

TIAA-CREF institute

THE RETIREE HEALTH CARE CHALLENGE

PREPARED BY HEWITT ASSOCIATES FOR THE TIAA-CREF INSTITUTE
SYMPOSIUM, *SEEKING REMEDIES TO THE RETIREE HEALTH CARE
CHALLENGE*

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EXECUTIVE SUMMARY

The provision of health care benefits to former employees is an undertaking that is both important and daunting for employers in higher education. The availability of retiree health benefits increases retirement income security and can be an integral component of workforce management, better enabling recruitment and retention of key academic and administrative talent. The availability of retiree health benefits also influences the age of retirement and the retirement decision itself, as employees with employer-sponsored health coverage are more likely to retire earlier than employees without such coverage.

As important as retiree health benefits are, they also pose distinct challenges. These include managing costs, addressing accounting rules, deciding on benefit design/redesign, determining the extent to which institutions are able to prefund these benefits and, if so, which vehicles for prefunding best fit the institution's situation. In addressing these challenges it is helpful for an employer to first develop a clear process and strategy that includes taking actions to:

- Define desired objectives and key outcomes for the future.
- Gather input of key stakeholders.
- Develop a benefit design that meets workforce needs — and that is affordable for the institution.
- Identify key transition and grandfathering needs for existing employees/retirees and formulate a transition strategy to meet those needs.
- Develop a funding strategy to support the institution's financial needs.
- Implement strategies developed under the preceding steps in this process; and
- Communicate actively with current employees and retirees.

This paper focuses on the factors affecting plan design and funding decisions. When the areas covered by this paper are addressed in the context of an integrated and strategic process, employers can make substantial progress in addressing their retiree health care challenges.

COST TRENDS AND CHALLENGES

The total cost (employer and retiree contributions) of providing health benefits for both pre-65 and age 65+ retirees has increased at double-digit rates, despite a downward trend from a 16% increase in 2002 to a 10.3% increase in 2005.

ACCOUNTING RULES

Another important factor that has generated increased attention to the extent of the employer's retiree health obligations are the accounting rules that govern the manner in which the benefits are valued. Statement of

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Financial Accounting Standards No. 106 (FAS 106), issued by the Financial Accounting Standards Board (FASB), became effective for most private sector employers in 1993. It requires employers to account for retiree health and group benefits as current liabilities (i.e., accounted for over active employees' working careers) — not when they are actually paid in the future.

A similar set of accounting rules (Statements 43 and 45) issued by the Government Accounting Standards Board (GASB) apply to state and local governments (including public universities and colleges) on a phased-in basis beginning in December 2006.

On September 29, 2006, FASB issued Statement of Financial Accounting Standards No. 158, making amendments to Employers' Accounting for Defined Benefit Pension and Other Postretirement Plans. These new requirements are generally for fiscal years ending after December 15, 2006, with earlier application encouraged. The new requirements apply to not-for-profit organizations, with a six-month delay in the effective date for nonprofits until the fiscal year ending after June 15, 2007. In effect, however, that means the new rules apply for the current fiscal years for institutions with a July 1-June 30 fiscal year.

The amendments make several important changes to the reporting requirements. Most significantly, the funded status of all postretirement plans would have to be recorded on the balance sheet instead of including it as a footnote to the financial statement. While prefunding of retiree health liabilities is not required by the amendments, they may add pressure on private sector institutions to begin doing so.

EFFORTS AT MANAGING COSTS

Employers have typically provided retiree health benefits to full-time employees and their spouses and to other dependents, and sometimes to part-time employees as well. As in corporate America, most institutions providing retiree medical coverage do so for both pre-65 and age 65+ retirees, although a minority of companies and higher education institutions provide coverage only for pre-65 retirees.

Trends in Retiree Health Plan Availability

Over the past two decades, the percentage of private-sector employers offering retiree health benefits declined dramatically from 66% in 1988 to 35% in 2006, among employers with 200 or more workers. Among larger employers with 1,000 or more employees, a similar decline has occurred. And one out of five large, private-sector employers who do offer retiree health care require new retirees to pay the full cost.

Higher education has remained more paternalistic than the private sector, and a recent survey by TIAA-CREF reflects that more than 75% of colleges and universities sponsored a retiree health plan in 2004. Twelve percent of those sponsoring such a plan, however, reported that they were likely to discontinue it in the next five years.

Benefit Design Modifications

Employers who continue to provide retiree health coverage have made a number of modifications to control the future growth of retiree health expenses, such as:

- Tightening eligibility, e.g., raising minimum age and service requirements.
- Increasing the retiree's contribution to the total health care premium and for payment of out-of-pocket expenses, or both.
- Capping the employer's contribution to the cost of retiree health care.
- Eliminating subsidized retiree health coverage for future retirees, mainly for new hires but also in some cases for current employees and, far less commonly, even for current retirees.

OPTIMIZING COST SAVINGS FROM MEDICARE PRESCRIPTION DRUG COVERAGE

Many employers realize that the new Medicare drug benefit can help reduce costs by using one or more options for coordinating the employer's retiree health strategy with Medicare prescription drug coverage. In 2006, the

two most common strategies for employers are to accept the federal retiree drug subsidy or to supplement Medicare drug benefits available through Prescription Drug Plans (PDPs) or Medicare Advantage (MA) plans, as described below.

- *Retiree Drug Subsidy*: Maintain prescription drug benefits that are at least actuarially equivalent to the standard Medicare drug benefit defined in law and receive tax-free payments equal to 28% of allowable drug costs between \$250 and \$5,000 (indexed annually) for each covered retiree not enrolled in Part D in 2006. Taking the retiree drug subsidy is the least disruptive approach for employers and retirees.
 - The Kaiser/Hewitt 2005 Retiree Health Benefits Survey and the Centers for Medicare and Medicaid Services estimated, respectively, an average tax-free retiree drug subsidy payment of between \$626 and \$668 for each Medicare-eligible retiree, which grows to hundreds of dollars more for each retiree after the tax benefits are added.
 - Without those additional tax savings, Medicare may provide a greater financial benefit to tax-exempt organizations and governmental plans if, instead of taking the retiree drug subsidy, retirees are enrolled in Part D plans and the employer wraps around the Part D coverage or drops prescription drug coverage altogether.
- *Supplement (or “wrap around”) Medicare Part D coverage* or achieve a similar result by contracting directly with a PDP or a Medicare Advantage prescription drug (MA-PD) plan to provide more generous coverage to retirees for an additional premium.
 - The Kaiser/Hewitt 2005 Survey on Retiree Health Benefits and the Centers for Medicare and Medicaid Services (CMS) estimated, respectively, that supplementing Medicare drug coverage will achieve employer cost savings between \$826 and \$900 for each retiree on average, due to the federal government subsidizing a significant portion of the cost of standard Part D coverage.

Based on the Kaiser/Hewitt 2005 Survey on Retiree Health Benefits, the most common option in the first year of Medicare drug coverage — chosen by 8 out of 10 large employers — was to take the tax-free subsidy for their largest group of age 65+ retirees. The same has generally been true among private and public higher education institutions.

Employers may find other options to be more attractive in future years, such as supplementing Medicare drug plans as a secondary payer. For tax exempt and governmental entities, their estimated average savings in that case would be approximately one-third more per individual retiree (approximately \$200 more in 2006) than if they took the subsidy, provided that the employer does not pay the Part D premium, which currently averages about \$300 per year.

Another potential accounting reason may prompt a shift away from the retiree drug subsidy in the future, among governmental plans. GASB Statements 43 and 45 accounting rules do not allow governmental plans to reflect any accounting savings associated with the 28% retiree drug subsidy. However, accounting savings can be reflected for other Part D coordination approaches (e.g., supplemental, PDP coverage). This may cause governmental plans to consider the other Part D approaches that provide more direct accounting savings than the retiree drug subsidy.

One other decision that could lower employers' future retiree health costs is the decision to prefund the future obligations.

FUNDING OF RETIREE HEALTH BENEFITS

Adoption of prefunding strategies by higher education institutions is still relatively low. Among 127 respondents to a November 2004 TIAA-CREF Survey, only 9% said they were “partially” prefunding, and only 13% of these institutions reported that they were fully prefunding their retiree health benefits.

But in light of recent accounting rule changes and concerns about meeting future commitments, prefunding retiree health benefits may garner more interest among private and public higher education institutions. If a

private institution decides to prefund its retiree health benefits, a key advantage is that the investment earnings will reduce the FAS 106 cost. While prefunding is also not required for public institutions, it can dramatically reduce the size of the GASB liability/expense. Rating agencies have indicated that they will be reviewing management's plan to prefund the obligations when determining credit ratings; in the long term this should prompt public institutions to review prefunding alternatives and potential GASB savings.

There are tax-favored vehicles that allow public and private (nonprofit) employers to prefund a large portion of their future retiree health expenses. In this regard, institutions have comparatively better funding opportunities than private, for-profit employers, for whom the available vehicles do not provide significant tax savings **and** allow for large amounts of prefunding. Many institutions, however, have strained resources with which to prefund retiree health benefits, pay for active employee health benefits, retirement and other benefits, pay competitive salaries, keep tuition cost increases moderate, and make other important investments for the future.

It is clear that no single source of funding will likely be available to do the whole job. The remedy may lie in integrating various combinations of strategies, including:

- Offering — or making available — group health coverage for retirees and considering prefunding of retiree health programs to reduce their long-term cost and to avoid adverse accounting effects that may result from a pure pay-as-you-go approach.
- Setting and expressing the level of the employer's commitment to the retiree health plan under a defined contribution approach or as a flat-dollar benefit amount, rather than as a percentage of ever increasing premium costs.
- Educating employees about their health care needs in retirement.
- Encouraging increased employee participation in existing, tax-favored retirement savings vehicles.
- Optimizing the use of Medicare and (where appropriate) other sources of retiree coverage.
- Recalibrating expectations of “career” and “retirement” to recognize the fact that more individuals will continue to be employed at ages that (historically) would have been considered a period of retirement.

Regardless of what the institution decides to do with respect to prefunding, it will be necessary to engage employees in taking more responsibility for their health care needs in retirement.

CREATING EMPLOYEE AWARENESS AND ENCOURAGING PREPAREDNESS

Among the vital functions employers can perform with respect to retiree health is to educate employees about the magnitude of the savings they may need and to encourage them to take an active role and prepare to meet that need.

The Employee Benefit Research Institute (EBRI) has recently re-estimated the total amount of retiree medical expenses that a retiree may have to finance. After making a variety of assumptions, the study found that an individual age 55 in 2006, who retires at age 65 in 2016 and lives to age 80, will need \$219,000 in savings (at age 65) to pay for the entire cost of employment-based health coverage, Medicare Part B premiums, and out-of-pocket expenses, if there is no employer contribution toward the cost of retiree health insurance coverage.

