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Issue BRIEF

Employment-Based Retiree Health Benefits: Trends in Access and Coverage, 1997–2010

By Paul Fronstin, Ph.D., and Nevin Adams, J.D., Employee Benefit Research Institute

AT A GLANCE

- Very few private-sector employers currently offer retiree health benefits, and the number offering them has been declining. In 2010, 17.7 percent of workers were employed at establishments that offered health coverage to early retirees, down from 28.9 percent in 1997.
- Between 1997 and 2010, the percentage of non-working retirees over age 65 with retiree health benefits fell from 20 percent to 16 percent.
- Because employers are under no obligation to provide retiree health benefits, except to current retirees who can prove that they were promised a specific benefit, and because (unlike defined benefit pension plans) employers are not under any obligation to pre-fund retiree health benefits, it is likely that employers will continue to make changes to those programs, especially for future retirees.
- Earlier research found little impact of reductions in coverage on retirees, but that may be because initial changes employers made to retiree health benefits affected *future* retirees as opposed to *then-current* retirees. Over time, more and more retirees have "aged into" those program changes, resulting in the greater impact found in more recent studies.
- While many employers have dropped retiree health benefits, especially for future retirees, most that have continued to offer retiree health benefits have made changes in the benefit package they offer: raising premiums that retirees are required to pay, tightening eligibility, limiting or reducing benefits, or some combination of these.
- Increasing retiree contributions tops the list of likely future changes: 43 percent of employers say they are very likely to increase the retirees' portion of premiums next year, and another 35 percent are somewhat likely to do so.
- Despite the fact that workers are more likely to expect retiree health benefits than retirees are actually likely to have those benefits, the expectations gap is closing: By 2010, 32 percent of workers expected retiree health benefits, while only 25 percent of early retirees and 16 percent of Medicare-eligible retirees had them.
- Public policymakers face the difficult task of trying to provide solutions for a system that is largely voluntary. As employers view state-based health exchanges as a viable option to retiree health benefits, they may view their own role in providing health coverage to retirees as no longer necessary.

Paul Fronstin is director of the Health Research and Education Program at the Employee Benefit Research Institute (EBRI). Nevin Adams is director of Education and External Relations at EBRI, and co-director of its Center for Research on Retirement Income (CRI). This *Issue Brief* was written with assistance from the Institute's research and editorial staffs. Any views expressed in this report are those of the authors and should not be ascribed to the officers, trustees, or other sponsors of EBRI, the Employee Benefit Research Institute–Education and Research Fund (EBRI-ERF), or their staffs. Neither EBRI nor EBRI-ERF lobbies or takes positions on specific policy proposals. EBRI invites comment on this research.

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Table of Contents

Figures

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Introduction

One of the most important factors (if not the single most important) contributing to the decline in the availability of retiree health benefits was a 1990 accounting rule change.[1]

The Financial Accounting Standards Board (FASB) issued Financial Accounting Statement No. 106 (FAS 106), "Employers' Accounting for Postretirement Benefits Other Than Pensions" in December 1990, and it triggered many of the changes that private-sector employers have made to retiree health benefits. FAS 106 required companies to record retiree-health-benefit liabilities on their financial statements in accordance with generally accepted accounting principles, beginning with fiscal years after Dec. 15, 1992. Specifically, FAS 106 required private-sector employers to accrue and expense certain payments for future claims as well as actual paid claims. The immediate income-statement inclusion and balance-sheet-footnote recognition of these liabilities dramatically affected companies' reported profits and losses. With this new view of the cost and the increasing expense of providing retiree health benefits, many private-sector employers overhauled their retiree health programs in ways that controlled, reduced, or eliminated these costs.[2]

More recently, the Governmental Accounting Standards Board (GASB) adopted Statements No. 43 and No. 45, which 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 GASB Statements 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. State and local governments with over $100 million in annual revenues were required to implement GASB Statement 43 for the fiscal years beginning after Dec. 15, 2005, and for governments with annual revenues of $10–100 million, the deadline was Dec. 15, 2006. GASB Statement 45 was required to be implemented one year later.

The Impact and Aftermath

Research on the impact of FAS 106 on retiree-health liabilities is quite limited. Today, nearly two decades after FAS 106 was issued, these benefit cuts would be expected to have had a major impact on employer-FAS-106 liabilities. However, when the U.S. Government Accountability Office (GAO) examined the financial statements of 50 randomly chosen Fortune 500 companies in 2005, it found that more than 90 percent of the employers offering retiree health benefits experienced increases in their postretirement benefits obligations between 2001 and 2003, with some being 50 percent or more higher (U.S. Government Accountability Office 2005). While the report did not go into the determinants of the increase in liabilities, one factor may be increases in costs of providing health benefits to the remaining pool of retirees, given that most of the changes made to retiree health programs occurred during the 1990s.

Numerous studies have examined the erosion in employment-based retiree health benefits and the impact of the erosion on retirees.[3] These studies have consistently found that fewer employers are offering retiree health benefits. These studies have also shown that, even when retiree health benefits are offered, retirees are seeing various combinations of rising premiums, rising out-of-pocket expenses, and more stringent eligibility requirements. It has also been shown that retirees are going to be asked to bear an increasing share of out-of-pocket costs in the future. The burden on retirees may grow as policymakers grapple with an unfunded liability of more than $30 trillion dollars in the Medicare program and current, overall, accumulated federal debt of $16 trillion.

While employers have been cutting back on retiree health benefits, few studies have examined the impact on retirees. Fronstin (2001) found no change in the percentage of early retirees with retiree health benefits between 1994 and

1999, though more recent research (Fronstin, 2005) has found that the percentage of retirees with retiree health coverage declined 37 percent among early retirees and 10 percent among Medicare-eligible retirees between 1997 and 2002. The fact that there was no impact on early retirees in the earlier period may be because initial changes employers made to retiree health benefits affected future retirees but not then-current retirees. Over time, more and more retirees eventually aged into to the program changes. Furthermore, individuals may have delayed retirement because of the absence of retiree health benefits, causing a selection effect when only looking at whether retirees had coverage.[4]

When it comes to Medicare-eligible retirees, the GAO (2005) also found that the overall percentage of Medicare-eligible retirees and their insured dependents obtaining health benefits through former employers remained relatively constant between 1995 and 2003, but it did find a modest decline in coverage among persons ages 65–79.

Additionally, few studies have focused on current workers and how many of them should expect to have retiree health benefits once they retire, although Fronstin (2005) found a 6 percent decline in the percentage of workers expecting health coverage in retirement between 1997 and 2005. However, a number of studies have examined the impact of the lack of retiree health benefits on savings needed to cover such expenses (Fronstin, Salisbury, and VanDerhei 2011).[5]

This *Issue Brief* uses recently released data from the U.S. Census Bureau to examine these questions. It also examines recent trends in offer rates for retiree health benefits, as well as changes to eligibility for coverage and changes to benefits packages. Later sections examine how the populations of retirees with retiree health coverage and workers expecting such coverage have changed between 1997 and 2010. This paper ends with a discussion of what might be next for retiree health benefits.

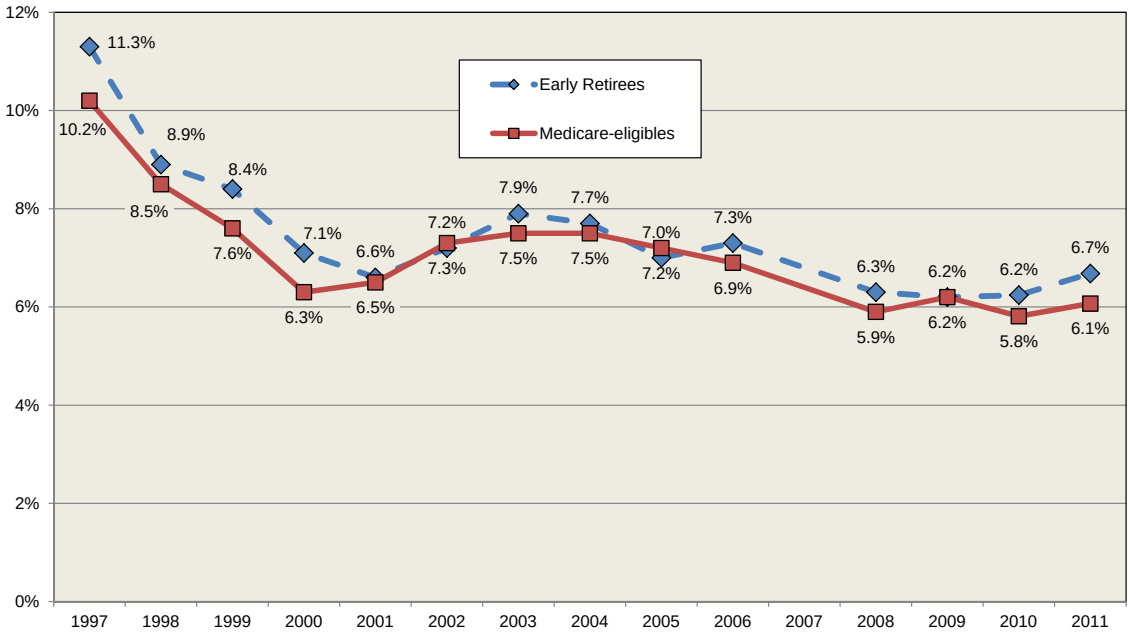
Trends in Retiree-Health-Benefit Offer Rates

Very few private-sector employers currently offer retiree health benefits, and the number offering them has been declining. The Agency for Healthcare Research and Quality (AHRQ) reported that in 2011 only 6 percent of private-sector establishments offered health benefits to early retirees, down from only 10 percent for Medicare-eligible retirees in 1997 (Figure 1). Furthermore, 6 percent of private-sector establishments offered health benefits to early retirees in 2011, down from 11 percent in 1997.

