

Introduction

Chairman Johnson, Ranking Member Andrews, and Members of the Committee, thank you for the opportunity to testify on the current environment for employer-sponsored retiree health plans. I am Chip Kerby, a consulting attorney and principal with the Washington Resource Group of William M. Mercer, Incorporated. Mercer is a global consulting firm that helps organizations in all aspects of strategic and operational human resource consulting. Our special areas of emphasis include employee benefits, compensation, communication, and actuarial services.

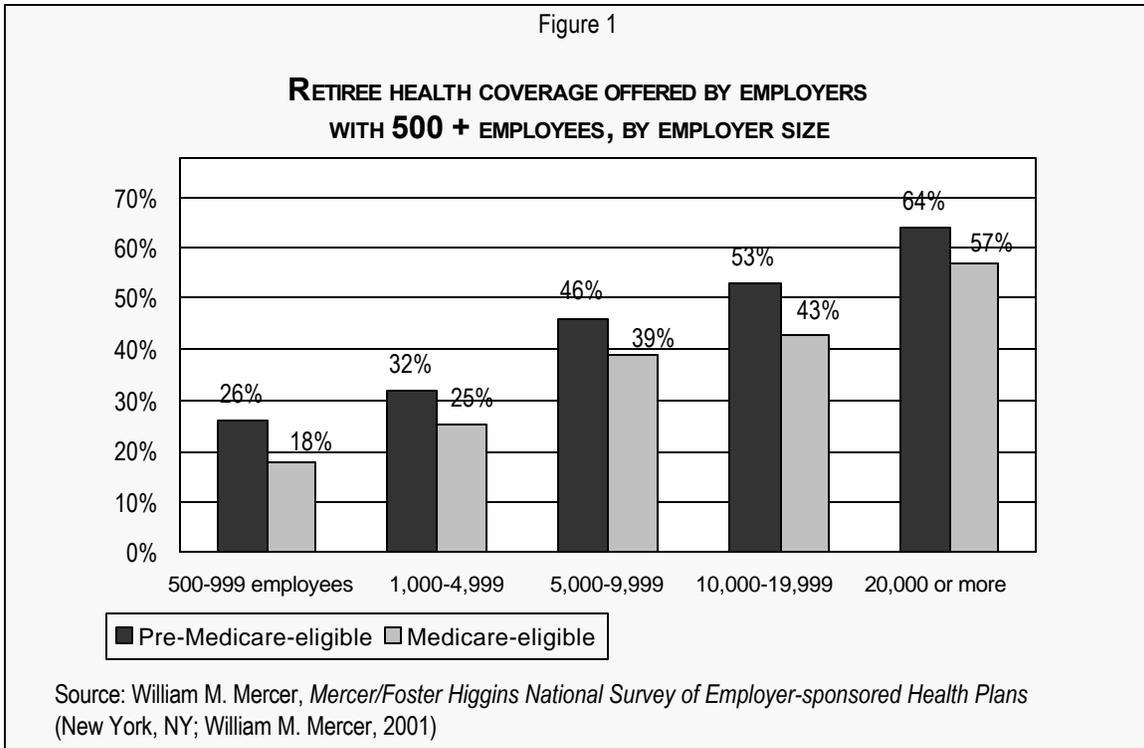
Mercer works primarily with large employers, many of whom sponsor retiree health plans. For years, these employers voluntarily offered retiree health coverage to their retirees. But the pressures on retiree health plan sponsors are significant and growing. Escalating retiree health costs, rapidly aging workforces, the volatility of the Medicare+Choice system, the possibility of a Medicare prescription drug benefit, and accounting, funding and litigation constraints are causing many employers to reevaluate their retiree health programs.

As Congress begins to tackle the complex issues facing retiring workers, this Committee is to be commended for its efforts to understand how retiree health plans fit into this equation. My testimony today will address recent retiree health plan trends, the challenges facing retiree health plan sponsors, and the policy consequences associated with these developments.