Medicare, the bedrock program for retirees age 65 and over, may be curtailed for future generations of retirees. Medicare is currently projected to experience severe financial strains, with the Part A Hospital Insurance Trust Fund alone projected to be in a deficit mode in 2010 and insolvent in 2018. Some future combination of tax increases and benefit reductions for Medicare, Social Security, and Medicaid will put further strain on the budgets of retirees.

Communicating with Employees, Retirees and Labor Representatives

Few employees probably fully appreciate the large sums that they may need to save to finance their health and

long-term care needs in retirement. According to the TIAA-CREF 2004 survey, only half (56%) of surveyed participants in employer-sponsored retirement plans believe that their institution offers retiree health care benefits and few actually know the details; 27% were not sure whether their institution offers retiree health care benefits and only 9% have estimated how much they will need to meet future medical expenses.

Employer efforts in this area face two challenges — conveying to employees the extent of the financial burden that will be generated by retiree medical costs (and steps needed to meet that burden) and turning employees and retirees into more sophisticated purchasers of health care.

Communications should also address the available vehicles that employees currently have to save for retirement needs, and offer relevant modeling tools so that employees can personalize the estimates to their particular family circumstances. It is also worth considering the development of strategies for informing and educating employees and retirees about how healthy behaviors, use of preventive services, and chronic care management can improve their health status and potentially reduce their retiree health expenses.

As a backdrop to all these communications, however, institutions should be mindful that any “entitlement mentality” toward health benefits among faculty and staff of higher education institutions probably has to be changed, in light of the strong likelihood of future changes in retiree health benefits. This message is a sensitive one, however, and along with other benefit changes, may require special negotiation and communication strategies involving labor representatives.

CONCLUSION

Expenses for retiree health care are large and growing at a rapid pace. The challenge is to find ways of enabling employees to meet those expenses in a manner that is also affordable to higher education institutions.

CONTENTS

THE RETIREE HEALTH CARE CHALLENGE	1
INTRODUCTION	1
Cost Trends and Challenges	2
Accounting Rules	3
FASB Statement 106	3
GASB Statements 43 and 45	4
EFFORTS AT MANAGING COSTS	5
Trends in Retiree Health Plan Availability	5
Plan Design Modifications	7
Optimizing Savings from Medicare Prescription Drug Coverage	7
FUNDING OF RETIREE HEALTH BENEFITS	10
Funding Options and Vehicles for Private and Public Institutions	11
Pay-As-You-Go	11
Voluntary Employees Beneficiary Association (VEBA)	11
Section 115 Trusts for Government Entities	13
Private Sector Tax-Exempt Employer Welfare Benefit Trust	13
Pension Plan Options	13
Use of Individual Accounts.....	14
Possible Additional Responses	15
Summary Comparison of Retiree Health Funding Vehicles.....	16
CREATING EMPLOYEE AWARENESS AND ENCOURAGING PREPAREDNESS	17
Understanding the Magnitude of the Savings Need and the Impact on	17
Employees' Retirement Security	
COMMUNICATING WITH EMPLOYEES, RETIREES, AND LABOR REPRESENTATIVES	19
CONCLUSION	20
ENDNOTES	21

THE RETIREE HEALTH CARE CHALLENGE

INTRODUCTION

The provision of health care benefits to former employees is an undertaking that is important yet daunting for employers in higher education, just as it is for employers in other sectors of the economy.

The availability of retiree health benefits can be an integral component of workforce management, better enabling recruitment and retention of key academic and administrative talent. The availability of retiree health benefits also influences retirement age and the retirement decision itself, as employees with employer coverage are more likely to retire earlier than employees without such coverage.¹

Increased life expectancy, however, coupled with the large size of the baby boom generation, the rising cost of health care, and the increasing utilization of health care services all make the financing of retiree health care an expensive proposition for employers and for employees.

Under Financial Accounting Standards Board (FASB) accounting rules applicable to private institutions and Government Accounting Standards Board (GASB) rules applicable to public employers, the provision of retiree health benefits impacts the balance sheet and financial health of institutions, and therefore, potentially affects credit and bond ratings.

There are tax-favored vehicles that allow public and private (nonprofit) employers to prefund a large portion of their future retiree health expenses. In this regard, institutions have comparatively better funding opportunities than private, for-profit employers, for whom the available vehicles do not provide significant tax savings **and** allow for large amounts of prefunding. Many institutions, however, have strained resources with which to prefund retiree health benefits, pay for active employee health benefits, retirement and other benefits, and still pay competitive salaries, keep tuition cost increases moderate, and make other important investments for the future.

Prefunding by public institutions must compete with many other state budget demands, e.g., Medicaid spending, public works and transportation, rebuilding infrastructure, K-12 education, public safety and more.

Prefunding decisions are further complicated by employer ambivalence about the desirability of funding retiree medical benefits; institutions may be reluctant, for example, to convey the implicit signal — embedded in any funding vehicle—that the institution is committed to maintaining retiree medical programs on an ongoing basis even when that commitment is uncertain.

The purpose of this paper is to provide the necessary background and set the stage for a more expansive discussion of the issues and factors affecting plan design and funding decisions by higher education institutions at the TIAA-CREF Institute's Symposium *Seeking Remedies to the Retiree Health Care Challenge*. When the areas covered by this paper are addressed in the context of an integrated and strategic process, higher education employers can make substantial progress in addressing their retiree health care challenges.

In addressing this challenge, it is helpful for an employer to first develop a clear process and develop a strategy to assess steps necessary to attain the institution's financial and workforce goals, including the following actions:

- Define objectives and key outcomes for the future — and set aside issues of grandfathering and transition. What are the institution's workforce needs in the future — whom do you want to attract and retain in the coming years? Institutions may answer these questions differently depending on how they define their primary mission.
- Gather the input of key stakeholders. These may include, for example, trustees, faculty and staff representatives, union representatives, governmental officials and legal counsel.

- Develop a plan design that meets these workforce needs — and that is affordable for the institution.
- Identify key transition and grandfathering needs and develop a transition strategy to meet those needs. Transition strategies may be based on legal constraints or may be driven by employee relations/collective bargaining needs. Regardless of the factors driving the transition strategy, separate identification of future direction and transition approaches can help clarify funding objectives.
- Develop a funding strategy that supports the institution's financial needs and is consistent with the institution's financial capabilities.
- Implement the strategies developed under these preceding steps and communicate them effectively to employees, retirees and labor representatives.

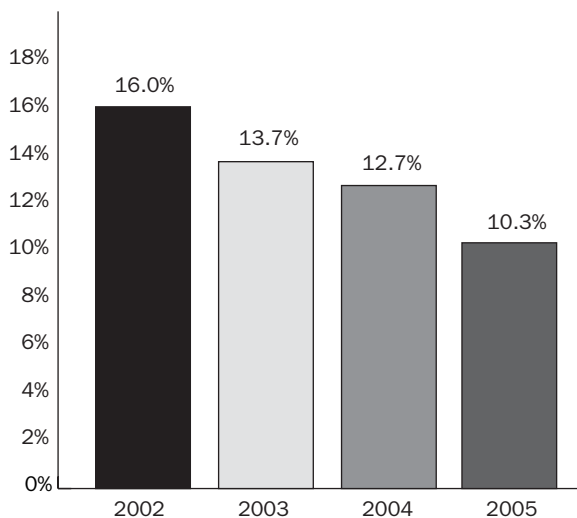
COST TRENDS AND CHALLENGES

Retiree health benefits have gained increased attention and concern over the past decade. The primary reasons are twofold. The first is that the actual cost of providing health benefits to retirees (as well as active workers) has increased dramatically during this period. This increased cost pressure is felt not only for non-Medicare, pre-65 retirees, but also for Medicare-covered retirees for whom employer-provided health benefits generally supplement Medicare coverage.

According to the Kaiser Family Foundation/Hewitt Associates 2005 Retiree Health Benefits Survey, the total cost (employer and retiree contributions) of providing health benefits for both pre-65 and age 65+ retirees has increased at double-digit rates, despite a downward trend from a 16% increase in 2002 to a 10.3% increase in 2005 (Figure 1).

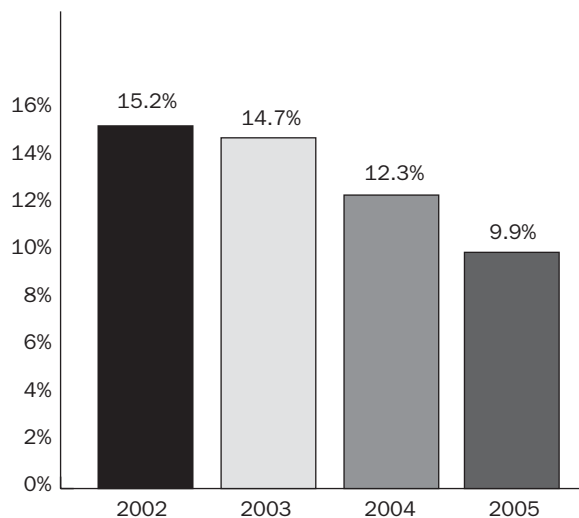
Large employer costs for active employees' health care followed a generally similar trend, according to Hewitt Associates data (Figure 2). But in three out of the four years between 2002 and 2005, annual retiree health costs grew at a rate higher than for active workers. Health care costs rise significantly with age, as chronic conditions become more common and utilization of prescription drugs and other medical services rises.

Figure 1: Annual Increase in Retiree Health Benefits Costs, 2002-2005



SOURCE: Kaiser/Hewitt Annual Surveys on Retiree Health Benefits.

Figure 2: Annual Large Employer Health Care Cost Increases for Active Employees, 2002-2005



SOURCE: Kaiser/Hewitt 2005 Survey on Retiree Health Benefits, December 2005.

Among large employers offering retiree health benefits, the cost of providing retiree health benefits represents nearly a third (29%) of the total cost of providing health benefits to active workers, retirees and their families.²

Pressure on health costs is likely to continue for an indefinite period. The rate of growth in *national* health spending has slowed slightly in the past few years, but it is expected to rebound and continue to outpace growth in gross domestic product (GDP) during the coming decade, with health care's share of the US GDP estimated to rise to 20% in 2015.³ Public sources are projected to finance less than half (48%) of national health care expenditures in 2015.

According to a recent Census Bureau report commissioned by the National Institute on Aging, this spending growth will be compounded by the projections that the post-65 population will *double in size* in the next 25 years. By 2030, one out of five Americans — 72 million people — will be age 65 or older. The age group 85 and older is now the fastest growing segment of the U.S. population.⁴

These data on private and public spending suggest that the cost burden on employers of providing health care is likely to continue to rise in the future, and there may be little opportunity for relief from the federal government, which itself faces greater costs of financing entitlement programs such as Social Security, Medicaid and Medicare, which face projected deficits in future funding.

