currently composed of two parts. Part A covers hospital and post-hospital skilled nursing care facility services, and Part B covers physician and outpatient services and medical devices. Both parts cover home health care services. Part D covers out-patient prescription drugs. The following discussion highlights some of the services that Medicare does not cover and Medicare's deductibles and copayments.

An important service to the elderly not covered by Medicare is long-term care. Long-term care includes nonmedical services, such as help with activities of daily living that may nevertheless require the assistance of a medical professional.

Medicare's deductibles and copayments can become quite expensive. For a hospital stay of up to 60 days, the deductible was $1,068 in 2009. Beyond the first 60 days in a hospital, Medicare beneficiaries are responsible for daily copayments. In 2009, a $267 per day copayment during days 61–90, and $534 per day during days 91–150 was required. Medicare provides all beneficiaries with 60 lifetime reserve days that can be used for hospitalizations longer than 90 days. Once these reserve days are all used, Medicare does not pay for any hospital days that exceed the 90-day limit. The copayment for the lifetime reserve days in 2009 was $534 per day. There was also a copayment required of $133.50 per day for services provided in a skilled nursing facility during days 21–100. For outpatient and physician services, Medicare required a $135 deductible and a 20 percent copayment for most services, although there is 50 percent coinsurance for mental health care services.

Integration With Medicare—Because Medicare does not cover some vital medical services and the copayments and deductibles can become quite expensive, a continuation of health benefits into retirement can be a great financial bonus to a retiree age 65 and older. Employers use various methods to integrate their retiree health plans for retirees age 65 and older with Medicare. Some of the more common methods are:

- *Medicare carve-out*—With this method, Medicare's payment is subtracted from the employer plan's normal benefit.
- *Exclusion or nonduplication*—With this method, Medicare benefits are deducted from a covered expense before normal employer plan benefits are calculated.
- *Medigap*—With this method, the employer plan pays for some services not covered or reimbursed by Medicare, based on standardized coverage outlined by the government.

Medicare Advantage—Medicare has long provided an option designed to control the government's costs while offering a wider array of services to beneficiaries who elect to deal with a preferred provider organization. Within this program, providers receive a fixed annual payment for each participating beneficiary, irrespective of the services required by the individual. Prior to 2004, this program was known as Medicare+Choice.

Proponents argued that, since health maintenance organizations (HMOs) had contracts with the government and agreed to care for beneficiaries for a fixed annual fee, they could deliver care more cheaply and thus afford to include added benefits at a lower total cost. But some argued that these plans would be attractive only to relatively healthy beneficiaries and would be ignored by the sick minority who are responsible for most of the costs.

Both sides agree that the critical calculation involves setting the HMO capitation rate at a level low enough to save the government money but high enough to be attractive to the HMOs. During the late 1990s and into early 2000, there had been a failure to reach this equilibrium point, and HMOs in many markets exited the program. As a result, during those years, this program was much more popular with beneficiaries than with providers. In an effort to revive the popularity of such plans, the 2003 Medicare Modernization Act included more generous reimbursement for a limited number of years.

FAS 106

In addition to issues concerning Medicare, employers are faced with Financial Accounting Statement No. 106 (FAS 106), which requires companies to accrue the cost of retiree health benefits and to record a liability for unfunded retiree medical costs explicitly on their financial statements. FAS 106 became effective starting with fiscal years beginning after Dec. 15, 1992. Many companies elected to recognize the "transition obligation" that FAS 106 created by reporting immediately and taking a one-time charge against earnings on their financial statements. Some companies instead elected to amortize the cost of the transition to the new accounting statement over time, spreading the cost over either a 20-year period or a period representing the future service to the participants at the date of transition. FAS 106 applies to current and future retirees, their beneficiaries, and qualified dependents. FAS 106 has forced employers to confront the issue of funding for their retiree health plans.

Other post-employment benefits (OPEB) obligations (including retiree health benefits) can be significant liabilities for individual companies. For example, in the automotive industry for the year ended Dec. 31, 2006,

each of the following companies recorded the following OPEB obligations (including medical, dental, life, and vision benefits), as reported in publicly available electronic copies of the annual reports filed with the Securities and Exchange Commission (SEC), in billions: Ford Motor Company, $25.9 billion; and General Motors Corporation, $64 billion.

