Fundamentals

of Retiree Group Benefits

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ACTEX Publications, Inc.
Winsted, CT
ActexMadRiver.com

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ACTEX Publications
P.O. Box 974
Winsted, CT 06098

Manufactured in the United States of America

10 9 8 7 6 5 4 3 2 1

Cover design by Christine Phelps

Library of Congress Cataloging-in-Publication Data

ISBN: 978-1-56698-586-4

PREFACE

This book should have been first written 25 years ago. In 1980, several employers offered retiree group benefits to their employees in the U.S. because of the tax-effective benefit and relatively low current costs. With retirees representing a small percentage of the overall covered population, it was an inexpensive fringe benefit. Some employers even paid for the Medicare Part B premium for the retiree and spouse. A few employers provided free coverage to their retirees—absolutely no contribution requirement for the former employees. These benefits were at the top of their game at this time.

Besides the tax-effectiveness of the benefit back then, most employers did not understand what the long-term cost of this obligation was. Unlike pension plans that were subject to the newly required minimum funding rules of the Employee Retirement Income Security Act (ERISA), retiree group benefits were largely unfunded and accounted for on a pay-as-you-go basis. For companies who did want to prefund their obligations, they could find vehicles that allowed them to almost fund as much as they wanted, sheltered the investment earnings from taxes and paid tax-free benefits.

Life was simple with very few rules and relatively low cost. Tax legislation passed in 1984 that restricted prefunding retiree obligations and subjected the investment earnings to taxes for certain types of funds. The Financial Accounting Standards Board (FASB) adopted new accounting standards in 1990 that required companies to accrue for future retiree group benefit payments during an employee's working career—similar to pension plans. This new accounting requirement along with high medical cost trends in the late 1990s sparked a major revolution in the design and employer financing. Other influences on retiree group benefit design include court decisions, new legislation, overall retirement strategy changes, and the health care market in general.

Much has changed in 25 years. There is a great variety of designs and financing arrangements utilized by employers that are very different from three decades ago. Few employers can claim to just have one

"plan." Most have different programs for salaried versus hourly employees; vary the plans by location, retirement date or employment date; have legacy plans due to prior mergers and acquisitions; and even have employees without a plan.

Retiree group benefits have earned a reputation for being difficult to understand. Half retirement benefit and half group insurance—few professionals have mastered both fields. In addition, complex finances blend the world of pension mathematics and health plan pricing.

This book attempts to provide a fundamental understanding of almost all of the elements that make up the world of retiree group benefits. Some things may have been missed and things will definitely change. I hope there is something of interest to everyone.

Because of the complex nature of the subject, I owe a great deal of gratitude to several friends who volunteered their time to review the drafts of this book. In alphabetical order, they are Paul Fronstin (Employee Benefit Research Institute), Randy Johnson (Motorola), Frank McArdle (Hewitt Associates), Tricia Neuman (Kaiser Family Foundation), Jeff Petertil (independent consultant), Adam Reese (Hay Group) and Allen Steinberg (Hewitt Associates). Each one of these reviewers is well-known in this field and provided invaluable input to make this a much better book.

I also want to thank Gail Hall of ACTEX for her encouragement to complete this project. This book was started four years ago as a collection of various articles and papers that I had authored over the years. Updating that material turned out to be more work than I had anticipated. And, there were several topics that I had never written about. Gail did what all great leaders do, she gave me a deadline. Material was further updated because of changes in the last four years and expanded with new text. And, this book is the result.

Finally, I thank my wife Louise and son Ben for sacrificing valuable vacation time so that I could write this book. It made for great conversation after taking two four week vacations, when most of the writing was done, to tell friends what I did on my time off of work. Typical response was, "are you nuts?" with a few just shaking their heads. Most days comprised of writing in the morning, doing something fun mid-day and back to writing in the evenings. So, the next vacations will include a lot more of the "fun" during the day.