ACCOUNTING RULES

Another important factor that has generated increased attention regarding the extent of employers' retiree health obligations is the accounting rules that govern the manner in which the benefits are valued.

Statement of Financial Accounting Standards No. 106 (FAS 106), issued by the Financial Accounting Standards Board (FASB), became effective for most private sector employers in 1993. It requires employers to account for retiree health and group benefits as current liabilities (i.e., accounted for over active employees' working careers) — not when they are actually paid in the future.

Similar accounting rules (Statements 43 and 45) issued by the Government Accounting Standards Board (GASB) apply to state and local governments (including public universities and colleges) on a phased-in basis for financial statements for fiscal years beginning after December 15, 2005 (Statement 43) and on a phased-in basis for financial statements for fiscal years beginning after December 15, 2006 (Statement 45).

Institutions using endowments to fund retiree health care cannot use earmarked funds for purposes of meeting the FASB and GASB accounting rules. Instead, the funds would have to be removed and segregated in a trust where their use would be restricted to paying the benefits available under the terms of the plan. In addition, the investment allocation of the fund in the segregated trust may have to be reconsidered in order to better align the asset allocation with the payment of liabilities.

FASB Statement 106

Statement of Financial Accounting Standards No. 106 (FAS 106) is an accounting standard that stipulates the manner in which employers expense for postretirement medical benefits. It requires employers to accrue the cost of retiree health and other postemployment benefits during the working careers of active employees. This accounting standard, in requiring private higher education institutions and other employers to account for their retiree health care benefits on an accrual basis (much like pensions), replaced the prevailing method of accounting that had existed, namely, the pay-as-you-go basis. For those private sector employers that did not change their retiree health plan design in response to FAS 106, their accounting costs for retiree health care benefits typically increased by factors of six to eight, or more, depending on the company's plan design and demographics.⁵

FAS 106 has had a major impact on employers' financial statements, retiree benefit design and funding decisions. Some employers concluded that the cost impact of changing from pay-as-you-go accounting to full accrual accounting was too great. As a result, these employers have made, and continue to make, modifications to their

retiree benefit programs in order to reduce the cost reflected on their balance sheets, including changes to plan design, eligibility requirements, and prefunding strategies.

Recent changes in the FASB 106 accounting rules represent phase one of a two-phase project to revisit the accounting rules for pensions and other postemployment benefit obligations.

On September 29, 2006, FASB issued Statement of Financial Accounting Standards No. 158, making amendments to Employers' Accounting for Defined Benefit Pension and Other Postretirement Plans. These new requirements are generally for fiscal years ending after December 15, 2006, with earlier application encouraged. The new requirements apply to not-for-profit organizations, with a six-month delay in the effective date for nonprofits until the fiscal year ending after June 15, 2007. In effect, however, that means the new rules apply for the current fiscal years for institutions with a July 1-June 30 fiscal year.

The amendments make several important changes to the reporting requirements. Most significantly, the funded status of all postretirement plans would have to be recognized in the statement of financial position as an adjustment to unrestricted net assets, instead of including it as a footnote to the financial statement. While prefunding of retiree health liabilities is not required by the amendments, they may add pressure on private sector institutions to begin doing so. This new requirement could also result in significant reductions in unrestricted net assets for any organization that sponsors defined benefit pension plans and/or postretirement health and welfare plans. In the near term, these reductions will cause private sector institutions to review loan covenants and other financial arrangements that might be impacted by changes in net assets and assess whether those arrangements can be renegotiated. However, it is currently premature to tell exactly how these reductions in net assets may drive decision making related to plan design and/or prefunding. The long-term impact of these accounting changes will ultimately depend on a number of factors, including the size of the funded status (and its growth) relative to the balance of unrestricted net assets, and an institution's risk tolerance for accepting increased balance sheet volatility from year to year.

In the second, multi-year phase of the project, FASB expects to comprehensively consider a variety of issues related to the accounting for postretirement benefits, such as (a) how the various elements that affect the cost of postretirement benefits are best recognized and displayed in either earnings or other comprehensive income, (b) how to measure an entity's benefit obligations, including whether more or different guidance should be provided about assumptions used in measuring benefit costs, and (c) whether postretirement benefit trusts should be consolidated by the plan sponsor. Furthermore, consistent with its efforts toward international convergence, FASB expects to conduct this comprehensive phase in collaboration with the International Accounting Standards Board (IASB).

GASB Statements 43 and 45

The new governmental accounting standards (GASB Statements 43 and 45) specify the rules for how public entities and their plans measure, recognize, and report costs for retiree health care and other postemployment benefits. GASB Statement 43 specifies the rules for plans and GASB Statement 45 specifies the rules for employers.

The effective date for employer accounting is phased-in over three years and depends on annual revenues for fiscal years ending after June 15, 1999, as follows:

Annual Revenue	Fiscal Years Beginning After December 15,
> \$100 million ("Phase 1" governments)	2006
\$10 million to \$100 million ("Phase 2" governments)	2007
<\$10 million ("Phase 3" governments)	2008

For plan accounting, the effective dates are one year earlier than for employer accounting.

GASB Statements 43 and 45 provide significant financial incentives for entities to prefund all (or a portion) of their retiree medical obligations in a protected, segregated trust fund. While prefunding is not required for public institutions, it can reduce GASB benefit obligations and expense (by up to 50%) by effectively increasing the discount rate used to value the benefit obligations. As explained in more detail below, in measuring the retiree health liability, the discount rate used is lower if there is no prefunding, thus resulting in higher liabilities than if there is prefunding. prefunding allows use of a higher discount rate based on expected investment returns from a diversified trust fund. Public institutions thus have new financial incentives to consider placing their retiree medical obligations in a protected, segregated trust fund.

In a manner similar to what occurred among private employers after FAS 106 was issued, public employers affected by GASB Statements 43 and 45 have also begun to examine possible changes to their plan designs. Plan design changes will be especially challenging for public employers in the many situations in which retiree health benefits are mandated by state and/or local law.

Public sector institutions will also need to determine how GASB Statements 43 and 45 apply to their plan(s) based on how they integrate with the local government entity's and/or state's plans and budgets. For example, an institution considered a separate governmental reporting entity (that manages and finances its own retiree health plan separately from the state) may need to recognize and report the liabilities and costs for its plan using GASB Statements 43 and 45. However, if an institution is not considered a separate governmental reporting entity then it may not need to recognize the costs under the new standards.

It is also important to note that GASB Statements 43 and 45 do not allow public entities to reflect any accounting savings associated with the 28% subsidy option under the Medicare Part D prescription drug program, as discussed below. However, GASB Statements 43 and 45 do allow the accounting savings to be reflected for other Part D coordination approaches (e.g., supplemental/wraparound PDP coverage). Indeed, the GASB's accounting approach for the 28% subsidy is entirely different than the FASB's approach. FASB Statement 106 actually requires private institutions to reflect the savings by reducing the FAS 106 expense for expected future subsidy receipts under Medicare Part D. This interesting facet of GASB Statements 43 and 45 should cause public entities to more strongly consider alternative Medicare Part D coordination approaches as a way of managing costs.

EFFORTS AT MANAGING COSTS

Generally, the benefits provided by employers to their retirees have been generous and comprehensive and include prescription drug coverage that is still frequently of greater value than what Medicare drug plans began providing in 2006 under the Part D program.

Employers have typically provided these benefits to full-time employees and their spouses and other dependents, and sometimes for part-time employees as well.

Increasingly, however, employers have taken significant steps to address the issue of rising costs.

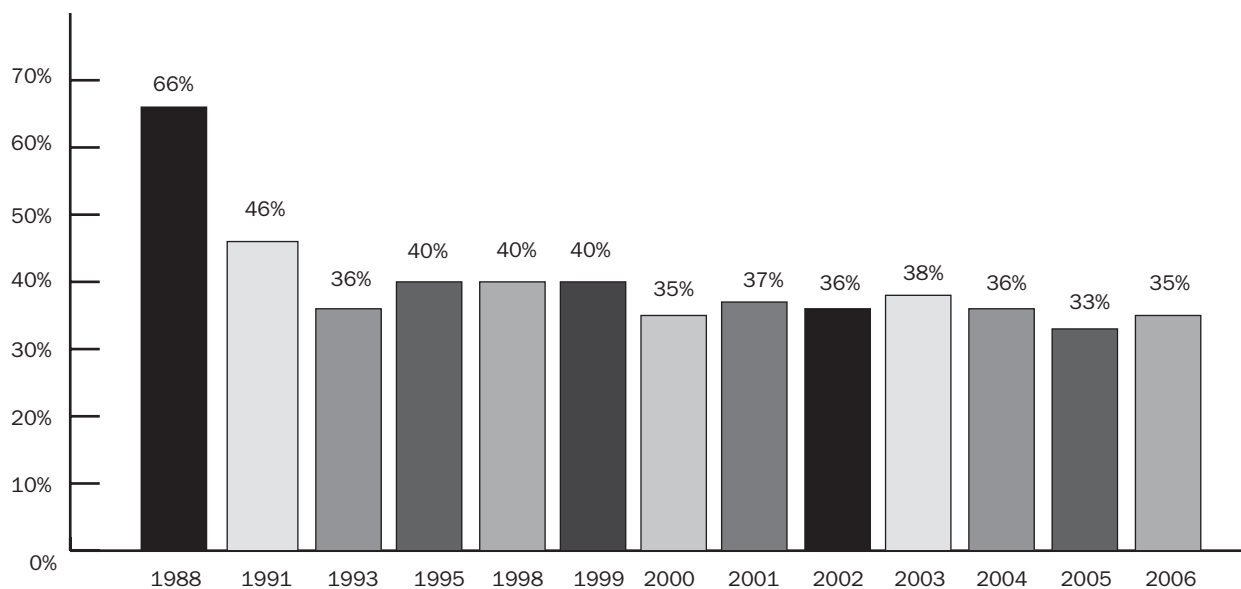
TRENDS IN RETIREE HEALTH PLAN AVAILABILITY

Over the past two decades, largely in response to rising health costs, a smaller share of employers have been providing retiree health benefits. The percentage of employers offering retiree health benefits has declined dramatically, from 66% in 1988 to 35% in 2006 among employers with 200 or more workers (Figure 3). Among larger employers with 1,000 or more employees, a similar decline has been experienced (Figure 4).