Tax Planning

Prefunding the retiree health liability is one option open to employers, with some tax advantages and limitations. Funds must be segregated and restricted (usually in a trust) to be used as an asset against the FAS 106 liability. Vehicles that can be used for this purpose include Internal Revenue Code (IRC) Sec. 501(c)(9) trusts, also known as voluntary employees' beneficiary associations (VEBAs), and IRC Sec. 401(h) plans. Alternatively, other retirement plans can be used to help employers and employees set aside monies to help plan for the purchase of retiree health insurance, although these funds are not specifically reserved for this purpose. Such plans include 401(k) plans, corporate-owned life insurance, and employee stock ownership plans. Not all are tax-deductible means of funding or setting money aside, and each has specific limits. In addition, under IRC Sec. 420(c)(3), well-funded pension plans may be able to use excess pension assets in a defined benefit plan to finance payment of retiree health care claim costs by transferring some of the pension surplus to a retiree medical account established under IRC Sec. 401(h).

Although VEBAs are generally tax-exempt, unrealized business income tax (UBIT) applies to a VEBA's taxable income (e.g., investment income) to the extent the VEBA's assets exceeds its "account limit." The account limit for non-collectively bargained retiree health VEBAs is zero. Accordingly, UBIT generally would apply to taxable investment income from assets set aside to fund retiree health benefits. There are two important exemptions to the taxability of unrelated business income that are utilized by sponsors looking for ways to finance these benefits. They are:

- Employee-pay-all VEBAs.
- Collectively bargained VEBAs.

IRC Sec. 401(h) permits a qualified retirement plan to provide medical benefits to retirees, their spouses, and their dependents so long as such benefits are "subordinate" to the primary purpose of providing retirement income to the participants. Earnings in a 401(h) account are generally exempt from income tax. Unfortunately, a rule in the tax code requiring that 401(h) benefits be "subordinate" effectively eliminates the ability of many plan sponsors to accumulate funds in a Sec. 401(h) account.

IRC Sec. 420 allows surplus assets to be transferred from overfunded pension plans to pay retiree medical claims and expenses. To use this provision, the sponsor must set up a 401(h) account in the pension plan that has surplus assets. The Pension Protection Act of 2006 allows pension plans with assets above 120 percent of the plan's current liability (or funding target) to transfer two years or more of estimated retiree medical costs to the 401(h) account. The maximum amount that could be transferred is the lesser of 10 years of estimated retiree medical costs or assets in excess of 120 percent of current liability. For each year in which a transfer is made, the employer must make contributions that are sufficient to maintain the plan's 120 percent funding level or it must transfer assets back from the 401(h) account to the pension account. In addition, employers that want to transfer excess pension assets to a retiree health account must not reduce the number of people covered by retiree health benefits by more than 10 percent in any year, and by no more than a cumulative 20 percent over a five-year period. In certain cases, bigger reductions may be made by combining the per-person minimum-cost rule with the number-of-persons rule.

Retiree Health Benefits Design

Because of the limited tax preferences of the available funding vehicles, employers are looking to reduce their FAS 106 liability by redesigning their retiree health benefit plans. In general, the percentage of employers offering health benefits to future retirees seems to be declining. An annual survey of employers with 500 or more workers shows that the percentage that offer retiree health benefits on an ongoing basis (meaning employers planning to offer coverage at retirement for the foreseeable future, to both current and newly hired employees) declined from 46 percent in 1993 to 29 percent in 2006 for pre-Medicare eligibles and from 40 percent in 1993 to 19 percent in 2005 for Medicare eligibles (Mercer Human Resources Consulting, 2007). The percentage of employers offering health benefits to Medicare-eligible retirees today and planning to offer them to future Medicare eligible retirees is also declining.

Another survey of larger employers (most with 1,000 or more employees) also showed that the percentage offering retiree health benefits has declined. The likelihood of offering retiree health benefits to early retirees declined from 88 percent in 1991 to 52 percent in 2005 (Hewitt Associates LLC, 2005). The decline in the likelihood that an employer offered retiree health benefits is mainly due to two factors: (1) some employers are terminating existing benefits, and (2) new organizations are choosing not to offer retiree

health benefits at all. To some degree the data above overstate the extent to which employers are *dropping* retiree health benefits. When broad cross sections of employers are studied over time, it appears that employers are dropping retiree health benefits; however, new large employers most likely never offered these benefits. Thus, the cross sections that include these new employers are not examining employer behavior over time as much as they are providing snapshots of the availability of retiree health benefits.

In order to understand how employers that offer retiree health benefits are changing their benefit packages, it is important to examine a constant sample of employers. McArdle et al. (1999) examined a constant sample of 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 found when examining a random cross section of employers. McArdle et al. (1999) shows the trend for the constant sample of employers and reports that there was a 7-percentage point drop in the likelihood that employers offered retiree health benefits to early retirees and a 9-percentage point drop for Medicare-eligible retirees.