Dale H. Yamamoto
October 2006

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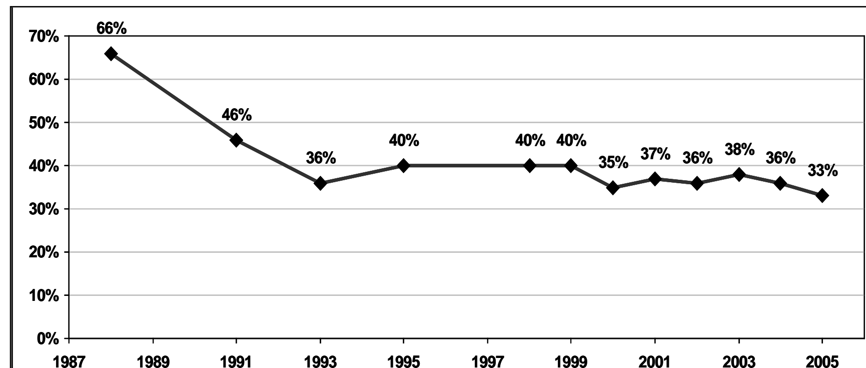
2 EROSION OF RETIREE HEALTH BENEFITS

No matter what survey the reader is studying, the theme is always a downward slope of employers offering retiree health care benefits. The titles of two papers have used the term "erosion" of retiree health benefits.[1] Although written four years apart from each other, many of the same issues are shared by them. It is likely that these same issues will continue during the next several years. Each paper cites surveys from various sources, graphically showing this erosion.

Percentage of Large Firms (200+ Employees) Offering Health Insurance to Retirees, 1988-2005



Source: Kaiser/HRET survey of employer-sponsored health benefits, 1999-2005; KPMG survey of employer-sponsored health benefits, 1991, 1993, 1995, 1998. The Health Insurance Association of America (HIAA), 1988.

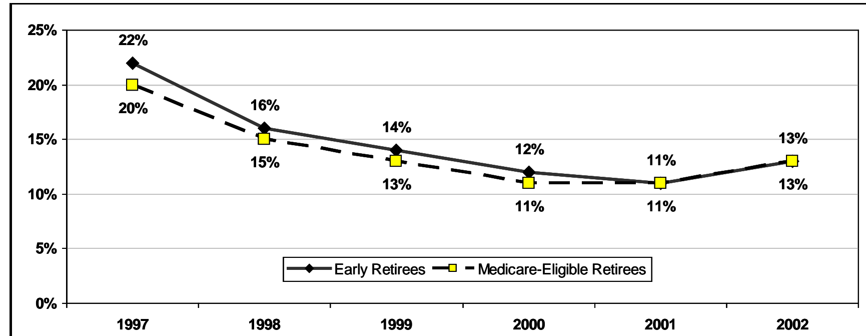
Figure 2.1

[1] Paul Fronstin, *The Impact of the Erosion of Retiree Health Benefits on Workers and Retirees*, [15] and *Retiree Health Benefits: Employer-Sponsored Benefits May Be Vulnerable to Further Erosion*, [38].

Figure 2.1 shows the typical downward slope of retiree group benefit prevalence. The largest decline took place in the early 1990s when the then new accounting standard, FAS 106, became effective.

Figure 2.2 shows the prevalence of retiree health care benefits over a shorter time period but with a split between pre- and post-Medicare eligible retirees, and with both large and small employers included in the analysis.

Percentage of Private-Sector Establishments Offering Health Insurance to Retirees, 1997-2002



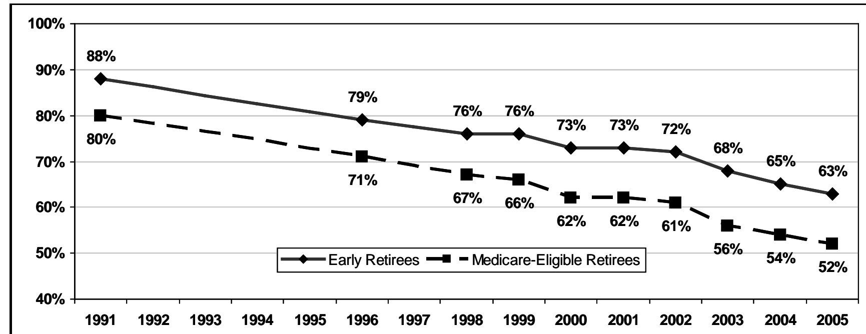
Source: EBRI from various tables at www.meps.ahcpr.gov/Data_Pub/IC_Tables.htm

Figure 2.2

The upward movement from 2001 to 2002 provides some hope. However, other survey data (including others referenced in this chapter) show a more continued downward slope including those from consulting firms (Hewitt Associates, Watson Wyatt, Mercer) and from policy organizations such as the Kaiser Family Foundation.