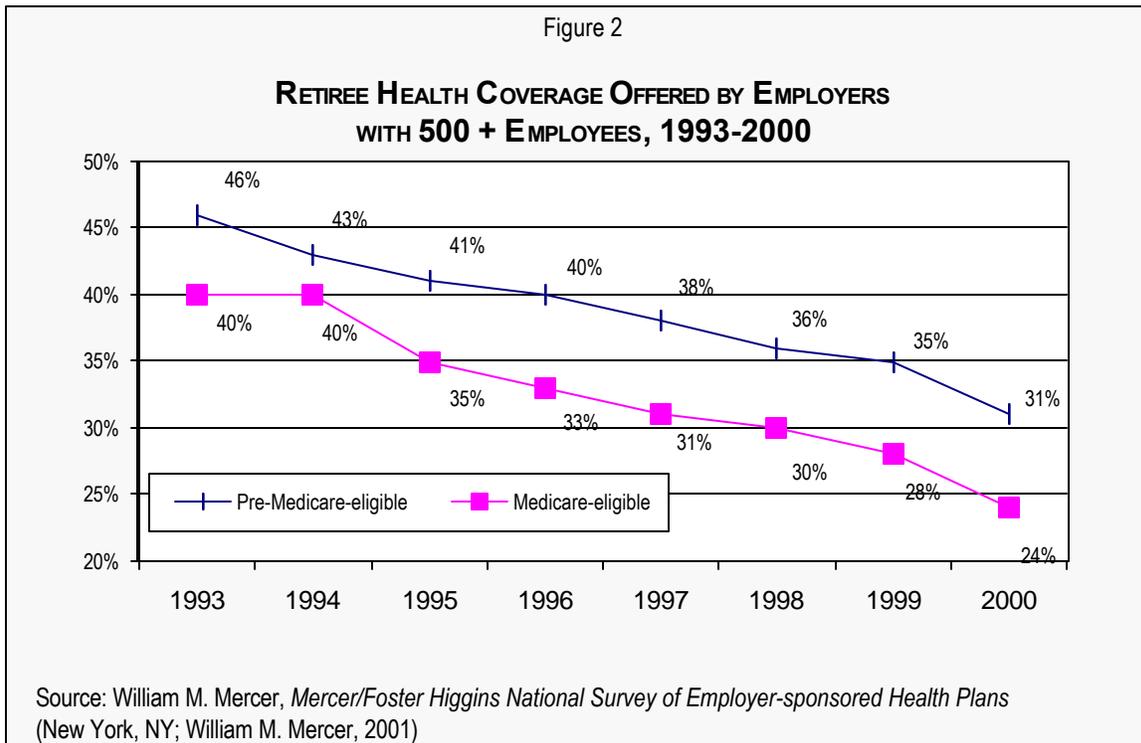
Retiree Health Trends

Each year, our company conducts a national survey of employer-sponsored health plans. The survey was established in 1986 by Foster Higgins (now merged with William M. Mercer), and since 1993 the survey has used a stratified random sample that produces comparable results from year to year. The survey identifies health care costs, trends and plan design information for both active and retired employees. The data that I'll be sharing with you today reflects responses from 1,924 large employers (500 or more employees) who responded to the 2000 survey, and is projectable to all large U.S. employers.

Employers sponsoring retiree health coverage. Most employers offer health coverage to active employees. But many employers do not offer health coverage to retirees. The larger the employer, the more likely it is to offer retiree health coverage. Among large employers, the prevalence of retiree health coverage for pre-Medicare retirees ranges from 26% of those with 500 to 999 employees to 64% of those with 20,000 or more employees. The prevalence of retiree health coverage for Medicare-eligible retirees is slightly lower, ranging from 18% of those with 500 to 999 employees to 57% of those with 20,000 or more employees (Figure 1). Among small employers (fewer than 500 employees) only 8% offer coverage to any retirees.



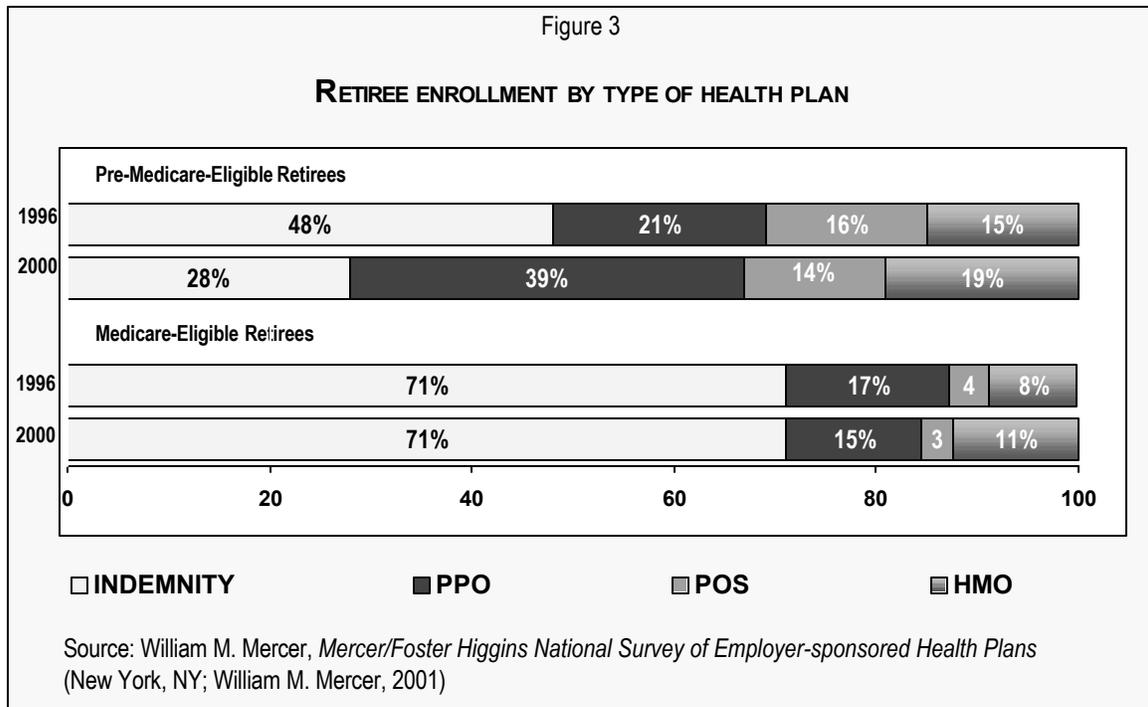
But the percentage of large employers offering retiree health coverage has been slowly eroding over the last eight years, and the decline accelerated in 2000. From 1999 to 2000, the percentage of large employers offering coverage to pre-Medicare retirees dropped from 35% to 31%, while the percentage offering coverage to Medicare-eligible retirees dropped from 28% to 24% (Figure 2). These numbers