Larger firms were much more likely than smaller ones to offer retiree health benefits. Among private-sector establishments with 1,000 or more workers, 31.7 percent offered health coverage to Medicare-eligible retirees, and 37.5 percent offered it to early retirees in 2011 (Figure 2). Even among larger firms, the percentage offering retiree health benefits either to early retirees or Medicare-eligible retirees has been declining. There was a drop between 1997 and 2000 and a drop between 2004 and 2010.

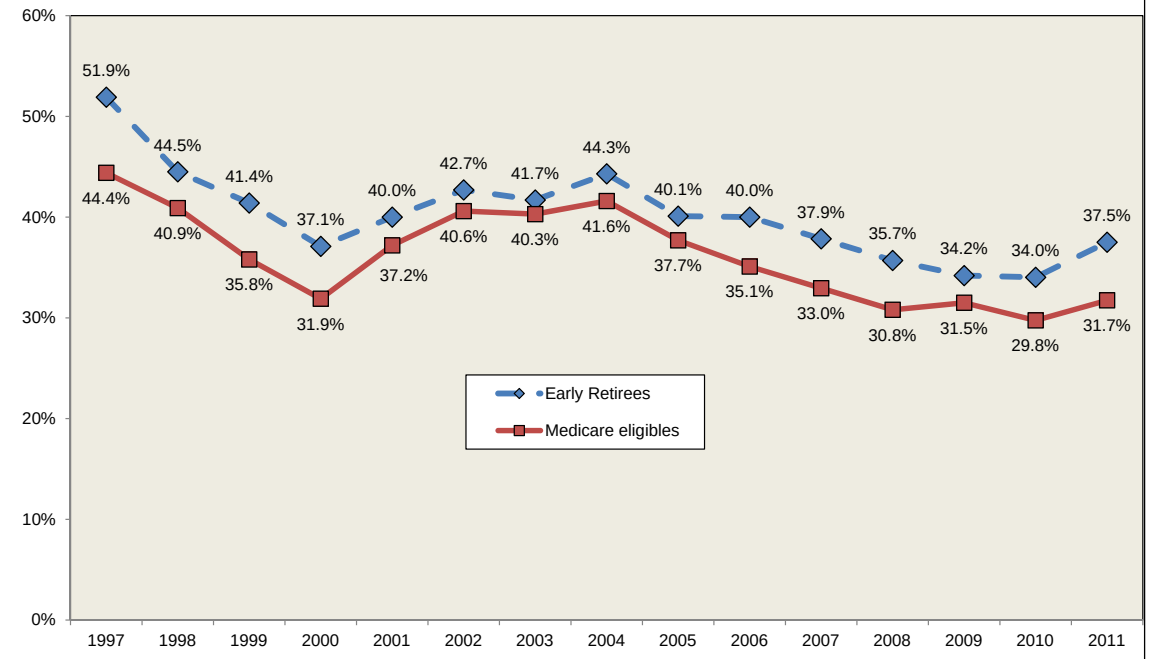
As a result of the decline in the percentage of employers offering coverage, the percentage of workers at firms that offer coverage has declined as well. In 2010, 17.7 percent of workers were employed at establishments that offered health coverage to early retirees, down from 28.9 percent in 1997 (Figure 3). Similarly, 15.9 percent of workers were employed at establishments that offered health coverage to Medicare-eligible retirees, down from 25.4 percent in 1997. However, these statistics should not be interpreted as meaning that 15.9 percent of workers should expect supplemental health coverage to Medicare when enrolled in the program, nor should it be implied that 17.7 percent of workers should expect to receive health coverage if they retire before age 65. Many of these workers will not be eligible for retiree health coverage for a number of reasons: They may be part-time; they may have not had enough years of service to qualify for the benefit; or new hires may not be eligible for coverage.

Figure 1
Percentage of Private-Sector Establishments Offering Health Insurance to Retirees, 1997–2011



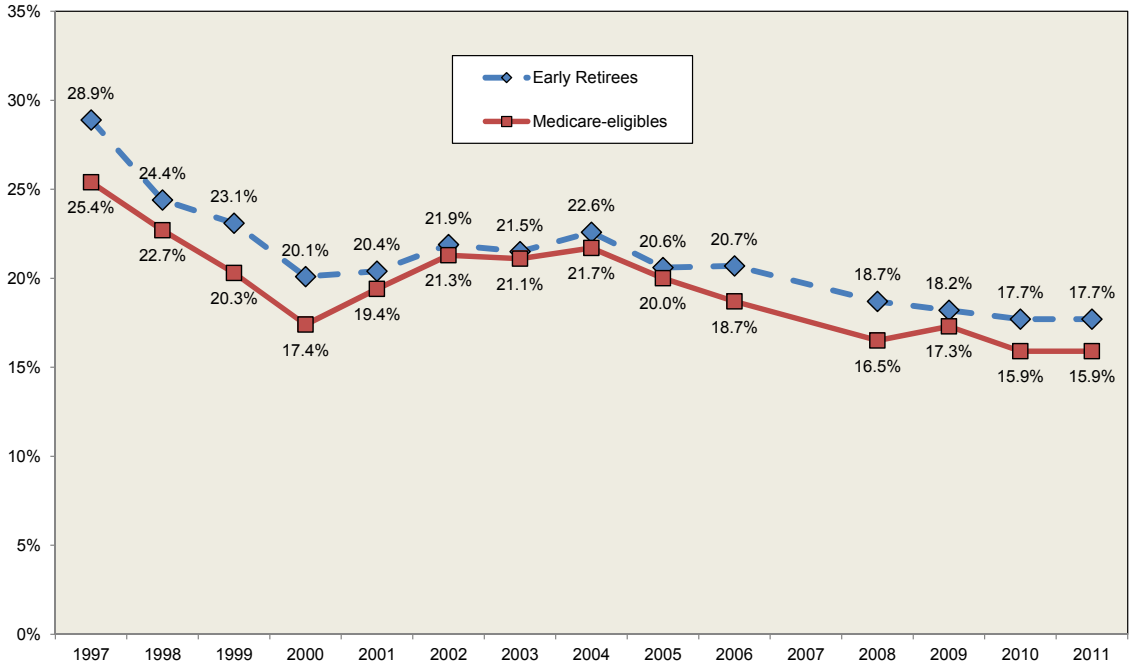
Source: EBRI estimates from various tables at http://meps.ahrq.gov/mepsweb/data_stats/quick_tables_search.jsp?component=2&subcomponent=1

Figure 2
Percentage of Private-Sector Establishments With 1,000 or More Employees Offering Health Insurance to Retirees, 1997–2011



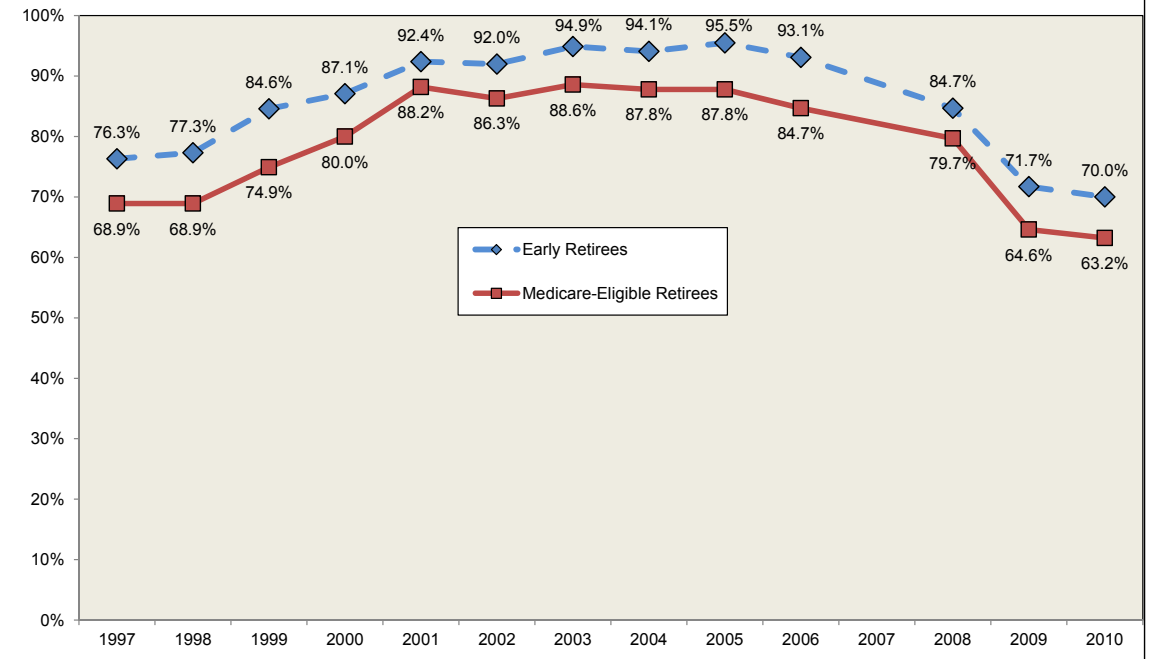
Source: EBRI estimates from various tables at http://meps.ahrq.gov/mepsweb/data_stats/quick_tables_search.jsp?component=2&subcomponent=1

Figure 3
Percentage of Private-Sector Workers Employed By Establishments Offering Health Insurance to Retirees, 1997–2011



Source: EBRI estimates from various tables at http://meps.ahrq.gov/mepsweb/data_stats/quick_tables_search.jsp?component=2&subcomponent=1

Figure 4
Percentage of State Governments Offering Health Insurance to Retirees, 1997–2010



Source: Various tables at http://meps.ahrq.gov/mepsweb/data_stats/quick_tables_search.jsp?component=2&subcomponent=1

Public-Sector Impact

The AHRQ data show a similar trend among state-government employers. Among state employers, the percentage offering retiree health benefits increased between 1997 and 2003. In 2003, 94.9 percent were providing health coverage to early retirees and 88.6 percent were providing health coverage to Medicare-eligible retirees (Figure 4). However, recently, the percentage of state-government employers offering retiree health benefits has fallen. By 2010, 70 percent were offering health coverage to early retirees and 63.2 percent were offering it to Medicare-eligible retirees.