More than three-quarters (76%) of colleges and universities surveyed by TIAA-CREF sponsored a retiree health plan in 2004, yet 12% of those sponsoring such a plan reported that they were likely to discontinue it in the next five years.⁶ As in corporate America, most institutions providing retiree medical coverage do so for both pre-65 and age 65+ retirees, although a minority of companies and higher education institutions provide coverage only for pre-65 retirees.⁷

Figure 3: Trends in Employer Retiree Health Coverage

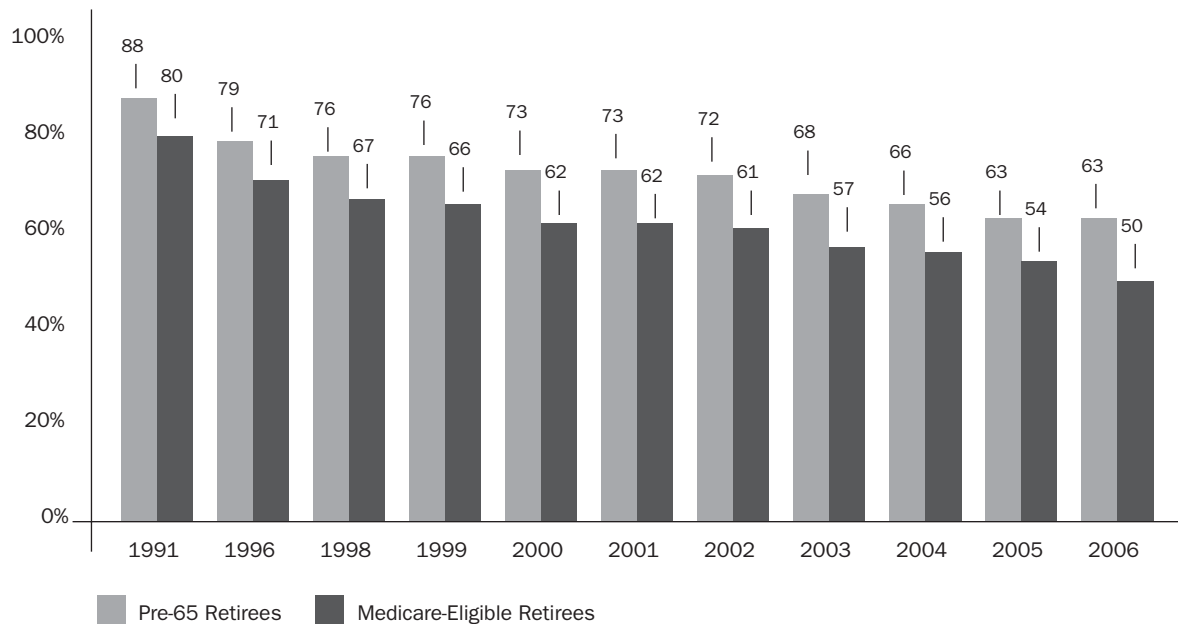
Percentage of All Large Firms (200 or More Workers) Offering Retiree Health Benefits, 1988-2006



Source: Kaiser Family Foundation/HRET, Employer Health Benefits, 2006 Annual Survey.

Figure 4: Trends in Employer Retiree Health Coverage

Percentage of All Large Firms (1,000 or More Workers) Offering Retiree Health Benefits, 1991-2006



Source: Hewitt Associates.

PLAN DESIGN MODIFICATIONS

For those employers that have continued to provide retiree health coverage, a number of benefit design modification trends have persisted. Some of the more prevalent strategies include:

- Increasing the retiree's contribution to the total health care premium or for out-of-pocket expenses, or both.
- Capping the employer's contribution to the cost of retiree health care.
- Tightening eligibility for retiree benefits by raising minimums under age and service rules.
- Controlling prescription drug costs by increasing retiree copayments or coinsurance, requiring use of mail-order for prescription refills of maintenance drugs, encouraging use of generics, and in some cases, replacing fixed dollar copayments with a percentage coinsurance approach.
- Eliminating subsidized retiree health coverage for future retirees, mainly for new hires but also in some cases for current employees and, far less commonly, even for current retirees.

In the Kaiser/Hewitt 2005 Survey on Retiree Health Benefits, 71% of respondents reported that they had increased premiums and 34% said they had increased cost sharing for retirees under their retiree health benefits programs between 2004 and 2005. Eight percent said they imposed new financial caps on their employer contributions.⁸

Financial caps are one technique for disconnecting the employer's contribution from the premium cost of the retiree health plan; once the limit on the employer contribution is hit, retirees bear the full cost of any further increases in premium costs. Another technique is to set and express the level of the employer contribution as a flat-dollar amount, e.g., \$200 per retiree per month or as \$5/month per year of service, rather than committing to a percentage of ever-increasing premium costs.

Similar trends and strategies as those used by the wider community of employers have also been observed among employers in higher education, except that the rate at which higher education institutions have eliminated future retiree health benefits has been much slower than in corporate America.

But the changes are not always aimed at cutting back. A minority of firms (9%) in the Kaiser/Hewitt survey said they added or improved coverage or benefits for retirees between 2004 and 2005. Similarly, some educational organizations have decided to add or improve retiree health benefits.

OPTIMIZING COST SAVINGS FROM MEDICARE PRESCRIPTION DRUG COVERAGE

Many employers are hopeful that the new Medicare prescription drug benefit — Medicare Part D — can help reduce cumulative double-digit increases in retiree health costs. The Kaiser/Hewitt 2005 Survey on Retiree Health Benefits (Kaiser/Hewitt Survey) asked employers to estimate the savings they would derive from the Medicare prescription drug coverage. Across all surveyed employers the weighted average savings were estimated to be \$644 per individual retiree in 2006.⁹

Among employers who continued to offer coverage in 2006, the two major options employers used in 2006 to derive savings from Medicare drug coverage are:

- *Retiree Drug Subsidy option.* When the employer maintains prescription drug benefits that are at least actuarially equivalent to the standard Medicare drug benefit defined in law, Medicare offers the employer tax-free payments equal to 28% of allowable drug costs between \$250 and \$5,000 (in 2006, indexed annually) for each covered retiree not enrolled in Medicare Part D. Taking the retiree drug subsidy is the least disruptive approach for employers and retirees.
 - The Centers for Medicare and Medicaid Services (CMS) estimated an average tax-free retiree drug subsidy payment of \$668 per participant in 2006, equivalent to \$891 for plan sponsors with a 25% marginal tax rate and \$1,028 for plan sponsors with a 35% marginal tax rate.¹⁰ The Kaiser/Hewitt Survey found similar results with a weighted average savings per retiree of \$626 (excluding tax benefits and administrative costs) in 2006.

- Tax exempt organizations and governmental plans obviously do not reap the additional tax benefits. For them, Medicare may provide a greater indirect financial subsidy if retirees are enrolled in Part D, as described below.
- *Supplemental drug coverage or group Part D plan.* With this option, the employer provides supplemental (or “wraparound”) Medicare Part D coverage or provides more generous group prescription drug benefits for an additional premium by contracting directly with a Medicare prescription drug plan (PDP) or Medicare Advantage prescription drug (MA-PD) plan. Supplementing the Medicare prescription drug benefit has been administratively challenging in the first year of the Part D program, particularly for multi-state employers. It might be easier for higher education organizations to supplement Medicare on a statewide basis, although even then, retirees may not continue to reside in the state or region where the institution is located.
- CMS estimated that supplementing Medicare drug coverage will achieve cost savings to employers of at least \$900 on average (than if the employer provided the full benefit) due to the federal government subsidizing a significant portion of the cost of standard Part D coverage.¹¹ The Kaiser/Hewitt Survey identified similar savings, with a weighted average estimated savings per individual retiree at \$826 among employers who supplement the Medicare drug benefit.

Note, however, that Medicare prescription drug coverage provides cost savings only for Medicare-covered retirees and dependents (over age 65 or covered by Medicare as disabled). These savings do not apply to prescription drug costs associated with pre-65 retirees (for whom the employer is the primary payer) and for other medical and supplemental drug benefits provided to age 65+ retirees. When placed in this broader context, the Kaiser/Hewitt Survey determined that the total employer savings attributable to Medicare drug benefit represented a median 7% of the total cost of retiree health benefits for pre-65 and age 65+ retirees.¹²

When the Kaiser/Hewitt Survey asked large, private-sector employers to identify which of the four Medicare Part D strategies their firm would most likely pursue in 2006 with respect to their largest age 65+ retiree group or largest age 65+ retiree plans, 79% of surveyed employers expected to take the retiree drug subsidy (representing 89% of these retirees); 10% expected to offer prescription drug coverage as a supplement (representing 7% of these retirees); 9% stated they were likely to discontinue drug and/or medical coverage (representing 2% of these retirees); and, 2% intended to become a Medicare prescription drug plan (representing 2% of these retirees) (Figure 5).

Thus far, higher education institutions have adopted comparable strategies, with the prevailing strategy among private and public institutions being to accept the 28% Medicare retiree drug subsidy, with small percentages of institutions supplementing Medicare, dropping prescription drug coverage or considering becoming their own Medicare prescription drug plan. Some institutions with relatively small numbers of Medicare-eligible retirees have chosen to forego the retiree drug subsidy, deciding that the administrative costs would outweigh the benefit.

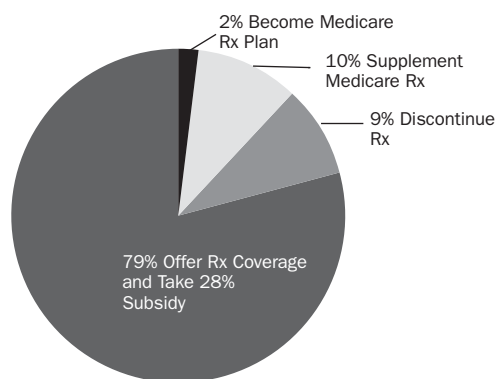
Modifying Medicare Strategies in Years Beyond 2006 to Further Reduce Costs

When the Kaiser/Hewitt Survey asked employers planning to take the retiree drug subsidy whether they intend to continue to do so beyond 2006, eight out of 10 employers responded that they were likely to continue doing so in 2007. But that proportion drops to five out of 10 employers in 2010, and the uncertainty among these employers as to whether they will continue taking the 28% subsidy grows between 2006 and 2010 (Figure 6).