Figure 2.3 shows a similar graph only for large employers who have historically been more likely to provide retiree health care. The downward trend for this group is less dramatic than Figure 2.1, but continues beyond 2001. And, the gap between pre- and post-65 prevalence appears to be widening.

Percentage of Large Employers Offering Health Insurance to Retirees, 1991-2005

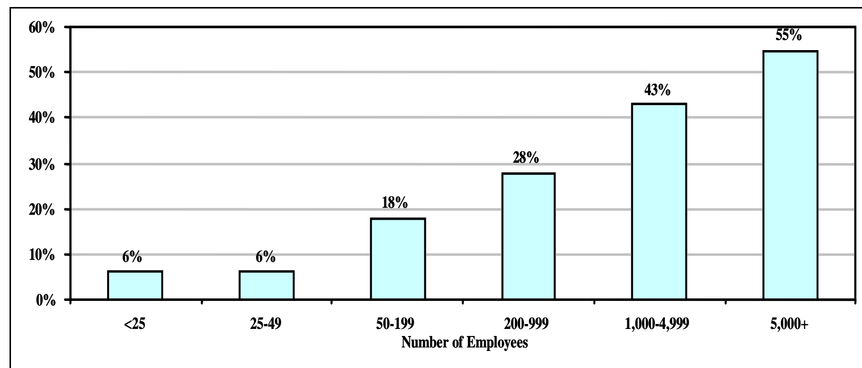


Source: © Hewitt Associates

Figure 2.3

The prevalence of retiree health care declines significantly by the size of employer. Figure 2.4 shows the differences in 2005.[2]

Percentage of Employers Offering Retiree Health Insurance Coverage by Size of Firm, 2005



Source: 2005 Kaiser/HRET Employer Health Benefit Survey

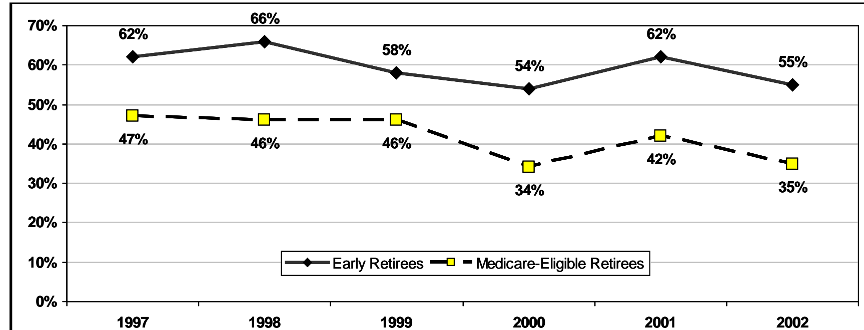
Figure 2.4

The public sector data (Figures 2.5 and 2.6) does show some variation from the steep downward slope. Those local governments offering retiree health care are relatively stable during the six year observation period. State governments have been less likely to eliminate retiree health care coverage but have followed a similar trend as the private sector in terms

[2] Kaiser Family Foundation and Health Research and Educational Trust, *Employer Health Benefits 2005 Annual Survey*, September 2005.

of modifying the plan designs to require greater contributions and cost sharing by retirees.

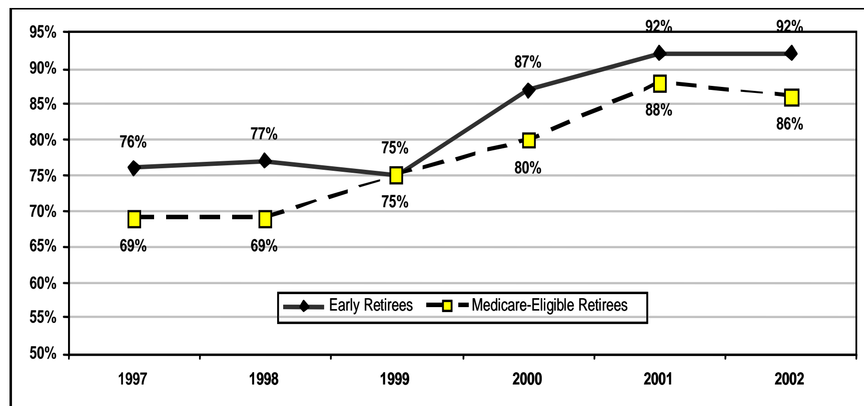
Percentage of Local Governments with 250-999 Employees Offering Health Insurance to Retirees, 1997-2002