refer only to plans that cover current and future retirees. An additional 5% of large employers sponsor plans covering only employees who were hired or retired before specified dates.

Type of plan. Over the last five years, the percentage of pre-Medicare retirees participating in traditional indemnity plans has been shrinking, while the percentage participating in preferred provider organizations has been growing. In 2000, 28% of pre-Medicare retirees participated in indemnity plans, 39% participated in preferred provider organization (PPO) plans, 14% participated in point-of-service (POS) plans and 19% participated in health maintenance organization (HMO) plans.

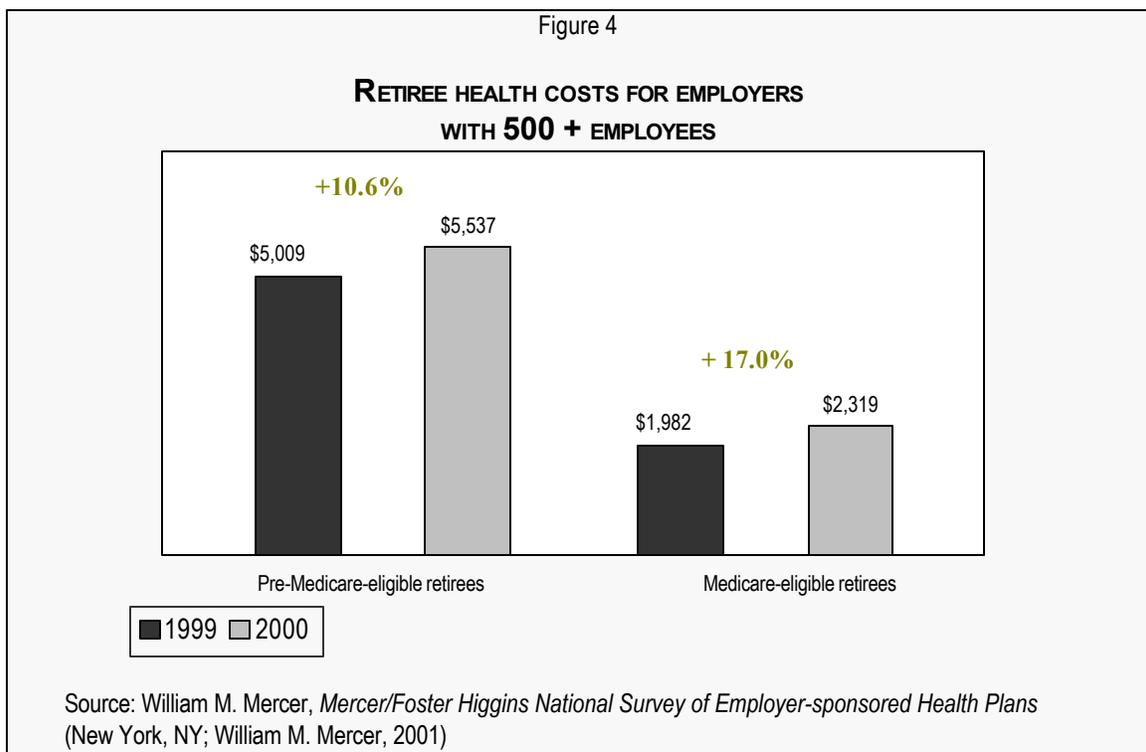
The great majority of Medicare-eligible retirees continue to participate in traditional indemnity plans. In 2000, 71% of Medicare retirees participated in indemnity plans, 15% participated in PPO plans, 3% participated in POS plans and 11% participated in HMOs. Although 43% of retiree health plan sponsors offered a Medicare + Choice (M+C) HMO in 2000, there was very little movement into these plans. This is consistent with the slowing enrollment in M+C plans observed nationwide (Figure 3).