Similarly, there has been a recent decline in the percentage of local-government employers offering retiree health benefits. Between 2006 and 2010, the percentage of local governments with 10,000 or more workers that offered health coverage to early retirees fell from 95.1 percent to 77.6 percent, and the percentage offering it to Medicare-eligible retirees fell from 86.2 percent to 67.3 percent (Figure 5). Some of this decline may be due to recent GASB rules mentioned above.

Only a few local governments reported that they have either recently or soon plan to eliminate health benefits for retirees. Instead, local governments have shifted (or plan to shift) the costs to retirees. In 2011, 2 percent of local governments reported that they eliminated coverage in the past two years or planned to eliminate coverage in the next two years for early retirees (Figure 6). Five percent reported doing so, or planning to do so, for Medicare-eligible retirees. In contrast, 21 percent reported that they eliminated the employer subsidy in the past two years or planned to do so in the following two years for early-retiree coverage, and 32 percent reported taking such an action for Medicare-eligible retirees.

Changes to Eligibility and the Benefits Package

While many employers have dropped retiree health benefits, especially for future retirees, most that have continued to offer retiree health benefits have made changes that raise the premiums that retirees are required to pay, tighten eligibility, limit or reduce benefits, some combination of these, or the employers have taken other approaches to manage costs.

About three-quarters of employers reported that they increased premiums for early-retiree coverage between 2011 and 2012, and 75 percent did so for Medicare-eligible retirees (Figure 7). In addition to increasing premiums, 34 percent increased cost sharing for early retirees, and 31 percent increased it for Medicare-eligible retirees. Other (though less frequently mentioned) recent changes included tightening restrictions on eligibility, introducing a health savings account (HSA) plan, and adopting access-only plans, by terminating the employer subsidization of premiums.

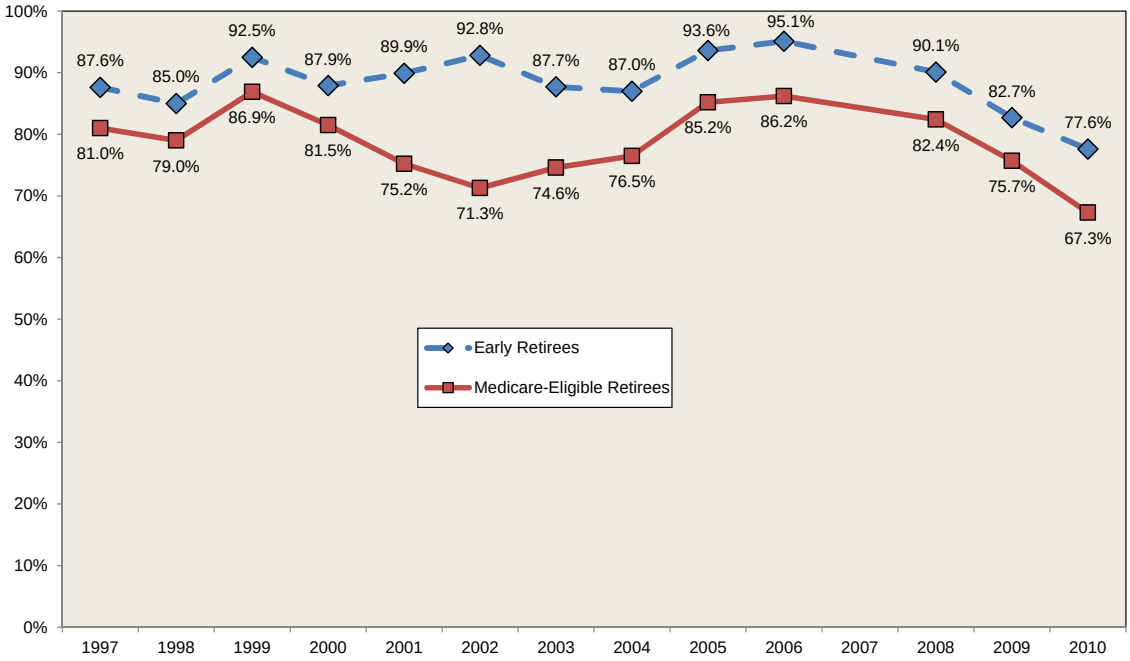
In a survey of mostly private-sector employers, only 25 percent of employers that continue to offer retiree health benefits had not adopted some type of defined dollar cap on their contribution in 2010 (Figure 8). Among the 75 percent that had adopted a cap, 24 percent limited their contribution, while 50 percent required retirees to pay the full cost of coverage via so-called "access-only" plans.

When it comes to the changes employers might make in 2013, increasing retiree contributions tops the list; 43 percent reported that they are very likely to increase the retirees' portion of premiums in 2013 (Figure 9) and another 35 percent reported they are somewhat likely to increase it. In addition to requiring retirees to pay more for insurance, 21 percent of employers reported that they are very likely to increase cost sharing and another 32 percent reported that they are somewhat likely to do so. Few employers reported that they are either very or somewhat likely to take a different approach with retiree benefits.

Public-Sector Shifts

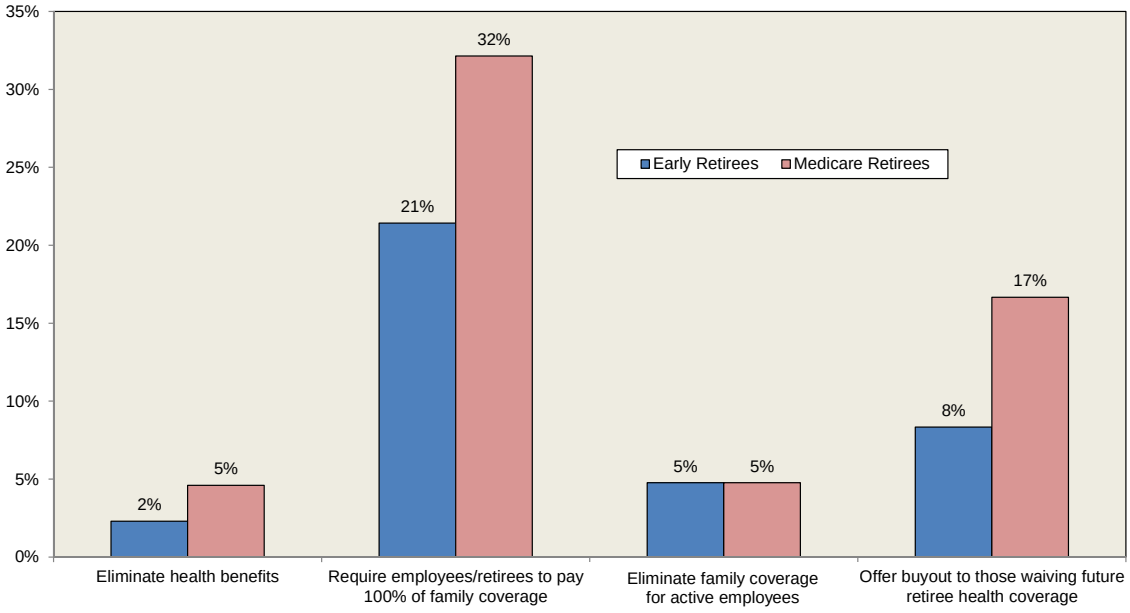
Similar to private-sector employer trends, local governments were also most likely to cite increasing premiums. In 2011, 46 percent of local governments reported that they had increased retirees' share of the premium for early

Figure 5
Percentage of Local Governments With 10,000 or More Workers Offering Health Insurance to Retirees, 1997–2010



Source: Various tables at http://meps.ahrq.gov/mepsweb/data_stats/quick_tables_search.jsp?component=2&subcomponent=1

Figure 6
Benefit Elimination Changes, Among Local-Government Employers, 2011



Source: Published and unpublished data from the Cobalt Community Research, Health and OPEB Funding Strategies: 2011 National Survey of Local Governments, www.cobaltcommunityresearch.org/images/stories/2011_HealthStrat/OPEB2011%20FINAL.pdf

Figure 7
Changes to Retiree Health Benefits From 2011 to 2012

	Early Retirees	Medicare-Eligible Retirees
Increased retiree contribution to premiums	73%	75%
Increased retiree plan design cost-sharing requirements	34	31
Tightened restrictions on new retiree eligibility	12	11
Introduced an HSA-compatible HDHP	12	N/A
Terminated subsidized benefits for some or all future retirees	11	14
Introduced a new premium subsidy cap for a group that was previously uncapped	6	5
Terminated subsidized benefits for some or all current Retirees	0	0
	5	6
Moved to a pure defined contribution subsidy approach through a health reimbursement arrangement (HRA)	2	4
Facilitated retiree purchase of individual medical insurance	3	9
Other	5	3
Introduced Medicare Advantage plans	N/A	6
Terminated Medicare Advantage plans	N/A	3

Source: Aon Hewitt, *2012 Hot Topics in Retirement* (2012). www.aon.com/attachments/human-capital-consulting/2012_Hot_Topics_in_Retirement_highlights.pdf

retirees in the past two years, or planned to do so in the next two years (Figure 10). Forty-four percent had either increased or planned to increase out-of-pocket limits; 37 percent had introduced, or planned to introduce, caps on the employer contributions; and 36 percent had increased, or planned to increase, deductibles. Among those offering retiree health benefits to Medicare-beneficiaries, nearly 40 percent had recently increased, or planned to increase, drug copayments, age and/or service retirements, or deductibles.