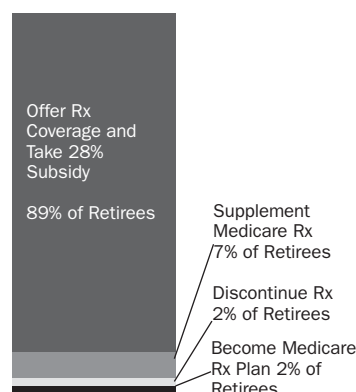
With additional data and experience with the Part D program, employers may find other options to be more attractive in later years, such as supplementing Medicare drug plans. Indeed, Medicare prescription drug plans have been actively marketing to employer groups, saying that employers are “leaving money on the table” by not taking advantage of this opportunity to wrap around Medicare Part D coverage. This argument may be particularly true for tax exempt and governmental entities. Without the tax benefit, their savings per individual retiree would be approximately one-third more per individual retiree (approximately \$200 more in 2006) than if they

Figure 5: Employer Strategies for 2006 in Response to the Medicare Drug Law

Strategies firms are likely to choose under the Medicare drug law for largest 65+ plan:



Percent of retirees in largest 65+ retiree plan:

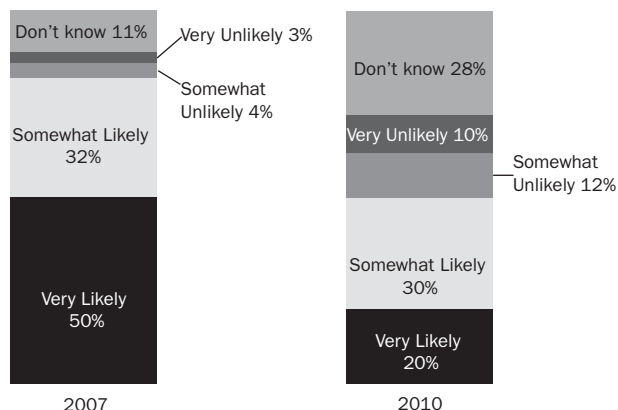


Note: Rx = prescription drug. Applies to plan with the largest number of Medicare-eligible retirees. Based on responses from private-sector firms with 1,000 or more employees offering retiree health benefits.

SOURCE: Kaiser/Hewitt 2005 Survey on Retiree Health Benefits, December 2005.

Figure 6: Likelihood of Accepting Employer Subsidy in 2007 and 2010

Among Employers Taking the Subsidy in 2006



Note: Data are for firms maintaining drug benefits and accepting the employer subsidy in 2006. Based on responses from private-sector firms with 1,000 or more employees offering retiree health benefits.

SOURCE: Kaiser/Hewitt 2005 Survey on Retiree Health Benefits, December 2005.

took the subsidy, provided that the employer does not pay the Part D premium, which currently averages about \$300 per year. This strategy may be even more worthy of consideration by governmental plans. As noted above, GASB Statements 43 and 45 accounting does not allow any accounting savings associated with the 28% subsidy but accounting savings can be reflected by using other Part D coordination approaches (e.g., supplemental, PDP coverage).

Employers may also contract with a Medicare Advantage plan, which is typically a health plan through which retirees receive all Medicare-covered services (Parts A and B, as well as Part D prescription drugs). The portion of the premium attributable to prescription drug coverage tends to be lower in such plans when compared with stand-alone PDP plans, as the MA-PD premium can be cross-subsidized through other Medicare payments to the health plan. Very few employers have taken this route in 2006, unless they previously offered a Medicare Advantage plan. Significant changes to the Medicare Advantage program in the past few years have resulted in an expanded number of plans and plan design options available to employer groups. But having experienced severe problems with the predecessor Medicare+Choice program and the withdrawal of participating health plans, employers are taking more of a wait-and-see approach to determine whether the market for such plans will remain attractive and stable, especially considering that federal legislative changes in Washington could potentially change the financial attractiveness of such plans if the Medicare funding is scaled back.

Other factors will also affect employers' future decisions. A key consideration will likely be the financial burden of providing retiree health coverage over time, but other issues could include the administrative costs and challenges associated with any of the options, labor-management relations involved in changing the current plan, and the ease or difficulty in contracting with or wrapping around Medicare drug plans.

One other decision that could lower employers' future retiree health costs is the decision to prefund the future obligations.

FUNDING OF RETIREE HEALTH BENEFITS

Unlike pension benefits, there are no federal laws mandating the funding and vesting of retiree health or other non-pension group benefits. Adoption of retiree health prefunding strategies by higher education institutions is still relatively low. Among 127 respondents to a November 2004 TIAA-CREF Survey, 47% reported they were not prefunding their retiree health benefits. Nine percent said they were "partially" prefunding, and only 13% of these institutions reported that they were fully prefunding their retiree health benefits (the remaining 32% were "not sure").

The most frequently reported reasons given for not prefunding included that it would be too costly, prefer pay-as-you-go, no liability because the benefit is employee-paid, or that the liability of the institution is relatively small or declining.¹³ But in light of accounting rule changes and concerns about meeting future commitments, prefunding retiree health benefits may garner more interest among private and public higher education institutions.

If a private employer decides to prefund its retiree health benefits, a key advantage is that the investment earnings will reduce the FAS 106 cost. In deciding whether or not to prefund, private employers weigh the relative reduction in the FAS 106 cost against alternative returns on investment that might result from using that money elsewhere. Another reason given by some employers for not prefunding is the concern that prefunding may imply that the employer intends to continue maintaining the retiree medical program; some employers are reluctant to take any actions that might convey such a message.

Prefunding Considerations for Public Institutions

While prefunding is also not required for public institutions, it can dramatically reduce the size of the GASB liability/expense by affecting the discount rate. The discount rate is the interest rate used to determine the present value of all of the expected future payouts under the plan. The new GASB accounting rules require that public institutions calculate the liability/expense for retiree medical benefits by using a discount rate that is dependent on how the benefits are financed. Specifically, the discount rate needs to be based on the "estimated long-term investment yield on the investments that are expected to be used to finance the payment of benefits." For this purpose, the investments to be used to finance the payment of benefits are:

(1) Assets of the employer for retiree health plans that have no plan assets. Under this option, the discount rate

would be based on employer assets, which for public entities is typically in the 3%-4% range (based on returns for short-term fixed income and money market instruments).

- (2) Assets of retiree health plans for which the employer's funding policy is to contribute consistently an amount at least equal to the Annual Required Contribution under GASB 43 and 45. Under this option, the discount rate could be in the 7%-9% range based on the expected return on the investments in a diversified trust fund. By increasing the discount rate from 3% to 7% an entity could reduce its GASB liability and expense by 50%.
- (3) A combination of the two approaches or plans that are being partially funded.

However, to reap the advantages of using the higher discount rate under option (2) or (3), the following four conditions must also be met under GASB rules:

- Contributions must be made to a trust or equivalent relationship (legally separate entity under the stewardship of a board of trustees, or equivalent);
- Employer contributions must be irrevocable and the employer no longer has ownership or control of the assets, except for a reversionary right once all benefits are paid;
- Assets must be dedicated exclusively to providing retiree benefits according to the terms of the plan; and
- Assets must be legally protected from creditors of the employer or plan administrator.

These four requirements preclude entities from using expected returns on earmarked funds or other designated fund balances. Effectively, the four requirements necessitate the use of tight-knit trusts and formal, legal documents to establish and govern those trusts.

A public institution considering the merits of prefunding will also need to analyze carefully whether it has the appropriate legal authority to prefund all or a portion of its retiree health obligations, how it will finance the contributions that it makes to a segregated trust fund, and how credit and bond ratings may be affected by its decisions. For example, continuing pay-as-you-go funding could lead to higher expense and balance sheet liabilities, which might adversely affect credit and bond ratings.

FUNDING OPTIONS AND VEHICLES FOR PRIVATE AND PUBLIC INSTITUTIONS

Some of the currently available options for employers and employees to finance or prefund retiree health benefits have been around for some time. Others have been developed more recently. All of them present certain advantages and disadvantages, and require tradeoffs. Generally, the prefunding vehicles available to private for-profit entities have restrictions that often limit their effectiveness and their ability to fully fund the level of benefits needed to cover the cost of retiree medical premiums and out-of-pocket expenses.¹⁴ However, public and not-for-profit entities do have access to tax-favored vehicles that can allow them to prefund a large portion of their future retiree health expenses (e.g., VEBA and IRC Section 115 integral part trusts). Even so, the primary impediment is a lack of funding sources as many institutions have strained resources with which to prefund retiree health benefits.

What follows is a brief discussion of the key funding approaches that are currently available.

PAY-AS-YOU-GO

Paying for benefits on a current plan year basis can be less costly than prefunding contributions in the short run. But if no future retiree health liabilities are prefunded with any current assets, the liability can start to grow significantly on an employer's balance sheet under FASB Statement 106 or GASB Statement 45. Pay-as-you-go also raises uncertainty about the entity's ability to actually pay for benefits in the future. Most higher education institutions are apparently using the pay-as-you-go method.

VOLUNTARY EMPLOYEES BENEFICIARY ASSOCIATION (VEBA)

A VEBA is a tax-exempt trust meeting requirements under section 501(c) (9) of the Internal Revenue Code. A VEBA trust may have a reserve account to prefund retiree health benefits, and it can also fund life, sickness,

accident or certain other benefits to eligible participants.

Among the advantages of a VEBA, prefunded assets are invested in a secure, nonreverting trust fund for future retiree health benefits, and VEBA funds count as a plan asset for FAS 106 and GASB 43 and 45 accounting purposes.

According to the 2004 TIAA-CREF Survey, awareness of VEBAs is not widespread among administrators, with only about 50% of responding institutions indicating that they are at least “somewhat familiar” with VEBAs. About a quarter (28%) indicated an interest in VEBAs as a prefunding vehicle. The primary reason for the apparent lack of interest in VEBAs was that administrators were unfamiliar with the viability of a VEBA (29%), with almost an equal proportion saying either that they had no interest in prefunding the liability (14%) or that their liability is being reduced or eliminated (11%). When asked about funding a VEBA, most employers indicated they would require employee contributions along with the employer contributions.

For taxing entities, VEBAs have limitations that do not exist for tax-exempt institutions and governments. In the case of a taxing entity:

- Employer contributions are subject to deduction limits under Section 419A of the Internal Revenue Code, impeding those employers that would otherwise want to deduct the full cost of benefits as part of their funding strategy.
- The ability to build up assets without taxation of the appreciation and earnings is also limited and the gross income of a VEBA reserve may be subject to taxation if invested in taxable investments.

However, collectively bargained plans, the plans of nonprofit (private) organizations, and plans of many governmental entities enjoy exceptions from the funding limitations.

- VEBAs covering benefit programs that have been the subject of collective bargaining (regardless of the identity of the plan sponsor) are exempt from contribution limits and enjoy tax-free buildup of assets set aside in the VEBA.
- Private not-for-profit organizations also have the ability to make contributions and enjoy tax-free buildup of amounts set aside for retiree medical benefits. This ability may be impaired unless “substantially all” of the contributions are for employees of a tax-exempt entity. Therefore, inclusion of employees of for-profit entities may impact this ability to prefund.