Defined contribution plans. Despite the significant media attention focused on defined contribution health plans, few employers currently offer such programs to retirees. Only 1% of employers provide retirees with a subsidy to purchase coverage on their own. Most employers are reluctant to consider defined contribution approaches, because they don't believe retirees could obtain coverage (based on preexisting conditions, chronic illness or affordability). Nevertheless, our recent consulting experience suggests there is considerable interest in account-based retiree health programs designed to assist retirees in accumulating sufficient funds to purchase health insurance coverage.

Cost trends. The average per-capita cost of retiree health benefits increased dramatically in 2000 – producing a 10.6% trend for pre-Medicare retirees and a 17.0% trend for Medicare-eligible employees (Figure 4). In comparison, the health care cost trend for active employees was 6.6% in 2000. The

increase for Medicare-eligible employees is significantly affected by increases in prescription drug costs. Medicare doesn't cover prescription drugs but most retiree health plans do. As a result, drug costs drive the total trend because they often exceed 50% of the employer's total cost.

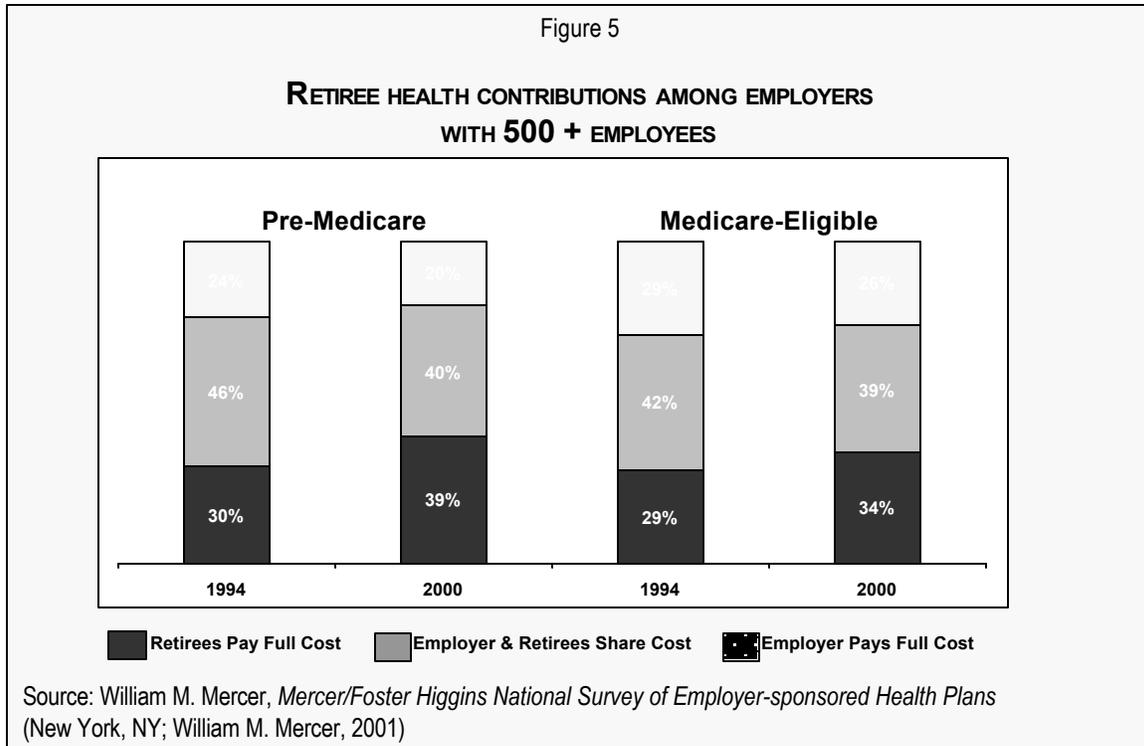


Retiree contributions. Many employers share the cost of retiree health programs with retirees. For pre-Medicare retirees, a fifth of employers pay the full cost of individual coverage, two-fifths require the retiree to pay the full cost and two-fifths share the cost. Where costs are shared, the average contribution for pre-Medicare retirees is 34% of premium. For Medicare-eligible retirees, approximately one-fourth of employers pay the full cost of individual coverage, one-third require the retiree to pay the full cost, and the remainder share the cost. Where costs are shared, the average contribution for Medicare-eligible retirees is 33% of premium. Some retiree health plan sponsors adjust the contribution amount on the basis of age or years of service or both. Such adjustments are made by 29% of sponsors for pre-Medicare retirees, and by 36% of sponsors for Medicare-eligible retirees. Although contribution strategies changed little from 1999 to 2000, they have changed considerably since 1994 (Figure 5).

