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. Since 1999, the percentage of Americans ages 55–64 without health insurance coverage declined, reaching 13 percent in 2003. Recently, the percentage of persons ages 55–64 with employment-based health benefits generally increased between 2000 (66.9 percent) and 2003 (68.1 percent).

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, 2001b), but fell to 13.1 percent in 2003. This trend masks important variation in the sources of health insurance. Overall, the percentage of workers ages 55–64 with employment-based health benefits has been increasing, while the percentage with insurance purchased directly from an insurer or public coverage has been declining. Specifically, the percentage of workers with employment-based health benefits increased from 77.1 percent in 1994 to 79.1 percent in 2003, while the percentage with insurance purchased directly from an insurer declined from 9.4 percent in 1994 to 6.8 percent in 2003, and the percentage with public coverage declined from 8.6 percent in 1994 to 6.6 percent in 2003.

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. 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. This increase in employment-based health benefits was partly due to the fact that the percentage of retirees with health benefits through a spouse increased from 19 percent in 1994 to 19.7 percent in 2003, while the percentage with health benefits through a former employer or union changed slightly. Despite the increase in the likelihood of being covered by employment-based health benefits, early retirees experienced an increase in the likelihood of being uninsured because the likelihood of purchasing health insurance directly from an insurer declined from 16.5 percent in 1994 to 11.1 percent in 2003.

The experience of 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 declin-
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In 1994, 14.1 percent of the ill and disabled were uninsured, compared with 6.5 percent in 2003. The ill and disabled experienced an increase in the likelihood of being covered by either Medicare or Medicaid between 1994 and 2003. 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, programs for early retirees have increasingly featured different premium sharing than programs for active employees. For retirees age 65 and older, the benefit plan is coordinated with Medicare. (See chapter on 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 for medical services for all enrollees, except for active workers age 65 and older with employment-based health benefits. All 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. The following discussion highlights some of the services that Medicare does not cover and Medicare’s deductibles and copayments. In 2006, Medicare beneficiaries will be able to enroll in Part D, an outpatient prescription drug plan.

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 is $912 in 2005. Beyond the first 60 days in a hospital, Medicare beneficiaries are responsible for a $228 per day copayment during days 61–90, and $456 per day during days 91–150. 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 2005 is $456
per day. There is also a copayment required of $114 per day for home health
care services provided during days 21–100. For outpatient and physician
services, Medicare requires a $110 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 sub-
  tracted 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 ben-
  efits 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 participat-
ing beneficiary, irrespective of the services required by the individual. Prior
to 2004, this program was known as Medicare+Choice.

Proponents argued that, since 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. In recent years, there has been
a failure to reach this equilibrium point, and HMOs in many markets have
exited the program. To date, this program has been much more popular with
beneficiaries than with providers. In an effort to revive the popularity of
such plans, the 2003 Medicare drug bill 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, effective for 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, 2001, 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: Daimler-Chrysler AG, 15.1 billion (Euros); Ford Motor Company, $25.4 billion; and General Motors, Corporation, $52.5 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 over-funded 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 employer can then annually transfer pension surplus sufficient to pay the retiree medical claims and expenses for the year, contingent upon meeting certain other conditions, including making a commitment to maintain the plan’s expenditure per average retiree for five years after the transfer is made. 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.

**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 currently expect to continue offering health benefits to future early 
retirees declined from 46 percent in 1993 to 28 percent 2000 (Mercer Human 
Resources Consulting, 2004). 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 employ-
ees) also showed that the percentage offering retiree health benefits has 
decreased. The likelihood of offering retiree health benefits to early retirees 
decreased from 88 percent in 1991 to 68 percent in 2003 (Hewitt Associates 
LLC). 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 2000, 38 percent of employers with 500 or more 
workers offering retiree health benefits required retirees to pay 100 percent 
of the premium for coverage, up from 31 percent of employers in 1997 
(Mercer Human Resources Consulting, 2004).

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 five years increased from 30 percent in 1996 to 38
percent in 2003 (Hewitt Associates LLC). 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. 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 46 percent in 2003 (Hewitt Associates LLC). Only 4 percent of those with a defined dollar cap on the employer subsidy have indexed it for inflation.

Employers also are continuing to consider more changes to retiree health benefits. Eighty-five percent of employers are likely to increase the amount retirees are asked to pay, while 13 percent are likely to impose a cap on their contributions (www.kff.org/medicare/med121404pkg.cfm).

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; and 9 percent reported doing so in 2004. 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.

“DC” Health

Currently, some employers are interested in the concept of “defined contribution” (DC) health benefits as an alternative to the current “defined benefit” health benefits system. This type of approach is also being considered as an alternative way to provide health benefits to retirees. There are numerous issues that employers and employees must address in order to switch to a DC health benefits system for active workers for current health insurance needs (Fronstin, 2001a), but many of these are not applicable or easily addressed in a DC health benefits system for retiree health benefits. However, there are different issues to address. The remainder of this section describes how DC health benefits for retirees could work in practice, as well as some issues specific to retiree health benefits.

1 Caps could work on a total aggregate spending basis or on a per-retiree basis.
Some employers already have established DC health benefits for retirees. These benefits are more similar to 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 in a DC health plan for retiree health benefits 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. 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. The opening balance also could be tied to age and/or years of service.

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 retiree’s choice directly.

Employers are interested in DC accounts for retiree health benefits 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 DC health account 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 upon payout if the retiree has a choice between receiving money or health insurance.

It is important to understand the basic difference in how DC health benefits would work in practice for active workers and for retirees. For active workers, a DC health benefit would be used to fund their current health insurance. While DC health benefits could be provided under a number of different scenarios, under all scenarios employers would generally provide a fixed contribution that employees would use to buy health insurance. In contrast, DC health benefits for retirees are a mechanism used to accumulate assets in an account, either a real account or a notional one, which could then be used to purchase health insurance once a person retires. While the risk of health care cost inflation is transferred to employees under both types of DC arrangements, the risk for retirees may be greater because of the longer time frame between the accumulation of assets to pay for health insurance and the actual purchase of insurance and the risk of assets being insufficient to keep up with the cost of health insurance increases.

Under both arrangements, individuals may have to use some of their own money to buy insurance, but the plans differ in of how much money and when it is used. For example, under a DC health benefits arrangement for active workers, employers may provide a fixed contribution that covers only 90 percent of the cost of health insurance. In order to buy insurance, employees would then have to pay the difference each month. Under a DC health benefits arrangement for retirees, it is likely that the retiree would have accumulated enough assets in the account to buy health insurance without
having to use his or her own funds for at least a few years, or could apportion the funds so that all of the assets accumulated in the account are not used at once. However, as mentioned above, once the assets in the fund are depleted, the retiree will then need to purchase health insurance with his or her own funds.

**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 2000, the percentage of retirees ages 55–64 with retiree health benefits 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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