Governmental entities are, generally, not subject to federal taxes and a retiree medical VEBA would enjoy the benefits of this tax-exempt status. However, a private letter ruling¹⁵ issued by the IRS indicates that a VEBA for employees of an institution of higher education that is maintained by a governmental employer is not exempt from taxes on earnings on assets set aside for retiree medical benefits. Private letter rulings do not represent an official IRS position, but are reflective of the IRS' thought process in addressing a question.

There is also a special exemption for welfare benefit funds (including VEBAs) that cover employers of 10 or more employees. This exemption applies to limits on the deductibility of contributions, but does not provide any protection from the taxation of earnings on assets accumulated for retiree medical benefits. This exemption is also contingent on a number of requirements (including rules restricting the contributions that can be made by any single employer and preventing employer-specific experience-rating).

Please be advised that determining the availability and impact of these exceptions is complicated, represents an area that is not always settled, and can be based on very specific facts and circumstances. As a result, any questions regarding the tax status of a retiree medical VEBA should be reviewed by the institution's legal counsel.

VEBAs do entail administrative complexity. They are subject to federal tax code nondiscrimination rules and other requirements relating to funding and use of assets. Annual filing of Form 990 and Form 1024 are required. In addition, administrative requirements for governments are relaxed in the following ways: IRS generally exempts governments from filing Form 990 (unless there is taxable unrelated business income). And IRS has deemed that the nondiscrimination rules are satisfied by a collectively bargained VEBA sponsored by a governmental employer.¹⁶

SECTION 115 TRUSTS FOR GOVERNMENTAL ENTITIES

A government trust that relies on Section 115 of the Internal Revenue Code for exemption from federal income taxes on its earnings is a funding option that is available to colleges and universities within or independently of state and local systems. This type of trust may also be used by a “consortium” of governmental employers. Obtaining IRS approval is recommended.

The prefunded assets are held and invested in a secure, exclusive benefit trust fund to help pay for retiree health benefits and they could be treated as a plan asset for GASB Statements 43 and 45 accounting purposes, as long as the trust also satisfies GASB’s four requirements for a trust, as discussed above.

PRIVATE SECTOR TAX-EXEMPT EMPLOYER WELFARE BENEFIT TRUST

In the past, on a case-by-case basis, IRS has given approval to individual higher education institutions to create a tax-exempt trust to fund benefits for employees (and retirees) of a tax-exempt, Section 501(c) (3) organization. In these cases, IRS considers the employee welfare benefit trust to be an “integral part” of the employer’s ability to attract and retain employees needed to carry out its educational or scientific research mission.

Though similar in effect to the Section 115 integral trust for governmental employers, no specific tax code provision addresses this tax-exempt welfare benefit trust. Interested institutions would have to seek the advice of their legal counsel to determine the desirability and the feasibility of pursuing an individual exemption letter from the IRS.

PENSION PLAN OPTIONS

Under ERISA and the Internal Revenue Code, qualified defined benefit and money purchase pension plans may create a subaccount within the pension plan, called a “401(h) account,” to which the plan sponsor may contribute funds dedicated to the purpose of funding retiree health benefits. There are, however, limits on the amounts that the plan sponsor may contribute to a 401(h) account that are tied to the amount that the plan sponsor contributes to the pension plan. Retiree medical benefits cannot account for more than 25% of the total contribution to the pension trust fund, i.e., one-third of the pension contribution. This limit is intended to assure that retiree medical benefits are “subordinate” or ancillary to the retirement benefits. As a result, if an employer does not make defined benefit pension plan contributions (because the pension plan is over-funded), the employer cannot make retiree medical contributions to the 401(h) account.

Plan sponsors are permitted to make tax-free transfers of “excess” pension assets to a 401(h) account to pay for retiree health expenses. Such transfers must comply with a series of requirements, most notably: (1) a minimum “cushion” of excess assets must remain in the pension plan, (2) participants in the pension plan must be fully vested in their pension benefits, and (3) the employer is subject to a “maintenance of cost” requirement applicable to its retiree medical costs for several years after the transfer. In the case of tax exempt organizations, the advantage for the retiree is that the sums transferred from the pension fund to pay for the retiree health benefits are tax free to the retiree. This technique also permits the plan sponsor to make use of excess pension assets without triggering a reversion of assets to the employer, which generates significant legal impediments and imposes strict requirements on employers.

The Pension Protection Act (PPA) of 2006 (Pub. L. 109-280) made changes to this retiree health transfer provision. The PPA includes a provision that permits employers with excess pension assets to transfer a greater amount toward payment of retiree health expenditures by allowing transfers for up to ten years of expected retiree health

benefits (instead of just the current year's costs) and by defining "excess assets" as those above 120% of the target funding level,¹⁷ instead of 125% under pre-PPA law. For determining excess assets, however, plan assets are reduced by credit balances. Additional pension contributions, or transferring some of the 401(h) assets back to the pension plan, would be required if and when plan asset values fall below 120% of target liability throughout the transfer period. The provision applies to both single employer plans and collectively bargained plans.

USE OF INDIVIDUAL ACCOUNTS

In addition to the employer funding vehicles discussed above, there are several newer approaches that represent ways of supporting retirees' ability to purchase retiree medical benefits, but do not necessarily entail dedicated employer-provided funding. Nonetheless, these vehicles are relevant to any discussion regarding the financing of retiree medical benefits. These approaches typically incorporate use of individual accounts.

Health Reimbursement Arrangements (HRAs)

HRAs are health care savings accounts to which employers credit a defined amount earmarked for an employee's health expenses. HRAs may be funded or not funded. Unlike Health Savings Accounts (discussed below), HRAs are not required to be attached to a high-deductible health plan, but they often are. They are used in conjunction with active employee health benefits, but many employers also allow retirees to draw upon these accumulated amounts to pay for premiums for a retiree health plan and/or for reimbursement of retiree out-of-pocket medical expenses. And some employers use HRAs exclusively as a specialized retiree medical individual account, to be used only for paying health care insurance premiums or out-of-pocket expenses after the employee retires. Often, the retiree will apply these funds toward health insurance premiums for plans made available by the employer, but to which the employer does not contribute (i.e., "access only plans").

For employers, HRAs offer the advantage of limiting the extent of the employer's financial exposure to essentially a defined dollar amount, and HRAs also allow employers to restrict the uses of the funds to medical expenses only. HRAs may encourage greater cost awareness and consumerism among employees, and create financial incentives for accumulating balances that can be used in retirement. Among the disadvantages: employees and retirees are not permitted to contribute to the accounts, the accounts themselves are usually not portable or vested (though they can be), and the accumulated balance may not be sufficient to cover the retiree's total health care expenses throughout retirement. In addition, if the accounts are not truly "funded," there are no "assets" to offset liabilities under the various accounting rules.

Health Savings Accounts (HSAs)

HSAs are tax-favored savings accounts that permit both employer and employee contributions to finance health care within limits established in the tax code.¹⁸ To be eligible to make contributions to an HSA in any given year, an individual must be enrolled in a high-deductible health plan for that year. Contributions are deductible if made by an eligible individual and excluded from gross income and wages if made by an employer (including contributions made through a cafeteria plan through salary reduction). The inside buildup of earnings in the HSA is not taxed under federal law.

Employee withdrawals from the HSA to pay for health care expenses are tax free. Withdrawals from the account for nonmedical purposes are subject to a tax penalty and ordinary income tax, except that withdrawals after age 65 for nonmedical purposes are permitted without penalty. Along with the favorable tax treatment, HSA contributions are fully and immediately vested, and the accounts themselves are held in trust and are portable.

HSAs are not without their own disadvantages, however. Under the current tax code limits on contributions, it is difficult for employees to accumulate a significant savings balance to fund retiree health care expenses because much of the annual contributions would typically be needed to pay for the employee's out-of-pocket medical expenses in the current year. But HSAs can be particularly helpful for pre-Medicare retirees by allowing them to pay for some portion of their medical expenses with pretax money. (Medicare-eligible retirees may not contribute to HSAs, though they may use any previously accumulated balances to pay for out-of-pocket medical expenses or for health plan premiums.)

The fact that an individual is required to be enrolled in a high-deductible health plan may be another disadvantage. Many employees are reluctant to participate in an HSA because they dislike the additional risk exposure compared to a conventional health plan and also because they dislike having most prescription drug costs, in particular, being subject to the high deductible.

HSAs have not yet attracted wide interest among higher education institutions, and surveyed higher education participants in employer-sponsored retirement plans have been even less interested than institutions. Participants anticipate having to make large annual withdrawals to cover their current medical expenses under the high-deductible health plans, an estimated withdrawal of \$1,183 on average for individual coverage and an average \$2,658 for family coverage.¹⁹

Federal legislative proposals have been made to raise the tax-deductible contribution limit for HSAs, along with other provisions to make them more attractive. These proposals are popular with many Republicans in Congress but disliked by most Democrats, who generally are critical of the HSA concept.

Individual Long-Term Care Insurance

Long-term care can be a major component of retiree health care needs. Among people turning age 65 in 2005, an estimated 42% will receive formal at-home care at some point in their future and 37% will receive care in nursing facilities.²⁰ Many Americans do not realize that Medicare does not cover long-term care to any significant extent, and that it is becoming more difficult to qualify for Medicaid long-term care coverage, which is based upon financial need.

Under Medicare Part A, coverage for “extended care” expenses is limited in both scope and duration to skilled nursing and rehabilitation facilities (with increasing copayments and a time limit), and to home health care when skilled nursing and other services are required for medical treatment, also with limits. The Deficit Reduction Act of 2005 also made restrictions intended to make it more difficult for individuals to hasten eligibility for Medicaid long-term care coverage by transferring personal assets to qualify.

The PPA made modifications regarding the tax treatment of long-term care riders to individual annuities and life insurance products. Under the provision, any charge against the cash value of an annuity or life insurance contract is not included in taxable income if the charge is used as payment for coverage under a qualified long-term care insurance contract that is part of a rider on the annuity or life insurance contract. The provision also expands the rules for tax-free exchanges of certain insurance contracts so that no gain or loss is recognized on the exchange of a life insurance contract, an endowment contract, or an annuity contract, for a qualified long-term care insurance contract. The PPA provisions are effective generally for contracts issued after December 31, 1996, but only with respect to taxable years beginning after December 31, 2009.

Regardless of what the institution decides to do with respect to prefunding, it will be necessary to engage employees in taking more responsibility for their health care needs in retirement and in understanding the reasons behind changes in the employer-sponsored plan.