Prescription drugs and other benefits. Although virtually all health plans for active employees cover prescription drugs, only 84% of retiree health plan sponsors offer this coverage. Drug benefit exclusions are more common among smaller employers – while 97% of employers with 20,000 or more employees cover prescription drugs, only 79% of employers with 500 to 999 employees cover prescription drugs. A few employers limit their liability with an annual or lifetime prescription drug maximum (3% of employers covering pre-Medicare retirees, and 6% of employers covering Medicare-eligible retirees include these limits).

More employers offer dental and vision coverage to pre-Medicare retirees than to Medicare-eligible

Figure 5



retirees. For pre-Medicare retirees, about 52% of retiree health plan sponsors offer dental coverage and 30% offer vision coverage. For Medicare-eligible retirees, about 42% of retiree health plan sponsors offer dental coverage and 22% offer vision coverage.

Challenges Facing Retiree Health Plan Sponsors

Several factors will influence the extent to which employers continue to voluntarily offer retiree health coverage. These include cost trends, labor market conditions, lack of alternative sources of coverage, M+C plan availability, Medicare changes, accounting requirements, funding constraints, and the recent age discrimination decision in *Erie County Retirees Association v. County of Erie*.

Cost trends. Our actuaries believe that retiree health plan costs will continue to increase faster than the overall consumer price index (CPI) and the medical portion of the consumer price index (MCPI). Employers are predicting an average 11.0% increase in health benefit costs for active employees in 2001, and expect even greater increases for their retiree health plans. Recent trends in prescription drug costs are also expected to increase at double-digit rates. This last development is especially disturbing, given the relative impact prescription drug costs have on the total cost of retiree health coverage for Medicare-eligible retirees. As a result, many employers are already indicating that they intend to pass some portion of these cost increases on to both pre-Medicare and Medicare-eligible retirees.

Labor market conditions. Employers offer health benefits to help attract and retain a high-quality workforce. But the relative generosity of these benefits may vary depending on the availability of human capital. When labor is in short supply, employers are less willing to modify health benefits or shift health benefit cost increases to plan participants. This was certainly true a year ago, when the unemployment

rate reached a 30-year low of 3.9% in October 2000. But the unemployment rate has increased to 4.9% in September 2001, and employers may now be more willing to change their health benefits and shift health benefit costs.

Retiree health benefits are part of this equation. Some employers have discovered that offering retiree health coverage improves their ability to “rightsize” their workforce. Employees with access to a retiree health plan are more willing to accept early retirement packages. But employees without a retiree health plan wait longer to retire – the median retirement age is 61 among employers that sponsor retiree health plans and 64 among employers that don’t. Other employers find that a lack of retiree health coverage may interfere with their ability to hire experienced, mid-career employees.

Lack of Alternative Sources of Coverage. Employees retiring at or after age 65 have access to generous healthcare coverage under Medicare. But employees retiring at younger ages have limited access to health insurance coverage. In the absence of employer-sponsored retiree health coverage, these early retirees must rely on a patchwork quilt of health insurance options:

- Early retirees may be able to continue their employer-provided coverage for 18 months under COBRA
- Early retirees who elect and exhaust COBRA coverage are guaranteed the right to purchase individual health insurance products under insurance reforms enacted as part of the Health Insurance Portability and Accountability Act (HIPAA), but there’s no guarantee that these products will be affordable
- Early retirees who don’t qualify for these HIPAA “guaranteed issue” products may still be able to purchase individual health insurance, assuming they are in reasonably good health

Other possible coverage options include access to health insurance coverage through (1) a spouse’s employer, (2) entitlement to veterans’ benefits, (3) state high risk pools, or (4) Medicaid. Without full access to coverage, it’s no surprise that employees who don’t have employer-provided retiree health coverage tend to retire later.