Most employers that continue to offer retiree health benefits have made changes in the benefit package. Modifications to cost-sharing provisions are a common change, with employers asking retirees to pick up a greater share of the cost of coverage. In 2006, 43 percent of employers with 500 or more workers offering retiree health benefits to pre-Medicare eligible retirees required retirees to pay 100 percent of the premium for coverage, up from 31 percent of employers in 1997 (Mercer Human Resources Consulting, 2007).

Employers do not have to change the benefits package to control spending on retiree health benefits. Instead, they can tighten eligibility requirements, for instance, by requiring workers to attain a certain age and/or tenure with the company before they can receive any retiree health benefits. Overall, the percentage of employers requiring an age of 55 and a service requirement of 10 years increased from 30 percent in 1996 to 37 percent in 2005 (Hewitt Associates LLC, 2005). At the same time, some employers instituted a requirement of age 55 and 20 years service or age 60 and 10 years service for the first time. Employers have also instituted caps on the total amount of money they are willing to spend on retiree health benefits.[1] In 1993, 72 percent of employers with 1,000 or more employees did not have any type of cap on their total contributions, compared with 38 percent in 2005 (Hewitt Associates LLC, 2005).

Employers also are continuing to consider more changes to retiree health benefits. Seventy-four percent of employers said they were likely to increase

[1] Caps could work on a total aggregate spending basis or on a per-retiree basis.

the amount retirees are asked to pay, while 7 percent were likely to impose a cap on their contributions between 2005 and 2006 (McArdle et al., 2006).

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 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; 9 percent reported doing so in 2004; and 11 percent between 2005–2006. It will be a few more years before sufficient data are available to explain how workers and retirees will be affected by cutbacks in retiree health benefits. Many workers may never qualify for retiree health benefits because their employers offer them only to workers hired before a specific date or because they may never reach the age and/or service requirements needed to qualify for benefits.

Employers should make any changes to a retiree health benefit plan with great care in order to avoid a class action lawsuit. Any ambiguity in plan documents can be interpreted in favor of retirees.

Retiree Medical Accounts (RMAs)

Some employers already have established retiree medical accounts (RMAs) for future and current retirees. These benefits are more similar to defined contribution (DC) or hybrid retirement benefits, such as 401(k) or cash balance plans, than DC health benefits would be for active employees. Like DC participants in a retirement plan, active employees with an RMA would typically accumulate funds in an account during their working lives. After retiring, they could use the funds in the account to purchase health insurance from their former employer or union, or directly from an insurer.

While working, each employee would have an account. The account might be funded or unfunded. Both employer and employees could contribute to the value of account balances. Employer contributions to the value of the account could be unfunded. If only employer contributions were made to the account, the employer could use a notional account similar to a cash balance pension plan, and could amend, modify, or even terminate the plan at any time for current and/or future retirees. If employee contributions were made to the account, an actual account would have to be established as the employees would "own" their contributions (i.e., such amounts would be fully funded), although they would not own the employer contributions.

One issue to consider when deciding who may contribute to the account is the tax treatment of contribution sources and of the resulting investment income. Employer contributions to the account could be designed so as not to

be treated as taxable income to the employee, either during working years or during retirement upon payout of insurance benefits. Active employee contributions, however, could not be excluded from taxable income like contributions employees make toward health benefits (through IRC Sec. 125 plans) during their working years, unless certain strict rules are met. If employer contributions are made to a funded, non-collectively bargained VEBA, the taxable income of the VEBA would generate unrelated business income tax. However, although employee contributions would be made on an after-tax basis, to the extent they are paid into an employee-pay-all VEBA, the investment income of that VEBA would not generally be subject to unrelated business income tax.

Another issue to consider in designing a plan is how to treat new employees who are older than the plan's entry age when they join the employer. A "lump-sum" or opening balance could be provided to employees who join the plan if they commence participation after entry age into the plan has passed.

Employers could require that employees meet an age and/or service requirement before being allowed to use the funds in the account to buy insurance during retirement. Employers could also vary their contribution to the accounts based on age and/or service requirements. Age requirements are common in defined benefit pension plans, in which an employee does not qualify for retirement benefits until he or she reaches a minimum age. As mentioned above, age requirements are also increasingly common for qualifying for retiree health benefits. It is likely that employers with both a defined benefit pension plan and retiree health benefits would consider using the same age qualifications across the benefit plans.

After retirement, retirees could use the funds accumulated in the account to buy health insurance. The insurance could be provided by the employer—meaning, the employer would continue to decide what benefits to offer and at what price or the employer could allow retirees to buy insurance on their own and pay an insurer of the retirees' choice directly.