POSSIBLE ADDITIONAL RESPONSES

Among possible legislative responses, perhaps the most attractive vehicle for institutions and participants to save for retiree health expenses is one that requires a law change, namely, allowing tax-free withdrawals from defined contribution retirement plans to pay for retiree health insurance premiums.²¹

Congress could also pass legislation that would create more tax-effective vehicles for employees to save for retiree health expenses, but it would be a mistake to view that possibility as the “answer.” The large federal revenue cost associated with proposals to allow greater prefunding or to allow individuals to tap retirement accounts to pay for health care expenses on a tax-free basis is a formidable hurdle to overcome, especially given the fiscal situation facing the federal government in the near term and the long term. Moreover, it is not clear how many employees would fully utilize any such vehicles; the number of employees who fail to maximize their

SUMMARY COMPARISON OF RETIREE HEALTH FUNDING VEHICLES*

Funding Vehicle	Availability?	FASB/GASB OPEB Asset?	Tax Treatment of Employee Contributions?	Limits on Funding?	Do Assets Revert to Employers?
VEBA/Section 501(c)(9) Trust	Private and Public Sector	Yes	After-tax employee contributions	Limits for private for-profit employers No limits for collectively bargained VEBAs (regardless of the plan sponsor) No limits for private tax-exempt institutions if “substantially all” contributions to the VEBA are made by entities that have been tax exempt (for at least last 5 years). Income on VEBA maintained by a state college or university may be subject to funding limits due to application of unrelated business taxable income rules (see PLR 200210025).	No, but excess assets may be used to provide other welfare benefits
Section 115 “integral part” Trust	Governmental employers only	Yes	After-tax employee contributions Pre-tax contributions (through employer “pick up”) uncertain	No	Yes (but only after all future liabilities satisfied)
Tax Exempt Section 501(c)(3) entity trust	Private sector, tax-exempt employers only; with an institution-specific, exempt letter ruling from IRS recommended	Yes	After-tax employee contributions	No	Yes (but only after all future liabilities satisfied)
Section 401(h) Retiree Medical Sub-account in a Pension Plan	Private and public sectors	Yes	After-tax employee contributions to private plans For governmental plans, pre-tax contributions are permissible but only if through a mandatory “pick-up” arrangement applicable to all eligible employees.	Yes, generally only up to one-third of total retirement contributions. (At all times, retiree medical, and any life insurance benefits must not exceed 25% of the aggregate pension contributions made after the date on which the plan first included the medical benefits.)	Yes (but only after all future liabilities satisfied)
Individual Account-type Arrangements (e.g., Health Reimbursement Arrangements (HRAs), and Health Savings Accounts (HSAs))	Private or public sector, may be funded or nonfunded by employer	Yes, if HRA is funded through a permitted vehicle (such as VEBA) No for HSA (employee owns the account)	Employer contributions only for HRAs Pre-tax employee HSA contributions subject to limits	Yes (limits on contribution amounts)	Yes. Some HRAs are designed to be portable for employee but it is not required. No. HSA funds are immediately & fully vested.

* This is a summary chart only. The law governing retiree health funding vehicles is complex and lacks definitive guidance in many key areas. Any specific actions or decisions should be made in consultation with tax counsel.

contributions to 401(k), 403(b) and other retirement plans demonstrates the difference between availability and actual utilization.

Even under current law, tools already exist to encourage more employees to participate in available savings vehicles and to set aside more funds generally for retirement. Automatic enrollment of employees in retirement savings plans and automatic escalation of their contributions, for example, are proven tools for increasing employee savings. And the recently enacted PPA provides further incentives for employers to adopt automatic enrollment and automatic escalation programs, as it creates a new safe harbor and clarifies permissible default investment vehicles.

Other possible responses involve curtailing the employer's level of commitment to financing retiree health. Higher education employers, like corporate employers, have been experiencing the financial strain of retiree health costs and have been forced to cut back on benefits, increase retiree contributions, and even eliminate coverage in some instances. Is there an alternative that would allow employers to better calibrate their contributions in this area, so that they can perhaps provide some level of assistance without assuming the lion's share?

With no single solution in sight, the remedy may lie in integrating various combinations of strategies, including:

- Offering — or making available — group health coverage for retirees and considering prefunding of retiree health programs to reduce long-term costs and to avoid adverse accounting effects that may result from a pure pay-as-you-go approach.
- Setting and expressing the level of the employer's commitment to the retiree health plan under a defined contribution approach or as a flat-dollar benefit amount, rather than as a percentage of ever-increasing premium costs.
- Educating employees about their health care needs in retirement, e.g., how much they need to save, the desirability of planning ahead at earlier ages, and how adopting healthy behaviors and using preventive medical services and chronic condition management can improve their health status and perhaps reduce future retiree medical expenses.
- Encouraging increased employee participation in existing, tax-favored retirement savings vehicles through methods such as automatic enrollment, automatic escalation of employee contribution percentages, and focused communication efforts.
- Optimizing the use of Medicare and (where appropriate) other sources of retiree coverage.
- Recalibrating expectations of “career” and “retirement” to recognize the fact that more individuals will continue to be employed at ages that (historically) would have been considered a period of retirement.

Employees are clearly going to need to save more in their working years to pay for medical expenses in retirement. The challenge is to educate employees about this situation, motivate them to increase their level of savings, and direct them to the most appropriate combination of savings vehicles that will maximize their chance of success.

CREATING EMPLOYEE AWARENESS AND ENCOURAGING PREPAREDNESS

Effective communication with employees, retirees and their family members about employee benefits and planning for the future is a vital function that employers historically perform. Of particular interest today is employer communications to educate employees about their retiree health savings needs and encouraging them to prepare for those needs.

UNDERSTANDING THE MAGNITUDE OF THE SAVINGS NEED AND THE IMPACT ON EMPLOYEES' RETIREMENT SECURITY

The share of national health care spending coming from out-of-pocket payments is relatively small, and has declined

steadily over time, from 16% of total health spending in 1993 to 11% in 2006 and to a projected 10% in 2015.²² Retirees with employer-provided retiree health coverage have historically had lower out-of-pocket expenses than retirees without employer coverage, which is particularly important for retirees given that they largely depend on relatively fixed incomes. By one estimate, retiree health insurance decreases out-of-pocket spending by 21%.²³

But these out-of-pocket cost trends are deceiving in that they mask the impact of changes that will cause retirees to pay more out of pocket in the future. As noted above, ongoing trends in employer-provided coverage sponsored by corporations and higher education institutions have been shifting more of the costs to retirees in the form of higher premiums, more cost sharing for overall medical expenses, and higher prescription drug copayments and coinsurance.

Even if these increases in retiree payments are at a lower percentage than the overall increases in total retiree medical costs, retirees on limited incomes will feel the pain. A recent study found that after adjusting for inflation, average annual out-of-pocket health care spending by adults age 65 and older rose 35% between 1998 and 2002, i.e., from \$1,833 dollars in 1998 to \$2,284 in 2002 (in constant 2002 dollars).²⁴ Furthermore, the current decline in the prevalence of employer-sponsored retiree health coverage is likely to decrease early retirement rates and decrease protection from high out-of-pocket medical expenses.²⁵

In addition, while Medicare coverage is available at age 65, Medicare pays for only about half of the medical expenses for retirees, leaving a substantial gap in coverage. Medicare has very limited coverage of extended care, and does not cover custodial care unless it is accompanied by the provision of medically necessary skilled medical services and even then, only for a relatively short period of time. Though they vary across the U.S., nursing home costs have been rising steadily, reaching an average private pay rate of \$64,240 per year for a semiprivate room in 2005.²⁶

The Employee Benefit Research Institute (EBRI) has recently re-estimated the total amount of retiree medical expenses that a retiree may have to finance.²⁷ In doing so, the study had to make a number of assumptions regarding the current and future cost of retiree health care coverage and out-of-pocket expenses and the life expectancy of a retiree or retiree and spouse at age 65.

For an individual age 55 in 2006, who retires at age 65 in 2016 and lives to age 80, EBRI estimates that the retiree will need \$219,000 in savings (at age 65) to pay for the entire cost of employment-based health coverage, Medicare Part B premiums, and out-of-pocket expenses. Using life expectancy of age 82 for men and age 85 for women, EBRI estimates an average couple will need \$560,000 at age 65. To the extent that the employer contributes toward the cost of retiree health insurance coverage, these figures would be reduced. But since many private companies and some institutions have shifted from a subsidized retiree health plan to one where the employer provides only access to a plan and the retiree pays the full cost, the “access only” plan is becoming more common. In 2005, 19% of large corporations required new retirees to pay 100% of the premium.²⁸

Medicare Part B premiums and Parts A and B deductibles continue to rise and, in 2007, Part B premiums, for the first time, will be income-adjusted for higher-income retirees. In September 2006, CMS announced that the 2007 Part A deductible will be \$992. The 2007 Part B deductible will be \$131 and the 2007 standard Part B monthly premium will be \$93.50. Beneficiary Part B premiums cover about 25% of Part B program costs, while general federal revenues finance the remaining 75% through the Part B Trust Fund. As required in the Medicare Modernization Act of 2003, beginning in 2007, single beneficiaries with annual incomes over \$80,000 and married couples with incomes over \$160,000 will pay an income-adjusted Medicare Part B premium. Such beneficiaries will pay a monthly Part B premium equal to 35%, 50%, 65%, or 80% of the total cost, depending on their income level, by the end of a 3-year transition period.

Not much further on the horizon lies the specter of potential, dramatic shifts in the Medicare program itself. The most recent forecast provided by the 2006 Medicare Trustees' Report projects that the Medicare Part A trust fund will reach insolvency by 2018, with Part A expenses exceeding income by 2010. The 2006 Social Security Trustees' Report also provides an intermediate estimate that, in 2006, the Medicare program will spend \$10,685

per year for an average beneficiary (for Parts A, B and D). These and other indicators serve to underscore why many commentators believe that Medicare's present funding and benefit structure may be unsustainable. Most parties agree that significant restructuring with some combination of tax increases and benefit reductions will be necessary to preserve the Medicare program for future retirees. Employers, employees and future retirees will need to respond and adapt to these changes as well.

COMMUNICATING WITH EMPLOYEES, RETIREES AND LABOR REPRESENTATIVES

As part of the education and communication process, employers may also want to engage in communications that address any vestigial employee sense of entitlement to lifetime guarantees of employer-financed retiree medical benefits. This is a sensitive message. The task is especially complicated in situations involving collectively bargained employees, where language in bargaining agreements may convey some guarantees of coverage or where ambiguity in the bargaining agreement provides fuel for litigation over employer efforts to reduce coverages or subsidies.

For those employees who recognize their financial responsibility for their future retiree health costs, few of them probably fully appreciate that they may need to save perhaps hundreds of thousands of dollars to finance their health care needs in retirement.