M+C plan availability. When employers began offering M+C plans to their retirees in the 1990s, they did so for two reasons – managed care provided a convenient way to save money, and pre-Medicare retirees wanted to continue with HMOs after they reached 65. Congress added additional flexibility to the M+C program in the Balanced Budget Act of 1997, and many employers expected the availability of M+C plans to increase. Unfortunately, the legislation produced the opposite effect, principally because government reimbursement rates have not kept up with inflation. The number of M+C plans available to retirees dropped precipitously (from 346 in December 1998, to 180 in October 2001), and the number of M+C plan enrollees also declined (from 6.06 million in December 1998, to 5.56 million in October 2001). Some retiree health plan sponsors were “burned” when M+C plans withdrew, leaving thousands of retirees with no HMO choices. As a result, some employers lost faith in the ability of the M+C market to service their retiree groups. While legislation enacted in December 2000 may help stabilize the M+C market, employers remain less than enthusiastic about the long-term prospects for M+C plans.

Medicare changes. Various legislative proposals have been introduced to reform the Medicare program. Several of these proposals would make prescription drugs a covered Medicare benefit. The impact of a Medicare prescription drug benefit on retiree health plan sponsors would vary, depending on the availability of the benefit, the level of benefits, the premium cost, any required cost-sharing, and the availability of an employer subsidy.

Depending on the design of a Medicare drug benefit, employers might choose one of several courses of action. One approach might be to continue offering Medicare-eligible retirees a prescription drug benefit, and coordinate with the new Medicare benefit. Another approach might be to cease offering a prescription drug benefit to Medicare-eligible retirees, and instead offer to pay any additional premiums for the new Medicare benefit. But predicting employer responses to a potential Medicare drug benefit is difficult in the absence of design specifics.

Employers recognize that a Medicare drug benefit is a two-edged sword. On the one hand, costs for employer-sponsored *retiree* health plans are likely to drop if the federal government picks up a portion of the cost of prescription drugs for Medicare-eligible retirees. On the other hand, costs for employer-sponsored *employee* health plans might actually increase. If the federal government demands discounts for drugs sold to the Medicare market, pharmaceutical companies may raise drug prices for other purchasers. Employers are likely to withhold judgment on a Medicare drug benefit until additional details are known.

Accounting requirements. Under Financial Accounting Statement (FAS) 106, employers are required to accrue and expense future retiree health claims and disclose unfunded retiree health liabilities on their financial statements. When employers adopted FAS 106 in the early 1990s, many opted to impose “caps” on their retiree health programs. A typical cap limits the employer’s annual financial commitment to a specified dollar amount, usually a higher amount for pre-Medicare retirees and a lower amount for Medicare-eligible retirees. Recent increases in health care cost inflation are causing some employers to bump into these caps, leading them to re-evaluate their retiree health plan designs. Employers in this situation are considering a number of options – raising the caps, passing future cost increases to retirees, indexing the caps to some inflationary measure, shifting to a defined contribution design, terminating the retiree health plan or some combination of these measures.

The Government Accounting Standards Board (GASB) is developing an accounting statement similar to FAS 106 that will apply to governmental employers that sponsor retiree health plans. This statement is likely to impose accrual accounting and greater disclosure requirements on governmental retiree health plan liabilities, and is likely to have an impact similar to FAS 106. Many governmental employers are already studying their estimated retiree health liabilities in anticipation of this new statement, and some can be expected to reduce their retiree health plan commitments. GASB expects to issue an exposure draft of the new statement in late 2001 or early 2002.

Funding constraints. ERISA requires employers to fund pension plans, and provides favorable tax treatment for these arrangements. Thus, when employers contribute to a “tax-qualified” retirement plan, the employer gets a current deduction and the trust assets grow tax-free. But ERISA does not require

employers to fund retiree health plans, and less favorable tax treatment is available for employers that do so.

Under current law, two types of retiree health funding arrangements receive limited tax-favored treatment. One arrangement is a 401(h) account attached to a pension plan. Employer contributions to a 401(h) account are deductible, the assets grow tax-free, and retirees receive tax-free health benefits. But contributions to a 401(h) account are severely limited and, in many cases, employers are precluded from making any contributions to a 401(h) account. Another arrangement is a voluntary employees' beneficiary association (VEBA). But VEBAs used to fund retiree health costs are subject to two significant limitations – employer contributions typically are not fully deductible, and earnings on retiree health reserves are generally taxable.

Erie County litigation. Last year, the Third Circuit Court of Appeals (covering Delaware, Pennsylvania, New Jersey and the Virgin Islands) held that Medicare-based distinctions in retiree health plans presumptively violate the Age Discrimination in Employment Act (ADEA). In *Erie County Retirees Association v. County of Erie*, the court concluded that this presumption may be overcome only if a retiree health plan satisfies ADEA's so-called "equal benefits/equal cost" test, under which benefits or costs for Medicare-eligible retirees must be equal to benefits or costs for younger retirees. This decision came as a surprise to many employers who assumed, based on ADEA's legislative history, it was permissible to offer different benefits to Medicare-eligible retirees.