Concerning design changes within a plan to control costs, with few exceptions, most local governments have not instituted them. However, at a macro level, 52 percent of local governments recently introduced tighter provider networks, 35 percent expanded the use of generic drugs, 32 percent implemented disease management, and 28 percent introduced HSAs or health reimbursement arrangements (HRAs) for early retirees (Figure 11).

It appears that local governments are more likely to adopt design changes that affect the type of plan offered, especially for Medicare beneficiaries. In 2011, 56 percent reported that in the past two years they have required Medicare Part D coverage as part of retiree health benefits for Medicare beneficiaries or that they plan to do so in the next two years (Figure 12).

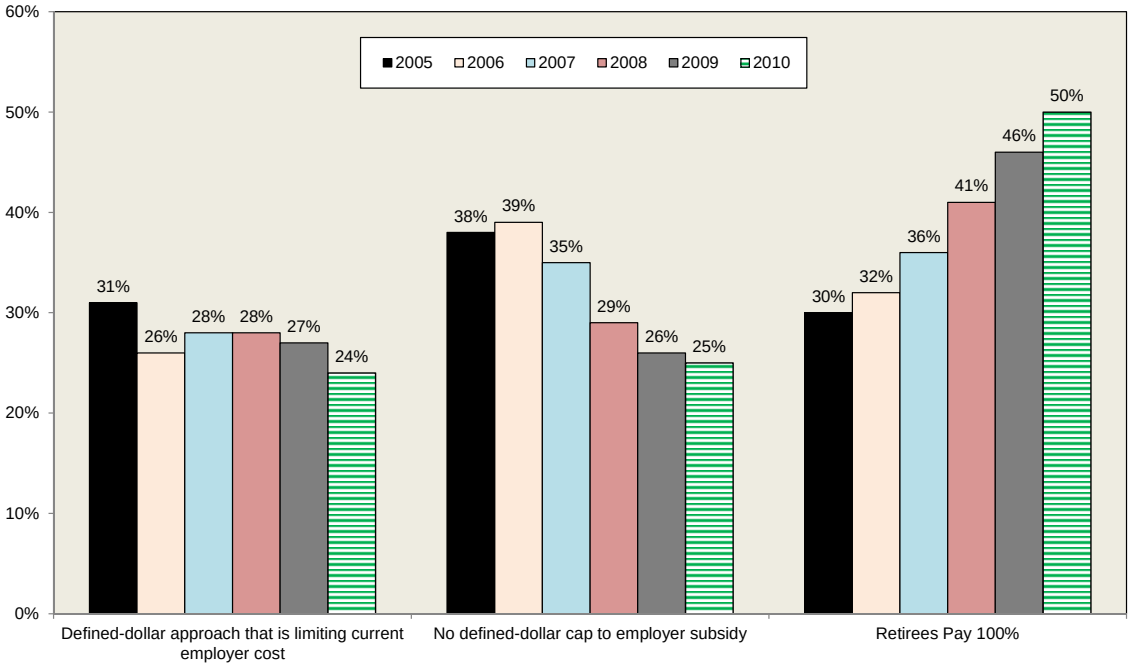
Local governments also reported that they have either recently introduced, or plan to soon introduce, purchasing changes to manage costs. Some of the more prevalent strategies for early retirees included moving from fully insured to self-insured plans (47 percent), shifting responsibility for benefit administration to unions (44 percent), and changing carriers (39 percent) (Figure 13). Among those having recently made or planning to soon introduce changes affecting health coverage for Medicare-eligible retirees, contracting with an organization to manage prescription drug spending was by far the most prevalent strategy reported.

Impact on Retirees

In order to understand the impact that the erosion of retiree health benefits has had on retirees, data from the Survey of Income and Program Participation (SIPP) were examined.[6] Data for this paper came from four panels: 1996, 2001, 2004, and 2008. In a topical module in each panel, questions were asked regarding health benefits in the workplace, health benefits in retirement, and job characteristics associated with the job from which an individual retired. These topical questions were asked in 1997, 2002, 2005, and 2010. Early retirees (people ages 45–64) were examined separately from Medicare-eligible retirees (people ages 65 and older) because employers are generally more likely to offer retiree health benefits to early retirees than to Medicare-eligible retirees.

Figure 8

Distribution of Various Ways in Which Employers Subsidized Early-Retiree Health Benefits, 2005–2010



Source: Aon Hewitt, *Spec Summary: US Salaried*, 2010 (formerly known as the Hewitt *Benefit SpecSelect: SpecSummary*).

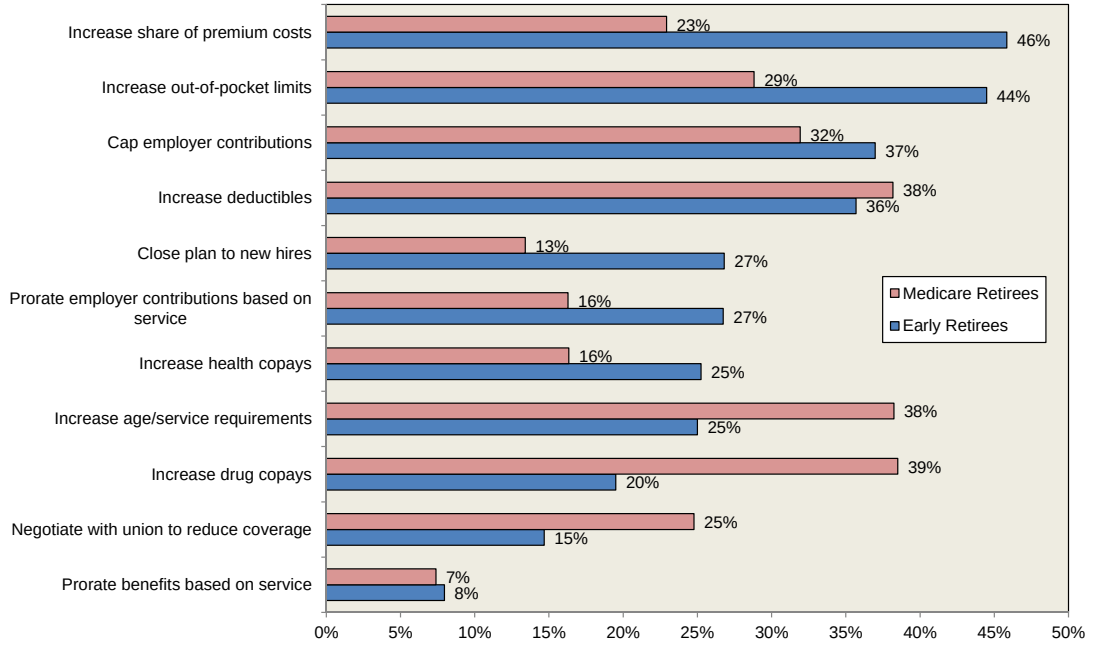
Figure 9

Likely Changes to Retiree Health Benefits Projected in 2013

	Very Likely	Somewhat Likely	Somewhat Unlikely	Very Unlikely
Increase retiree contributions to premiums	43%	35%	7%	15%
Change Medicare Rx/Part D strategy	15	16	22	47
Increase retiree plan design cost-sharing requirements	21	32	20	28
Facilitate retiree purchase of individual medical insurance	9	21	22	48
Tighten restrictions on new retiree eligibility	9	11	18	62
Introduce Medicare Advantage plans	7	15	19	59
Terminate subsidized benefits for some/all future retirees	6	10	15	69
Introduce HSA-compatible HDHP	6	16	16	62
Move to a pure defined contribution subsidy approach through a health reimbursement arrangement (HRA)	5	10	21	65
Introduce a new premium subsidy cap for a group that was previously uncapped	3	9	21	67
Terminate Medicare Advantage plans	3	3	21	74
Terminate subsidized benefits for some or all current retirees	3	6	12	79