Source: EBRI from various tables at www.meps.ahcpr.gov/Data_Pub/IC_Tables.htm

Figure 2.5

Percentage of State Governments Offering Health Insurance to Retirees, 1997-2002



Source: EBRI from various tables at www.meps.ahcpr.gov/Data_Pub/IC_Tables.htm

Figure 2.6

Many observers will be watching the public sector offering of these benefits in light of new accounting standards going into effect from 2006-2009 for trust funds and government entity financial statements.[3]

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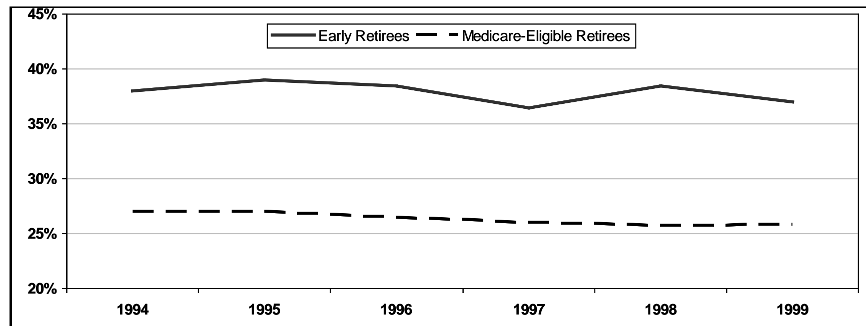
[3] Statement No. 43, *Financial Reporting for Postemployment Benefit Plans Other Than Pension Plans*, [17] and Statement No. 45, *Accounting and Financial Reporting by Employers for Postemployment Benefits Other Than Pension Plans* [18].

These standards will require public sector employers to include the value of retiree health plan obligations on their financial statements on an accrual basis similar to the FAS 106 rules for private sector employers. FAS 106 is commonly "blamed" as the reason for the decline in employer-sponsored retiree health care benefits. Many have instead viewed the accounting standard as an "eye-opener" to the real current value of the benefits that were often considered nominal.

Figure 2.7 shows an interesting trend line – the number of retirees with employer-sponsored health benefits between 1994 and 1999 was relatively stable. This is over the same period of time where many surveys show dramatic reductions in the number of employers offering retiree health coverage. This phenomenon occurs because when employers change their plans and drop coverage, they almost always "grandfather" current retirees and some active employees so that their coverage is not completely eliminated.

Percentage of Retirees with Employer-Sponsored Health Benefits



Source: GAO analysis of Current Population Survey, March Supplements 1995-2000

Figure 2.7

Besides the prevalence of employers offering retiree health care, both papers note that many other employers are reducing their benefits design by increasing various cost-sharing elements (e.g., increasing deductibles, out-of-pocket maximums and copays), restricting eligibility and increasing retiree contribution requirements. The common cost control method of placing caps on the employer obligation will continue to have a very big impact on the cost-shifting to retirees.

The introduction of the new Medicare prescription drug program may further entice employers to drop coverage—at least for Medicare-eligible retirees. Nine percent of respondents to the 2005 Kaiser/Hewitt survey of large private sector employers indicated that they plan to discontinue drug coverage in 2006.[4] However, with the government taking on more responsibility in financing health care for these retirees, it could delay much further action to reduce coverage, at least in the short-term. In the same survey, 91 percent of employers planned to continue their drug coverage, representing 98 percent of all retirees.

The GAO report cited the Hewitt study that estimated employers will have cost savings from the introduction of the Medicare drug benefit and would likely retain the employer coverage.[5]

The Congressional Budget Office (CBO) assumed in their estimates of the new program that 2.7 million Medicare beneficiaries would lose their employment-based benefits. Another CBO study concluded that 17 percent of Medicare Part B enrollees would lose their employer-sponsored plans.[6] And another study estimates that about a quarter of retirees (2.1 million) will lose their coverage.[7]

Estimates made by an EBRI analysis found that two to nine percent of current Medicare beneficiaries would lose their employee benefits because of the new Medicare benefit. They cite other factors that may also force employers to drop benefits such as business conditions, accounting, and cost trends. The GAO paper adds other factors such as the Erie County age discrimination case[8] and the aging baby boom generation as contributions to the decision to drop coverage.

[4] Kaiser Family Foundation and Hewitt Associates, *Prospects for Retiree Health Benefits as Medicare Prescription Drug Coverage Begins*, December 2005.