On remand, the District Court for the Western District of Pennsylvania considered whether Erie County's retiree health plan satisfied the equal benefits or equal cost test. The County conceded that it didn't satisfy the equal cost test, because it paid less to provide coverage for Medicare-eligible retirees than for pre-Medicare retirees. The District Court concluded that the County didn't satisfy the equal benefit test because: (i) pre-Medicare retirees paid less for their coverage than Medicare-eligible retirees (*taking into account Medicare Part B premiums paid to the federal government*); (ii) the County offered a choice of indemnity and HMO plans to pre-Medicare retirees but offered only an HMO plan for Medicare-eligible retirees; and (iii) the County offered a more generous prescription drug benefit for pre-Medicare retirees than for Medicare-eligible retirees.

The *Erie County* case has caused great consternation among retiree health plan sponsors, who never viewed their retiree health plans as a potential source of ADEA liability. Especially troubling is the District Court's novel interpretation that Medicare Part B premiums must be taken into account in determining whether Medicare-eligible retirees receive lesser benefits than pre-Medicare retirees. This interpretation appears to be inconsistent both with ADEA's legislative history and with EEOC guidance regarding retiree health plans that coordinate with Medicare. The EEOC is aware of these employer concerns, and is studying ADEA's application to retiree health plans. Nevertheless, employers with retiree health plans remain vulnerable to additional ADEA lawsuits.

Employers with limited contacts in the Third Circuit are taking a "wait and see" approach pending additional judicial developments. Other employers are considering various ways to "fix" possible ADEA problems. One possibility might be to offer the same health plan options to all retirees. But in many locations the same managed care option won't be available for both Medicare-eligible and pre-Medicare retirees. A second possibility might be to equalize benefits and retiree contributions. But it may not

be possible to provide equal benefits and/or require equal or proportionate retiree contributions without reducing subsidies for some retirees and increasing subsidies for others. A third possibility might be to eliminate health coverage for all retirees. But such a decision may trigger additional litigation and adverse employee and retiree relations.

Policy Consequences

Retiree health plan sponsors are reacting to these challenges. But they are doing so in ways that concern us, and may concern policymakers as well. Our survey data reveals a disturbing trend – employers are slowly, but consistently, terminating their retiree health plans for future retirees. The trend is slower among large employers, but still universal. While recent consulting activity suggests that some employers are considering defined contribution plans for future retirees, these plans are still in their infancy.

Despite the evident decline in employer-sponsored retiree health plans, there hasn't been a similar decline in the number of retirees with health insurance. A recent analysis of the March 2000 Current Population Survey by the Employee Benefit Research Institute (EBRI) shows virtually no change in the number of pre-Medicare retirees with health insurance coverage from 1994 through 1999. Does this mean we shouldn't worry? To the contrary, the EBRI analysis suggests that the day of reckoning is still to come. According to EBRI, "many current employees will never qualify for retiree health benefits because their employers offer them only to workers hired before a specific date." See "Employment-Based Health Benefits: Trends and Outlook," Paul Fronstin, *EBRI Issue Brief Number 233*, May 2001.

Which leads us to the age-old question – what should policymakers do?

There are two key issues – one is access to health insurance coverage, and the other is funding the cost of the coverage. On the access issue, should pre-Medicare retirees continue to have access to an employer-sponsored plan? Should we allow younger retirees to "buy-in" to the Medicare program? Should we encourage the insurance industry to create sources of group coverage for pre-Medicare retirees other than employer-based coverage? On the funding issue, should we encourage or require employers and employees to pre-fund the cost of retiree health coverage? Should we establish federal or state subsidies for pre-Medicare retirees? Should we do both?

A related question is whether employers should continue to be involved. In large measure, the employment-based health system is a historical accident, having developed during World War II when employers were able to avoid wage and price controls by offering health benefits to attract workers. If the access and funding issues can be addressed through mechanisms that don't involve employers, then policymakers may need to consider non-employment-based alternatives. Indeed, the interest in defined contribution plans is a signal that employers are looking for a solution with less employer involvement. To facilitate change from the current system, one possibility is a "dual-track" strategy – keeping employers involved in the short-term, but building mechanisms that facilitate greater individual and market involvement in the long-term.

When tackling these issues, it's critically important to think "outside the box." Too often, there is a tendency to focus on solutions within the particular confines of the existing order – we limit our thinking

to the silos with which we are most familiar. Instead of focusing narrowly on employers and their benefit plans, or insurance carriers and their products, or government subsidies and entitlement programs, why not focus on what the customer – the retiree – needs? A retiree doesn't view Medicare, Social Security and employer-provided benefits in isolation, but rather in combination. From this perspective, a retiree needs two things – cash and access to health coverage.