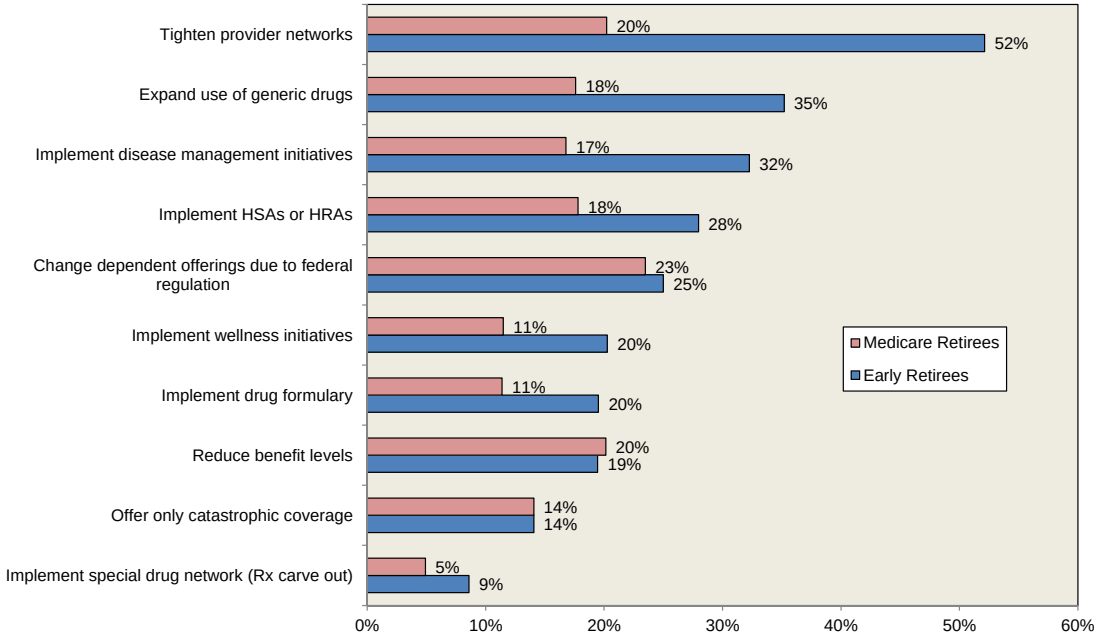
Source: Aon Hewitt, *2012 Hot Topics in Retirement* (2012). www.aon.com/attachments/human-capital-consulting/2012_Hot_Topics_in_Retirement_highlights.pdf

Figure 10
Eligibility and Contribution Changes to Manage Costs, Among Local Government Employers, 2011



Source: Published and unpublished data from the Cobalt Community Research, Health and OPEB Funding Strategies: 2011 National Survey of Local Governments, http://www.cobaltcommunityresearch.org/images/stories/2011_HealthStrat/OPEB2011%20FINAL.pdf.

Figure 11
Design Changes to Manage Costs, Among Local Government Employers, 2011



Source: Published and unpublished data from the Cobalt Community Research, Health and OPEB Funding Strategies: 2011 National Survey of Local Governments, www.cobaltcommunityresearch.org/images/stories/2011_HealthStrat/OPEB2011%20FINAL.pdf

Overview

The sample of data used from SIPP for this paper represented 12.3 million retirees ages 45–64 in 1997 and 13.3 million in 2010 (Figure 14). The sample also included 29.8 million retirees ages 65 and older in 1997 and 34.2 million in 2010. The sample of retirees included people who have retired from jobs, but have returned to work. Among these retirees still working, the percentage of 45–64-year-olds expecting health coverage in retirement was unchanged between 1997 and 2002 at 33 percent, declined to 27 percent in 2005, and remained at 28 percent in 2010 (Figure 15). Similarly, the percentage of retirees still working after age 65 and expecting health coverage in retirement fell from 15 percent in 2002 to 9 percent in 2010.

Among retirees not working, regardless of age, the percentage with retiree health benefits has shown no clear upward or downward trend. However, the percentage of non-working retirees with retiree health coverage is lower than the percentage of workers (including those retired and still working) that expect health coverage in retirement. In 2010, 25 percent of non-working, early retirees ages 45–64 and 16 percent of non-working retirees ages 65 and older had health coverage in retirement through a former employer (Figure 16). (In comparison, Figure 18 shows that 32 percent of never-retired workers ages 45–64 expected employment-based health coverage in retirement.) Similarly, 21 percent of never-retired workers ages 65 and older expected health coverage in retirement compared with16 percent that had it.

Demographic Differences

As noted earlier, the overall percentage of non-working retirees with health coverage through a former employer fell from 20 percent in 1997 to 16 percent in 2010, and, as a result, the characteristics of the population with retiree health coverage have changed. Between 1997 and 2010, the population of retirees with health coverage from a former employer became older. In 1997, 20.1 percent of non-working, Medicare-eligible retirees with retiree health coverage were 80 or older (Figure 17). By 2010, it was 31.3 percent, a 56 percent increase in the likelihood that a retiree with retiree health coverage is at least 80 years old. This may be due to the combination of fewer employers providing health coverage to new retirees and older retirees being grandfathered into their existing plans. A slight change in the gender distribution and an increase in the percentage of minority retirees with coverage was found. These findings were consistent with changes in the labor-force demographics.

There was a relatively large change found in the distribution of retirees by education level. In 2010, 8 percent of non-working, Medicare-eligible retirees with retiree health coverage did not have a high school education, down from 23.2 percent in 1997. In contrast, the percentage of non-working, Medicare-eligible retirees with retiree health coverage with a post-graduate degree doubled during this period, increasing from 9.7 percent in 1997 to 18.9 percent in 2010.

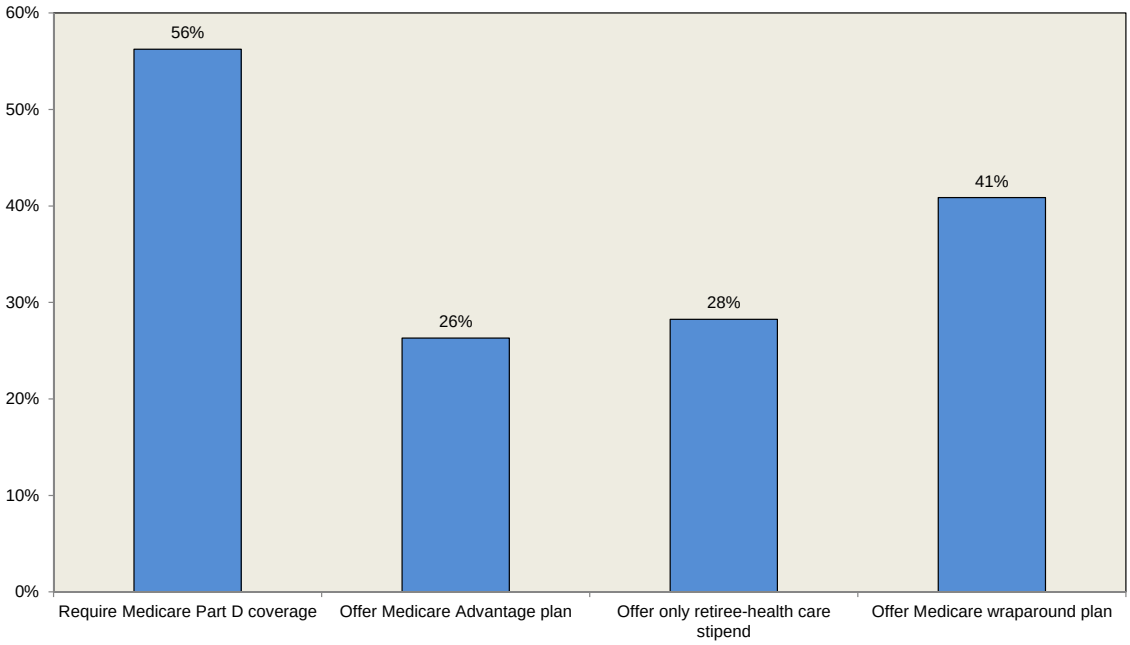
Prior-Job-Characteristic Differences

When it came to differences in the distribution of certain characteristics of prior jobs from which individuals retired. There was very little change in the distribution of retirees by firm size and no change by union status. There was a change in the distribution of non-working, Medicare-eligible retirees with retiree health coverage by industry: The percentage retiring from public-sector jobs increased from 37.7 percent to 47.2 percent between 1997 and 2010. This may be due to the fact that the public sector has been slower than the private sector to drop retiree health benefits.

Impact on Workers' Expectations

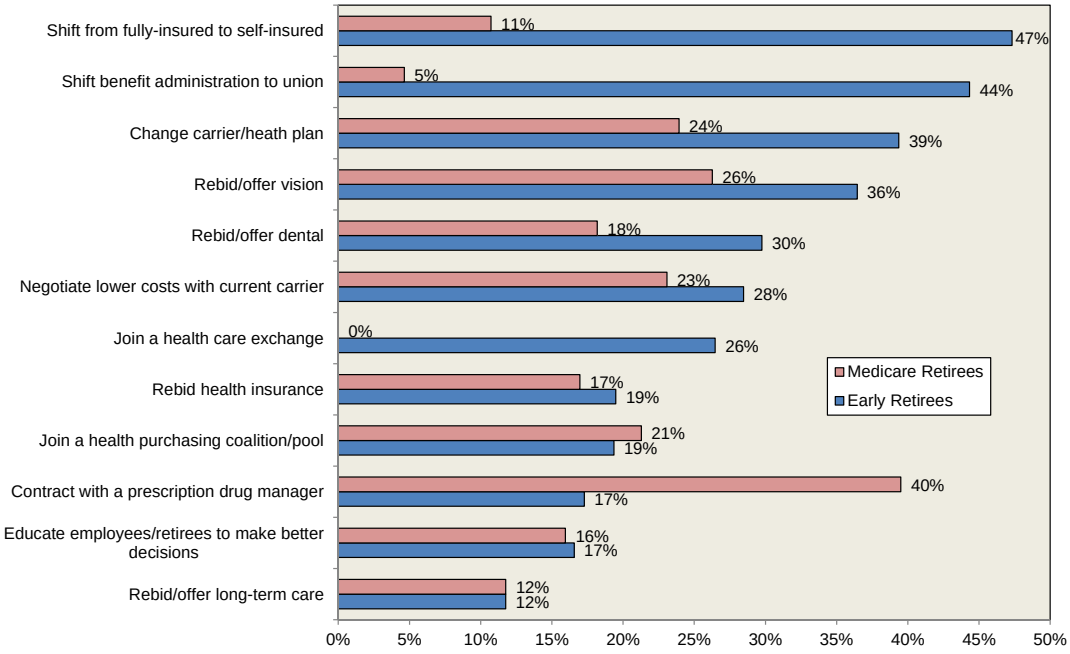
Data from SIPP were also used to examine the impact of the erosion of retiree health benefits on never-retired workers. The sample of data used from SIPP for this analysis represented 35.7 million wage and salary workers ages 45–64 in 1997 and 52.7 million in 2010 (Figure 14).