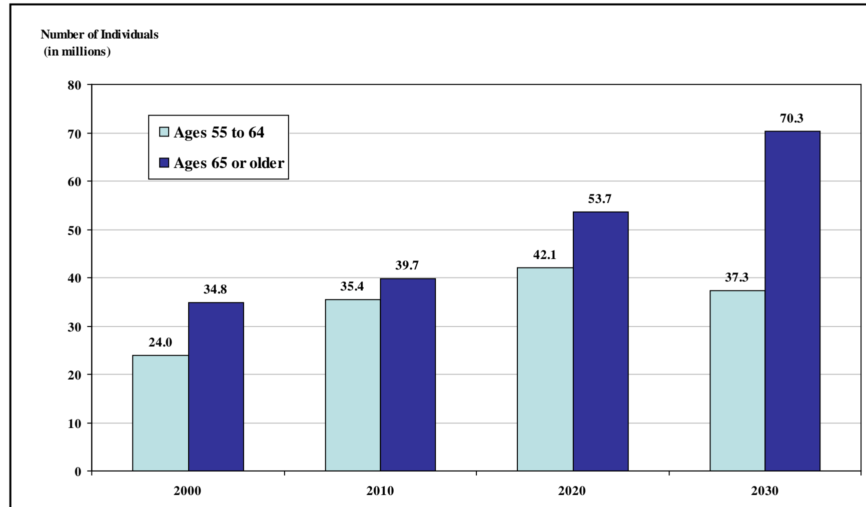
[5] Hewitt Associates, *The Implications of Medicare Prescription Drug Proposals for Employers and Retirees*, Kaiser Family Foundation, July 2000.

[6] Holt-Eakin, Douglas, CBO letter to Senate Budget Committee, November 20, 2003.

[7] Thorpe, Kenneth E., *Implications of a Medicare Prescription Drug Benefit for Retiree Health Care Coverage: An Update Based on the Medicare Conference Agreement*, Emory University, November 17, 2003.

[8] *Erie County Retirees Association v. County of Erie*, 220 F.3d 193 (3rd Cir. 2000) cert. denied, 69 U.S.L.W. 3409 (U.S. March 5, 2001) (No. 00-906). See Chapter 6.

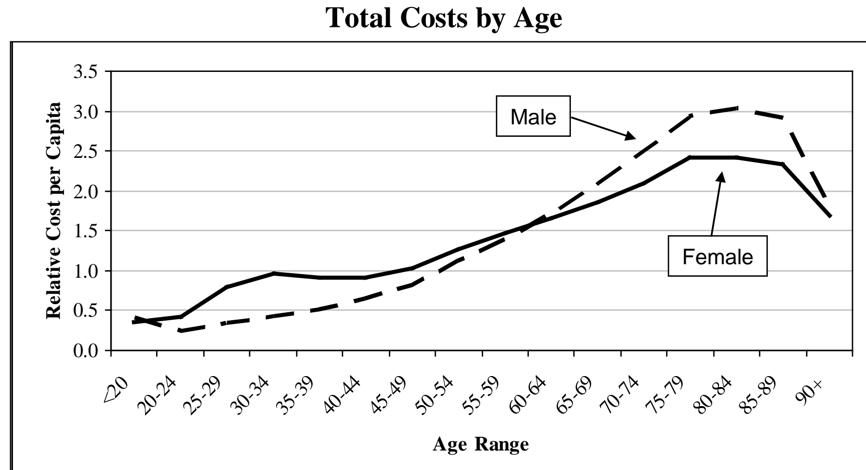
Baby Boom Generation Will Greatly Increase the Elderly and Near-Elderly Population



Source: GAO Report. U.S. Census Bureau, "Projections of the Total Resident Population by 5-Year Age Groups and Sex with Special Age Categories: Middle Series," selected years 2000 to 2030, January 2000

Figure 2.8

The post-65 population is expected to double between 2000 and 2030. This will put an increasingly severe strain on the health care system because the average cost of care is higher for this population than all others. Figure 2.9 provides a relative comparison of costs by age. Both male and female costs per capita continue to increase until age 75 and then begin to decline. Most clinical experts anecdotally believe that the observed decline is because individuals reaching these ages are healthier than average and there is less heroic medicine performed. A 75 year female costs 2.7 (2.4 ÷ 0.9) times a 40 year old female and a 75 year old male costs 4.1 (2.9 ÷ 0.7) times 40 year old male.