There are many different ways to approach the access and funding issues. We describe below some suggested policy options, with no comment on their political feasibility. Each of these options will influence employer, individual, insurance carrier and government behaviors, and each will come with different costs.

Expanding access for retirees. There are several approaches that could be considered to expand access to health care for retirees.

First, employers could be required to offer continued coverage rights to employees who terminate at or after age 55. In effect, this would create “super-COBRA” rights for pre-Medicare retirees. But employers are not likely to support this approach, even if they could charge the full age-rated value of the coverage.

Second, the federal government could establish federal regulation for group and individual insurance products sold to individuals over age 55. This would not be a federally financed program like Medicare, but would provide federal rules (with state enforcement) to regulate insurance carriers who create over-55 products. This is similar to the approach currently used to regulate Medigap plans.

Third, the federal government could establish a subsidy program to provide refundable tax credits for individuals over age 55 who don't have another source of group coverage. This is the approach taken in S. 590, although a more targeted approach may be necessary to address the higher health insurance costs of retirees.

Fourth, various existing federal programs (such as the Federal Employees Health Benefits Program or Medicare) could be opened to individuals over age 55 who don't have another source of group coverage. To enhance budget neutrality, eligible individuals would be required to pay the full premium cost. This option may not be feasible for Medicare, given the problems currently facing that program.

Finally, employers could be penalized for terminating existing retiree health plans. This is the approach adopted in H.R. 1322. But this approach is antithetical to the voluntary employment-based system endorsed and preserved by ERISA. Employers would strongly object to any proposal obligating them to continue offering a retiree health plan.

Encouraging funding of retiree health costs. There are also several alternatives that could be considered to provide incentives for employers and individuals to fund retiree health costs.

First, federal tax law could encourage employers to fund retiree health costs by making the existing rules governing 401(h) accounts and VEBAs more flexible. With minor changes, these vehicles could provide the same favorable tax treatment for retiree health funding that is available for retirement plans. The rules

governing 401(k) plans, 403(b) annuities and 457 plans could also be modified to encourage similar retiree health funding opportunities within those plans as well.

Second, federal tax law could allow employers and individuals to establish tax-favored Retiree Medical Savings Accounts (“Retiree MSAs”) to accumulate funds to pay for retiree health coverage. Retiree MSAs might receive the same tax treatment as Roth IRAs, with contributions being made on an after-tax basis and assets growing tax-free.

Third, by combining the previous approaches, employers could be given a current tax deduction for contributions to fund retiree health costs through *any* dedicated retiree health funding vehicle (e.g., Taft-Hartley trusts, 401(h) accounts and equivalent arrangements in defined contribution plans, VEBAs, or Retiree MSAs). Similarly, employees might be permitted to make pre-tax contributions to one or more of these dedicated retiree health funding vehicles.

Fourth, employers could be given greater flexibility to use existing asset accumulations to pay for retiree health benefits. For example, the federal tax laws might expand and extend section 420 to encourage employers to use excess pension assets and/or other accumulated benefits (such as vacation or sick pay) to pay for retiree health costs.

Finally, employees could be given greater flexibility to use existing asset accumulations to pay for retiree health benefits. For example, the cafeteria plan rules could allow employees to use accumulated pension and 401(k) assets to pay for retiree health costs on a pre-tax basis. Similarly, it might also be possible to let employees use other accumulations (such as IRAs, U.S. Savings Bonds, life insurance cash values and equity in a personal residence) to pay for retiree health costs on a pre-tax basis.

Conclusion

The erosion of employer-sponsored retiree health benefit plans is not a trivial concern. Although the full impact of this development has not yet been felt, many current employees will not have access to employer-sponsored health coverage when they retire. When this happens, and 80 million individuals will reach age 55 over the next 20 years, there are sure to be societal repercussions.

Is it possible to reverse this trend? Some employers have already concluded that they don’t need to offer retiree health benefits to remain competitive in the global economy. But other employers believe they must provide retiree health benefits to attract and retain a high-quality workforce. If we do nothing, the pattern of erosion is likely to continue.

There is still time to develop policy options that may slow this trend. The options should be holistic – we should stand in the shoes of retirees and contemplate how to provide an integrated and seamless solution to the issues of access and funding. The options should be flexible – flexible enough to encourage employers and insurance carriers to offer health coverage to retirees; flexible enough to encourage employers and employees to accumulate assets, or use previously accumulated assets, to pay for retiree health costs; and flexible enough to encourage the establishment of non-employer-based mechanisms to enable individuals to obtain and purchase coverage when they retire.