Figure 12
Design Changes Affecting Medicare Beneficiaries, Among Local Government Employers, 2011



Source: Published and unpublished data from the Cobalt Community Research, Health and OPEB Funding Strategies: 2011 National Survey of Local Governments, www.cobaltcommunityresearch.org/images/stories/2011_HealthStrat/OPEB2011%20FINAL.pdf

Figure 13
Purchasing Changes, Among Local Government Employers, 2011



Source: Published and unpublished data from the Cobalt Community Research, Health and OPEB Funding Strategies: 2011 National Survey of Local Governments, www.cobaltcommunityresearch.org/images/stories/2011_HealthStrat/OPEB2011%20FINAL.pdf

Figure 14
Main Activity, by Age, 1997–2010

	1997	2002	2005	2010
	(in millions)			
Ages 45–64	55.0	65.9	72.1	80.0
Working, never retired	35.7	42.9	49.3	52.7
Retired	12.3	14.1	12.3	13.3
Still working	4.9	5.7	4.6	4.7
Not working	7.4	8.4	7.7	8.5
Not working due to health status	3.4	4.5	5.9	7.1
Other	3.6	4.4	4.6	7.0
Ages 65 and older	32.0	33.8	34.0	38.6
Working, never retired	1.6	1.7	1.9	3.6
Retired	29.8	31.4	31.3	34.2
Still working	3.1	3.5	2.9	3.3
Not working	26.7	27.9	28.4	30.9
Not working due to health status	0.4	0.4	0.6	0.6
Other	0.3	0.3	0.2	0.3
	Percentage Distribution			
Ages 45–64	100%	100%	100%	100%
Working, never retired	65	65	68	66
Retired	22	21	17	17
Still working	9	9	6	6
Not working	13	13	11	11
Not working due to health status	6	7	8	9
Other	7	7	6	9
Ages 65 and older	100	100	100	100
Working, never retired	5	5	6	9
Retired	93	93	92	88
Still working	10	10	9	8
Not working	83	82	83	80
Not working due to health status	1	1	2	2
Other	1	1	1	1

Source: Employee Benefit Research Institute estimates based on data from the Survey of Income and Program Participation, 1996, 2001, 2004, and 2008 panels.

Among workers ages 45–64, the percentage expecting retiree health coverage in retirement fell from 45 percent in 1997 to 32 percent in 2010 (Figure 18). Workers ages 65 and older have shown a slight decline in the percentage expecting retiree health coverage, if 2002 data are ignored. The percentage expecting retiree health coverage fell from 23 percent in 1997 to 21 percent in 2010. The remainder of this section examines changes between 1997 and 2010 to the population of never-retired workers ages 45–64 expecting retiree health coverage.

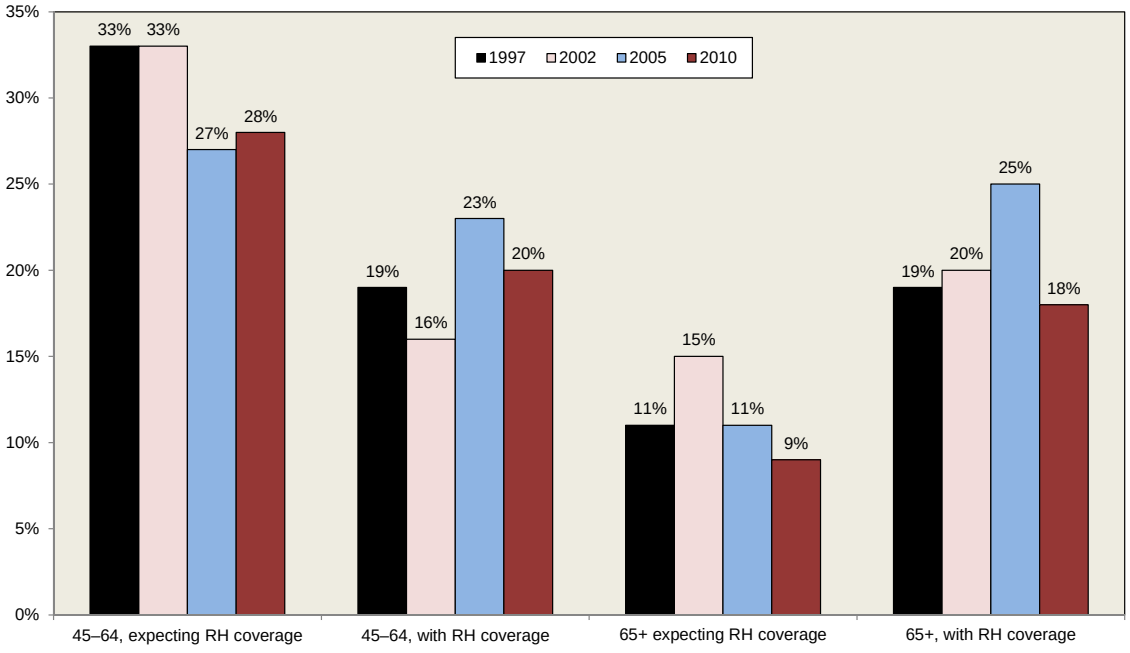
Demographic Differences

The distribution of workers expecting health coverage in retirement has shifted to an older population. In 2010, 28 percent of workers expecting to receive retiree health benefits once retired were ages 45–49, down from 42.5 percent in 1997 (Figure 19), a decline of 34 percent. This also may have been due to the combination of fewer employers providing health coverage to new retirees and older retirees being grandfathered. Otherwise, there was a slight shift toward more women and more minorities, which also may have been due to the way in which the labor force is changing. There was a slight movement toward more-educated workers being more likely to comprise the population of workers expecting health coverage in retirement.

Job Characteristic Differences

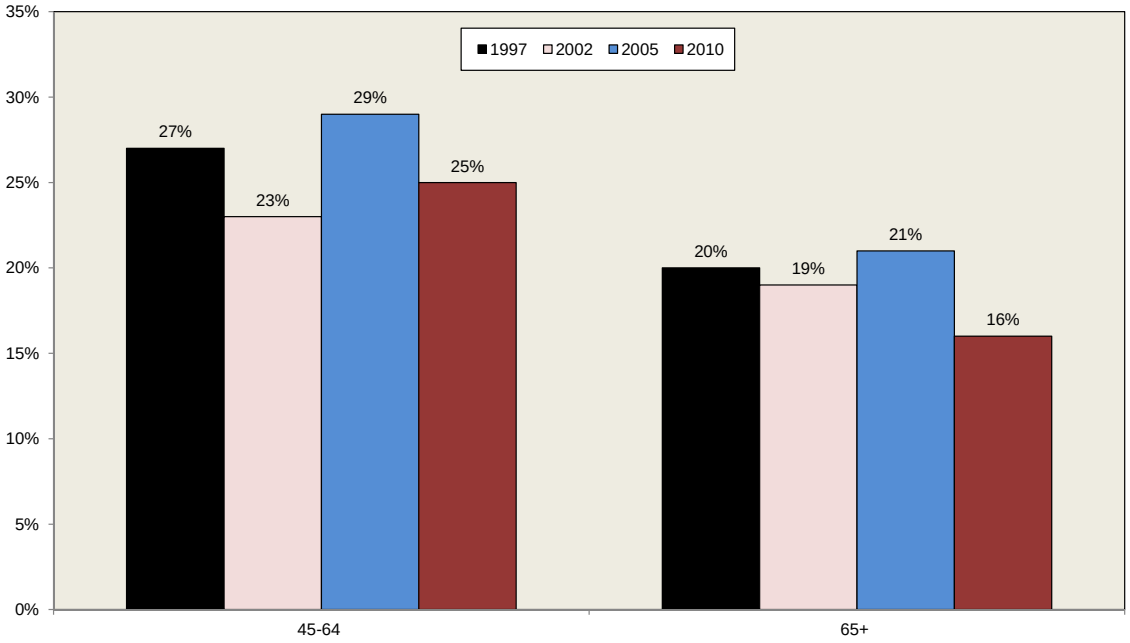
There were some notable changes to the distribution of workers expecting health coverage in retirement by job characteristics (Figure 20). The distribution of sector of employment shifted slightly from private-sector to public-sector workers. This may have been due to the fact that the private sector has been cutting back on retiree health benefits since the mid-1990s, whereas the public sector has only recently had to address changes in accounting for retiree-health-care costs because of GASB Statements 43 and 45, so private-sector workers have had more time to see the changes coming.

Figure 15
Percentage of Retirees Still Working With Retiree Health Benefits or Expecting Them, by Age, 1997–2010



Source: Employee Benefit Research Institute estimates based on data from the Survey of Income and Program Participation, 1996, 2001, 2004, and 2008 panels.

Figure 16
Percentage of Retirees Not Working With Retiree Health Benefits, by Age, 1997–2010



Source: Employee Benefit Research Institute estimates based on data from the Survey of Income and Program Participation, 1996, 2001, 2004, and 2008 panels.