Source: © Hewitt Associates 2006 medical pricing model

Figure 2.9

IMPACT ON RETIREES

The impact of eroding coverage on individual retirees is varied and depends on a number of factors. EBRI compiled various statistics from the Survey of Income and Program Participation (SIPP) that show interesting characteristics of the currently covered retirees and how access to retiree coverage has changed between 1997 and 2002. The following table is an extract of some of the analysis.[9]

Key points in their analysis include:

- Early retirees lost coverage at a greater rate than Medicare-eligible retirees.
- Females had higher drop of coverage than males,
- Those with lower education levels saw higher erosion of coverage than those with advanced education.

[9] Extracted from Figures 14 and 15 from EBRI Issue Brief No. 279, March 2005 [15].

Table 2.1

Percentage of Retirees with Employer-Sponsored Retiree Health Coverage

	Early Retirees (55-64)			Medicare-Eligible Retirees		
	1997	2002	Percentage Change	1997	2002	Percentage Change
Total	39.2%	28.7%	− 26.8%	28.1%	25.5%	− 9.1%
Gender						
Male	48.5	40.6	− 16.3	34.2	33.3	− 2.8
Female	29.0	18.5	− 36.2	21.6	18.4	− 14.7
Education						
>high school	18.3	12.1	− 33.7	18.6	16.2	− 13.1
High school	42.0	28.0	− 33.4	29.7	25.7	− 13.4
College	49.4	35.4	− 28.4	39.3	33.5	− 14.6
Post-college	63.1	53.6	− 15.1	48.6	46.1	− 5.1
Union status						
Union	57.1	49.9	− 12.5	42.6	37.9	− 11.1
Nonunion	32.1	21.8	− 32.1	22.8	21.4	− 6.1

Other characteristics analyzed include race/ethnicity, region of the country, age retired, industry, class of worker (i.e., private versus government), annual income and firm size.

In virtually all groups, early retirees lost more ground than Medicare-eligible retirees. Overall, the percentage of early retirees with coverage declined 26.8 percent compared to 9.1 percent for Medicare-eligible retirees. This is an interesting result when compared to the prevalence data in Figure 2.3 that shows that Medicare-eligible retirees lost more ground during the same period (about 7 percent reduction in early retiree coverage compared to 12 percent for Medicare-eligible retirees). This seems to imply that the drop in early retiree coverage occurred at small to medium sized employers in greater numbers than at larger employers.

This loss of coverage will affect retirees differently. Some may have other coverage available through their spouse or from another association program or public program for which they may be eligible. Some early retirees may use the health continuation coverage (COBRA) available from their former employer, but that coverage is generally only for 18 months. Some may be healthy enough to have individual health insurance available. Many retiring are, however, in poorer health and there-

fore will not be eligible for individual insurance coverage. The GAO paper shows the percentage of employed and retired individuals who reported their health to be fair or poor.[10] In general, these individuals are not likely to be eligible for individual medical policies. And without access to a nationalized program like Medicare, they enter the uninsured statistics.

Percentage Reporting Fair or Poor Health		
Age	**Employed**	**Retired**
55 – 64	11.3	21.7
55 – 61	10.6	19.7
62 – 64	14.5	23.7
65+	17.7	35.3
65 – 74	17.0	30.0
75+	20.0	40.2

For those lucky enough to be eligible for coverage, they may be surprised at the rates that they will have to pay. The GAO requested rates from some carriers in a variety of states and include the following table of the differences in rate between a 30-year old and a 60-year old for illustrative purposes.

	Deductible (plan type)	**Monthly Premium 30-Year Old**	**Monthly Premium 60-Year Old**
Carrier A (Arizona)	$250 (indemnity)	$ 162	$ 512
Carrier B (Illinois)	$500 (PPO)	$ 116	$ 439
Carrier C (Colorado)	$0 (HMO)	$ 132	$ 324

Note that the GAO report was released in May 2001 so these rates need to be adjusted appropriately for cost trends between today and then. Even in 2001, for a retiree to have to pay $5,000 a year for health care coverage ($10,000 for a family of two), it is a very visible part of their budgets. Health care costs have increased 7 to 10 percent between 2001 and 2006 which makes the cost $7,000 to $8,000 per person!

[10] GAO analysis of the March 2000 Current Population Survey.