Higher education institutions, like other major employers, can help the situation by educating employees about their future responsibilities in this area, estimating how much financial assistance will be available for retirees under the current plan for employees, and clarifying that the institution reserves the right to change or even eliminate the plans in the future.

- According to the TIAA-CREF 2004 survey, more than three quarters (77%) of surveyed participants in employer-sponsored retirement plans expressed concern about being able to meet their medical expenses during retirement.
 - Only half (56%) believe that their institution offers retiree health care benefits and few actually know the details; 27% are not sure whether their institution offers retiree health care benefits.
 - Only 9% have estimated how much they will need to meet future medical expenses.
 - Among the 91% of those participants who have not estimated what the expenses would be, the median guess is \$94,000, compared to a median guess of \$48,000 by the relatively few participants who had estimated the cost.

Communications should also address the available vehicles that employees currently have to save for retirement needs, and offer modeling tools to illustrate how much additional savings may be required in anticipation of retiree health needs.

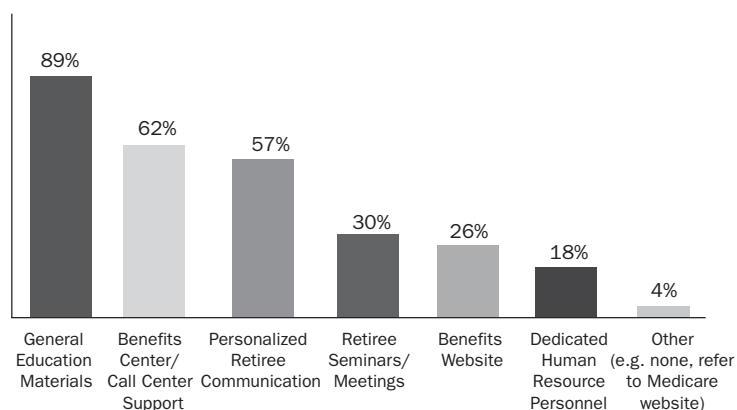
Such communications should also leverage messages to employees and retirees about how preventive health services and healthy lifestyles may help reduce future retiree health expenses on account of good health.

Employers are also a key source of information for their age 65+ retirees with respect to the Medicare prescription drug benefit. Employers are legally required to provide their Medicare-eligible retirees with a notice each year — and, if applicable, at other times during the year — as to whether their employer-provided drug coverage is “creditable” (i.e., at least as good as the Medicare prescription drug benefit) or “noncreditable” (i.e., less than the actuarial value of the Medicare drug benefit). Retirees with creditable coverage are generally protected against having to pay a late enrollment penalty if they eventually enroll in Medicare Part D. Employers may want to leverage these required communications as opportunities to initiate a broader conversation about retiree health benefits.

Many large employers report that they are providing additional Medicare-related information to their age 65+ retirees in 2006 (Figure 7). According to the Kaiser/Hewitt Survey, these employers are using multiple strategies, such as: distributing general educational materials, maintaining a benefits center or call center, providing personalized retiree communications (in addition to required notices), hosting retiree seminars or meetings, hosting a website, and/or designating human resources personnel for this specific purpose.

Efforts to educate faculty and staff about the retiree health benefits available to them through work and through Medicare, along with information on the costs of retirement health care, are essential to an overall strategy for addressing the retiree health care needs of the institution's workforce. It is probably a responsibility that needs to be shared by employers, employees, labor unions, financial services providers and health care providers to achieve optimal results.

Figure 7: Share of Employers Reporting Education and Outreach Efforts Related to the Medicare Drug Benefit



Note: Based on responses from private-sector firms with 1,000 or more employees offering retiree health benefits.

SOURCE: Kaiser/Hewitt 2005 Survey on Retiree Health Benefits, December 2005.

CONCLUSION

Expenses for retiree health care are large and growing at a rapid pace. The challenge is to find affordable ways of enabling employees to meet those expenses, when it is clear that no single source of funding will likely be available to do the job.

The federal government already makes a substantial contribution toward paying for retiree health costs by its funding of the Medicare and federal/state Medicaid programs, as well as its contributions to health plans for federal employees, military personnel and veterans. But the impact of the baby boom generation is projected to result in serious shortfalls in funding for federal health and retirement programs unless taxes are raised, benefits are reduced, or there is some combination of benefit reductions and increased taxes.

The challenges posed by financing retiree health care expenses will continue to require the attention of employers, including employers in higher education, for years to come. We anticipate that employers will, in turn, continue to seek and develop new solutions and approaches. Thus, the next few years will prove to be a period of challenge and opportunity for employers, employees and HR professionals.

ENDNOTES

- ¹ Based on a recent study, the offer of retiree health insurance increases early retirement by 35%. See *The Decline in Employer-Sponsored Health Insurance for Retirees and Its Impact on Older Americans*, Presentation by Erin Strumpf, Academy Health Annual Research Meeting, June 26, 2006. <http://www.academyhealth.org/2006/612/strumpf.ppt>
- ² Kaiser Family Foundation/Hewitt Associates 2005 Retiree Health Benefits Survey, December 2005.
- ³ Christine Berger et al., "Health Spending Projections Through 2015," *Health Affairs*, W61, February 22, 2006.
- ⁴ U.S. Census Bureau, *65+ in the United States: 2005*, March 2005.
- ⁵ "Retiree Health Trends and Implications of Possible Medicare Reforms," by Hewitt Associates for the Kaiser Family Foundation, September 1997.
- ⁶ *Summary of Findings: Retiree Health Care Savings Study*, TIAA-CREF, November 2004.
- ⁷ In 2000, a ruling by the U.S. Court of Appeals for the Third Circuit in the *Erie County* case found it is a violation of the Age Discrimination in Employment Act (ADEA) to provide benefits to age 65+ retirees that are not equal to those benefits provided to pre-65 retirees. The Equal Employment Opportunity Commission (EEOC) has proposed a narrow exemption from the ADEA to permit employers to provide health benefits to age 65+ retirees that are different or of lesser value than those provided to pre-65 retirees. AARP sued to block the EEOC from issuing the rule, and after the federal district court ultimately ruled in favor of EEOC, AARP's appeal of that decision is pending before the U.S. Court of Appeals for the Third Circuit. A decision of the appeals court is expected in 2007. Until the appeals court rules, implementation of the EEOC rule is blocked by a temporary restraining order.
- ⁸ Kaiser Family Foundation/Hewitt Associates, *Prospects for Retiree Health Benefits as Medicare Prescription Drug Coverage Begins*, December 2005.
- ⁹ In some instances, there are no savings to the employer because the retiree pays 100% of the premium. In other cases, employer savings may be lower because the employer contribution is capped and/or the employer pays a smaller percentage of the overall cost than do other employers. Savings will also be lower if the employer intends to share a portion of the savings with retirees (a question not asked in the survey).
- ¹⁰ Centers for Medicare and Medicaid Services, *The Retiree Drug Subsidy: Why Employers and Union Plan Sponsors Should Consider It*, April 2005, <http://www.cms.hhs.gov/medicarereform/pdbma/RetireeDrugSubsidy4Emp04-06-05.pdf>.
- ¹¹ Centers for Medicare and Medicaid Services, Overview of Plan Sponsor Supplemental Coverage Options and TrOOP, <http://www.cms.hhs.gov/medicarereform/pdbma/OverviewofPlanSponsorSupplementalCoverageOptionsandTrOOP.pdf>.
- ¹² This percentage savings was calculated by taking the total savings for each employer (i.e., savings per individual retiree multiplied by the total number of the company's age 65+ retirees) and dividing that sum by the employer's estimated 2005 total cost (employer and retiree share) of providing retiree health benefits to pre-65 and age 65+ retirees. We then calculated the median percentage savings among these companies.
- ¹³ *Summary of Findings: Retiree Health Care Savings Study*, TIAA-CREF, November 2004.
- ¹⁴ Paul Fronstin, "Savings Needed to Fund Health Insurance and Health Care Expenses in Retirement," *EBRI Issue Brief* No. 295, Employee Benefit Research Institute, July 2006.
- ¹⁵ See IRS Private Letter Ruling 200210025, November 30, 2001, which states: "[23] Sections 419 and 419A of the Code apply in connection with an employer making contributions to a welfare benefit fund. In this case the employer is the State or an agency or instrumentality of the State. Absent specific statutory authorization for taxing such income, the income of a state, including its agencies and instrumentalities, is not taxable. Pursuant to section 511(a)(2)(B) of the Code, colleges and universities that are state agencies or instrumentalities, including corporations owned by the colleges and universities, are taxable on the gross income from any unrelated trade or business, less the deductions allowed by chapter 1 of the Code that are directly connected with the carrying on of the unrelated trade or business."
- ¹⁶ Brian B. Murphy and Paul Zorn, "Managing the Impact of GASB Statement 45," *Benefits & Compensation Digest*, Vol. 43, No. 5, May 2006, Web exclusives.
- ¹⁷ A drafting error in the PPA expresses the excess assets as being those above 120% of the funding shortfall instead of the funding target, as intended. This drafting error is likely to be fixed in expected technical corrections legislation.
- ¹⁸ In 2006, the maximum annual contribution is the lesser of (1) 100 percent of the annual deductible, or (2) \$2,700 for self-only coverage or \$5,450 for family coverage. Additional contributions are permitted for individuals age 55 or older. There is no limit on the amount that can be accumulated in the account.
- ¹⁹ *Summary of Retiree Health Care Savings Study*, TIAA-CREF, November 2004.
- ²⁰ Richard W. Johnson, *Health Insurance Coverage and Costs at Older Ages: Evidence from the HRS*, Presentation before AARP Public Policy Institute, September 28, 2006.
- ²¹ *Summary of Retiree Health Care Savings Study*, TIAA-CREF, November 2004.

- ²² Frank McArdle, *Can an Employer-Based Health Care System Survive in a Global Economy?* Presentation before Academy Health Annual Research Meeting, June 25, 2006. <http://www.academyhealth.org/2006/mcardlef.pdf>
- ²³ Erin Strumpf, *The Decline in Employer-Sponsored Health Insurance for Retirees and Its Impact on Older Americans*, Presentation before Academy Health Annual Research Meeting, June 26, 2006. <http://www.academyhealth.org/2006/612/strumpf.ppt>
- ²⁴ Richard W. Johnson, *Health Insurance Coverage and Costs at Older Ages: Evidence from the Health and Retirement Study*, AARP Public Policy Institute, September 2006.
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- ²⁷ Paul Fronstin, "Savings Needed to Fund Health Insurance and Health Care Expenses in Retirement," *EBRI Issue Brief* No. 295, Employee Benefit Research Institute, July 2006.
- ²⁸ Kaiser Family Foundation/Hewitt Associates, *Prospects for Retiree Health Benefits as Medicare Prescription Drug Coverage Begins*, December 2005.

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