Figure 17

Distribution of Non-Working Retirees Ages 65 and Older Receiving Health Benefits in Retirement, by Demographics and Previous Job Characteristics, 1997 and 2010

	1997	2010	Percentage Change	Percentage Point Change
Age				
65–69	27.0%	26.6%	-1%	-0.3
70–74	29.6	22.0	-25.8	-7.6
75–79	23.4	20.2	-14.0	-3.3
80 and older	20.1	31.3	56.0	11.2
Gender				
Male	59.9	58.5	-2.5	-1.5
Female	40.1	41.6	3.7	1.5
Race/Ethnicity				
White	90.5	84.6	-6.6	-6.0
Black	7.1	9.3	32.0	2.3
Hispanic	1.4	2.9	106.5	1.5
Other	1.1	3.3	211.4	2.2
Education				
Less than high school	23.2	8.0	-65.7	-15.3
High school and/or some college	55.6	57.3	3.1	1.7
College	11.5	15.9	37.7	4.3
Post-college	9.7	18.9	95.6	9.2
Age at Retirement				
Under age 55	15.6	17.6	12.9	2.0
55-64	61.1	59.7	-2.3	-1.4
65 and older	23.3	22.7	-2.6	-0.6
Union Status				
Union	40.2	40.4	0.5	0.2
Non-union	59.8	59.6	-0.3	-0.2
Industry				
Manufacturing	27.9	19.2	-31.4	-8.8
Trade	6.3	4.4	-31.2	-2.0
Services & Other	28.0	29.3	4.4	1.2
Public sector	37.7	47.2	25.2	9.5
Firm Size				
Under 25	8.2	8.2	-0.2	0.0
25–99	7.5	6.5	-13.5	-1.0
100 or more	84.3	85.3	1.2	1.0

Source: Employee Benefit Research Institute estimates based on data from the Survey of Income and Program Participation, 1996, and 2008 panels.

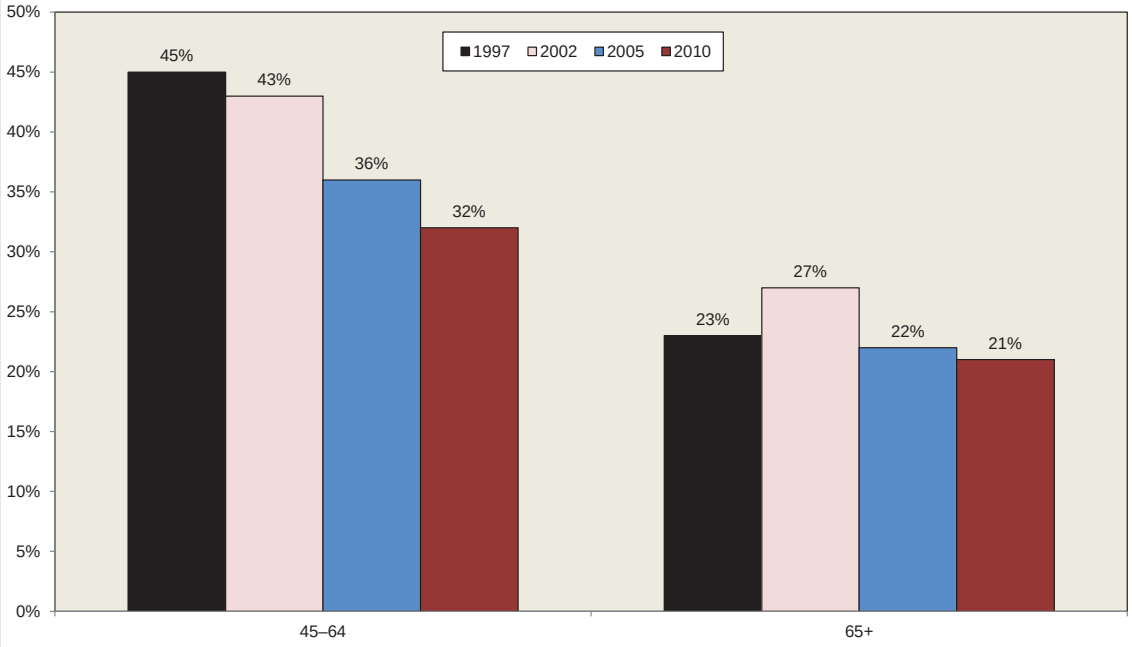
There was also a slight movement from manufacturing jobs to jobs in the trade industry, consistent with broader labor-force changes. There was a big shift toward higher-income workers, a slight shift toward smaller firms, and a slight shift toward non-union jobs.

The findings for hours of work suggested a shift from full-time work to unknown hours, but this may have been due to a methodological change in the way hours of work are reported.

What's Next for Retiree Health Benefits

In 2011, one year after the passage of the Patient Protection and Affordable Care Act of 2010 (PPACA), it was found that while most employers did not think health insurance exchanges would become a viable option for active workers, more than one-half were either very confident (16 percent) or somewhat confident (37 percent) that they would become a viable option for retirees (Figure 21). Furthermore, a 2012 TowersWatson/National Business Group on Health survey of employers found that the use of health accounts for retiree health benefits is already expanding. Calculations from Figure 22 show that between 2012 and 2013, the percentage of employers offering retiree health benefits that will convert the employer subsidies to health accounts will increase from 15 percent to 22 percent, with another 35 percent considering doing so by 2015 (Figure 22).

Figure 18
Percentage of Workers Who Have Never Retired Expecting Retiree Health Benefits, by Age, 1997–2010



Source: Employee Benefit Research Institute estimates based on data from the Survey of Income and Program Participation, 1996, 2001, 2004, and 2008 panels.

Figure 19
Distribution of Workers Ages 45–64 Expecting to Receive Health Benefits in Retirement, by Demographics, 1997 and 2010

	1997	2010	Percentage Change	Percentage Point Change
Age				
45–49	42.5%	28.0%	-34%	-14.5
50–54	30.1	32.6	8.3	2.5
55–59	18.8	25.0	33.0	6.2
60–64	8.6	14.4	67.8	5.8
Gender				
Male	57.5	52.4	-8.9	-5.1
Female	42.5	47.6	12.1	5.1
Race/Ethnicity				
White	81.4	76.2	-6.3	-5.1
Black	10.3	10.7	3.7	0.4
Hispanic	5.3	7.4	39.3	2.1
Other	3.0	5.7	89.0	2.7
Education				
Less than high school	8.0	3.6	-55.8	-4.5
High school and/or some college	57.2	55.4	-3.1	-1.8
College	18.1	23.0	27.4	5.0
Post-college	16.7	18.1	7.9	1.3

Source: Employee Benefit Research Institute estimates based on data from the Survey of Income and Program Participation, 1996, and 2008 panels.

Figure 20

Distribution of Workers Ages 45–64 Expecting to Receive Health Benefits in Retirement, by Job Characteristics, 1997 and 2010

	1997	2010	Percentage Change	Percentage-Point Change
Sector of Employment				
Private	64.2%	58.4%	-9%	-5.8
Local government	14.2	16.7	17.2	2.5
State government	9.7	10.9	12.7	1.2
Federal government	6.8	7.7	13.4	0.9
Unpaid in family business	0.1	0.2	60.0	0.1
Don't know	5.1	6.2	23.2	1.2
Industry				
Manufacturing	31.5	19.9	-36.8	-11.6
Trade	15.2	20.1	32.1	4.9
Services	33.4	34.8	4.2	1.4
Public sector	11.7	12.5	6.9	0.8
Other	3.6	6.7	87.2	3.1
Don't Know	4.7	6.1	29.3	1.4
Earnings				
Under $10,000	9.9	9.6	-2.9	-0.3
$10,000–$19,999	16.3	7.1	-56.3	-9.2
$20,000–$29,999	19.8	11.5	-41.8	-8.3
$30,000–$39,999	18.5	14.0	-24.1	-4.5
$40,000–$49,999	12.8	11.7	-8.8	-1.1
$50,000 or more	22.8	46.1	102.2	23.3
Firm Size				
Under 25	7.8	8.8	12.6	1.0
25–99	8.0	9.6	20.1	1.6
100 or more	79.2	75.4	-4.8	-3.8
Don't know	5.1	6.2	23.2	1.2
Hours Worked				
1–19	0.9	1.4	60.0	0.5
20–34	4.3	5.1	18.0	0.8
35 or more	90.2	79.8	-11.5	-10.4
Don't know	4.7	13.8	194.0	9.1
Union Status				
Union	28.1	26.3	-6.5	-1.8
Non-union	71.9	73.7	2.5	1.8

Source: Employee Benefit Research Institute estimates based on data from the Survey of Income and Program Participation, 1996, and 2008 panels.

Similarly, calculations from Figure 22 show that the percentage of employers offering retiree medical-savings accounts will increase from 13 percent to 17 percent, with another 21 percent considering doing so by 2015.

It can be argued that the employers that continue to offer health coverage to retirees are providing a service to their retirees. Because of stringent medical underwriting requirements in the individual market, retirees would likely have a difficult time qualifying for such insurance. However, PPACA changes the playing field. Under PPACA, retirees (as well as many other Americans) will be able to purchase health insurance directly from health insurance exchanges; and they stand to benefit from insurance-market reforms combined with the exchanges (such as guaranteed issue, modified community rating, premium and cost-sharing subsidies for those under 400 percent of poverty) as well as increased choice of health plans. With those expanded options, employers that currently provide retiree health benefits may well find themselves considering an exit strategy (Towers Watson/National Business Group on Health 2012).

Starting in 2014, employers can simply give retirees money in an HRA to allow them to purchase coverage through state-based exchanges. There may be an issue with the employer-contribution level and whether it meets the annual limit test, unless the plan is set up as a retiree-only plan. Also, as long as the employer contribution to the HRA is funded with pre-tax dollars, it is unlikely that retirees will be eligible for any premium tax credits. Finally, while current

regulations allow group plans with fewer than 50 workers to purchase coverage through state-based exchanges, retiree groups may be excluded from the state-based exchanges if they are simply above the size threshold. Ultimately, additional guidance is needed on these issues.