Employers are interested in RMAs for a number of reasons. Prefunding an account could reduce future employer costs for retiree health benefits. By prefunding an account, an employer decides how much to contribute to retiree health benefits while a person is working. Contributions to the account could accumulate interest and the value of the contribution could grow over time or could vary with age or years of service, but it is possible that the value of the account would not grow as fast as the anticipated cost of providing retiree health benefits. Essentially, in this type of model the risk of unpredictable health benefit cost inflation is borne by employees.

Employers must also specify how the account could be used once an employee retires. As mentioned above, employers could continue to provide

the health benefit. This means retirees would be purchasing health insurance from their former employer using funds accumulated in the account. In contrast, employers might allow retirees to use the funds to purchase any health insurance, including policies sold directly by insurers. Account balances also could be used to pay out-of-pocket expenses, such as deductibles, co-payments, and health care services not covered by the benefit plan.

Whether retirees are allowed to use the funds accumulated in the account to purchase insurance on their own or as a spending account, they run the risk of depleting the assets in the account while money is still needed to purchase insurance. As a result, employers run the risk of losing a tool to manage the retirement process. If employees think that the balance of their account is not large enough to pay for retiree health benefits, they may postpone their retirement date until they are closer to being eligible for Medicare. Research already shows a strong link between a worker's decision to retire and the availability of retiree health benefits (Fronstin, 1999).

Hence, it will be an important exercise for retirees to predict how much it will cost them to purchase health insurance during retirement, and whether there will be enough assets accumulated in the account to purchase health insurance throughout their lifetimes. If a shortfall is expected, retirees may want to start saving additional funds for later years. They also may want to use some of their own money up front, rather than the funds in the account, if they expect the cost of insurance to increase faster than the gains on the assets accumulated in the account, or because health care cost inflation is typically higher than overall inflation and may outpace what the account earns over time. The decision to use personal assets, rather than the assets accumulated in an unfunded account, is highly complex and involves predicting the cost of health insurance, the composition of the benefits package, the rate of return on personal assets, the rate of return on the assets in the paper account, life expectancy, future income, other budget needs, and the ability of the plan sponsor to make good on its promise to fund the liability.

Because the RMA could be depleted before the death of a retiree, employers could consider allowing retirees to convert their account balance to an annuity. While the annuity may not provide enough funds to cover the full cost of health insurance, retirees would be guaranteed a stream of funds until their (or their spouse's) death. The annuity also could allow for different payouts before and after age 65, when the cost of health insurance falls substantially for retirees because they become eligible for Medicare. Annuities, however, may be taxable if the retiree has a choice between receiving money or health insurance.

Conclusion

FAS 106 triggered substantial changes to retiree health benefits. Some employers capped their spending on retiree health benefits. Others required employees to meet age and service requirements before becoming eligible for retiree health benefits. Still others moved to defined contribution health benefits, or completely dropped retiree health benefits.

However, the changes that employers have made to retiree health benefits have not yet had a huge impact on current retirees. Between 1994 and 2005, the percentage of retirees ages 55–64 with retiree health benefits from their own employer was unchanged at roughly 37 percent, although it is likely that many current retirees are paying more to maintain retiree health benefits.

The changes that employers have made to retiree health benefits will likely have a greater impact on future retirees. These changes may not have noticeable effects on trends in insurance coverage until a few years after the baby boom generation starts to retire. 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.

Public policymakers face the difficult task of trying to provide policy solutions for a system that is largely voluntary. By law, employers are under no obligation to provide retiree health benefits except to current retirees who can prove that they were promised a specific benefit. In the meantime, it is likely that employers will continue to make changes to retiree health benefits in response to future predicted health care costs and potential federal legislative initiatives.

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Additional Information

AARP
601 E Street, NW
Washington, DC 20049
(202) 434-2277
www.aarp.org/health

Aon Corporation
Research and Technical Services
P.O. Box 926
222 Merrimac Street
Newburyport, MA 01950
(800) 438-6487
www.aon.com

The Conference Board
845 Third Avenue
New York, NY 10022
(212) 759-0900
www.conference-board.org/knowledge/hrOrganization.cfm

Hewitt
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Lincolnshire, IL 60069
(847) 295-5000
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18700 W. Bluemound Road
Brookfield, WI 53008
(414) 786-6700
www.ifebp.org

Kaiser Family Foundation
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Menlo Park, CA 94025
(650) 854-9400
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National Academy of Social Insurance
1776 Massachusetts Avenu, NW, Suite 615
Washington, DC 20036
(202) 452-8097
www.nasi.org