Conclusion

Two decades ago, FAS 106 set in motion substantial changes to private-sector retiree health benefits. Some employers capped their spending on retiree health benefits, some required employees to meet age and service requirements before becoming eligible for retiree health benefits, and others moved to access-only plans, defined contribution plans, or completely eliminated retiree health benefits for either current retirees or future retirees.

The changes that employers have made to retiree health benefits are now having an impact on the percentage of retirees with retiree health benefits and the percentage of workers expected to have those benefits in the future. Between 1997 and 2010, the percentage of non-working retirees over age 65 with retiree health benefits fell from 20 percent to 16 percent. As mentioned above, it is also possible that workers are delaying retirement because of the absence of retiree health benefits. The percentage of workers ages 45–64 expecting retiree health benefits dropped from 45 percent to 32 percent between 1997 and 2010.

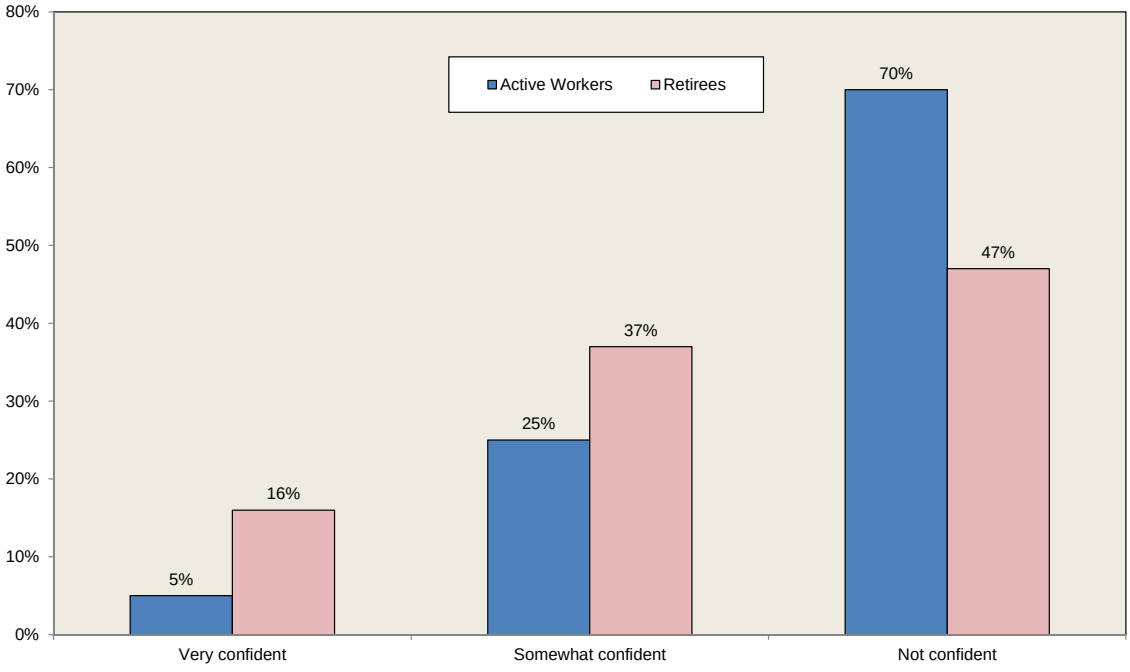
Despite the fact that workers are more likely to expect retiree health benefits than retirees are to actually have those benefits, the expectations gap is closing. In 1997, 45 percent of workers expected retiree health benefits while only 27 percent of early retirees and 20 percent of Medicare-eligible retirees had them. By 2010, 32 percent of workers expected retiree health benefits, while only 25 percent of early retirees and 16 percent of Medicare-eligible retirees had them.

In addition, changes that employers have made to retiree health benefits will continue to have a greater impact on today's workers, namely *future* retirees. In prior work, Fronstin (2005) wrote "changes that employers have made may not have a noticeable effect on trends in insurance coverage until a few years after the Baby Boom generation starts to retire." It is now apparent that those changes are finally affecting workers' perceptions of retirement.

Retirement behavior patterns also may change as employees nearing retirement age learn that, without a job, they may not be able to obtain health insurance coverage, and postpone their decision to retire—or (as shown in previous work) they are unable to afford insurance premiums and/or out-of-pocket expenses.[7]

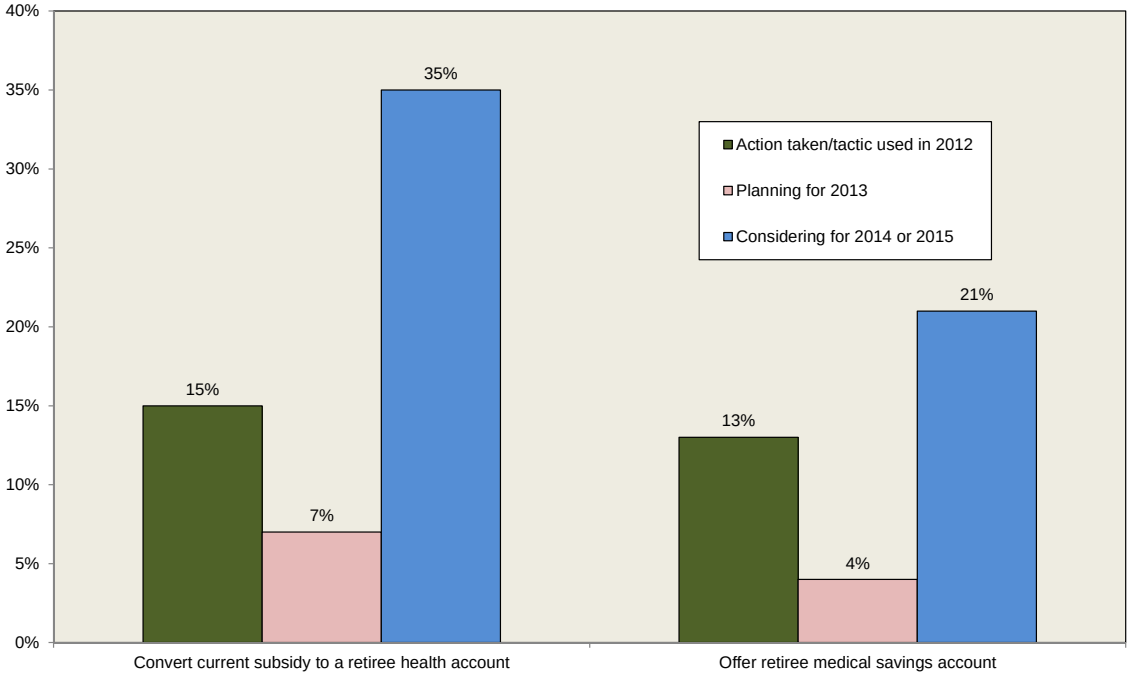
Public policymakers face the difficult task of trying to provide solutions for a system that is largely voluntary. They tried with the retiree drug subsidy in 2003 as part of the Medicare Modernization Act, but when PPACA introduced a tax on that subsidy it became less valuable to employers. Policymakers tried again with the Early Retiree Reinsurance Program that was part of PPACA, but that program was temporary, and (as predicted) the funding ran out before the program ended (Fronstin 2010). Because employers are under no obligation to provide retiree health benefits, except to current retirees who can prove that they were promised a specific benefit, and because (unlike defined benefit pension plans) employers are limited in their ability to pre-fund retiree health benefits, it is likely that employers will continue to make changes to those programs, especially for future retirees. Furthermore, as employers view state-based exchanges as a viable option to retiree health benefits, they may view their role in providing health coverage to retirees as no longer necessary.

Figure 21
Employer Opinions of the Viability of Health Insurance Exchanges as an Alternative to Worker and Retiree Health Coverage in 2014 and 2015



Source: Towers Watson, 2011.

Figure 22
Plans to Use Retiree Health Accounts



Source: Towers Watson/National Business Group on Health, 2012.

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Endnotes

[1] In the early 1980s, employers were aware that FASB was considering accounting-standard changes that would affect the way to account for retiree health benefits on financial statements. There were a number of studies on the earliest FASB guidelines for "Other Post-Employment Benefits" (OPEBs) and broader proposals that were issued in the mid-1980s. The early 1980s standards and the later draft proposals and subsequent research undoubtedly resulted in some employers making changes to retiree health benefits even before FASB's expanded standards were finalized in 1990.

[2] In order to avoid court challenges over benefit changes affecting current and future retirees, generally, employers explicitly reserve the right in plan documents to modify those benefits. According to the U.S. General Accounting Office (1998) virtually all employers have such language in their plan documents.

[3] See Fronstin (1996, 2001, 2005), Fronstin and Salisbury (2003 & 2004), Gabel (2002), McArdle et al. (1999 & 2004), McDevitt et al. (2002), and Mercer Human Resources Consulting (2004).

[4] Prior research has found that the availability of retiree health benefits affects a worker's expectation regarding age of retirement (Fronstin, 1999).

[5] Also see www.fidelity.com/inside-fidelity/individual-investing/retiree-health-care-costs-2012

[6] SIPP provides comprehensive information about the income of individuals and households in the United States. It also provides information on participation in public programs. SIPP is a nationally representative, longitudinal survey of the civilian noninstitutionalized U.S. population. People selected into the SIPP sample are interviewed once every 4 months over the life of the panel. In addition to the core set of questions asked of participants each 4 months, a rotating set of topical questions supplement the core questions.

[7] See Fronstin and Salisbury (2003 and 2004) and VanDerhei and Copeland (2001, 2002a, 2002b, and 2003).

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