THE FUTURE OF RETIREE HEALTH BENEFITS IN HIGHER EDUCATION IN THE UNITED STATES

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Prepared for the TIAA-CREF Institute Conference
Recruitment, Retention, and Retirement:
The Three R's of Higher Education In the 21st Century

New York City, April 1-2, 2004

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Abstract

Employer provision of health insurance for retirees arose somewhat accidentally several decades ago when many employers did not understand the nature of the commitment they were making. Over the decades, all employer-sponsored health benefits have been subject to high rates of cost inflation. That phenomenon in combination with the common practice of providing retiree health benefits on a pay-as-you-go basis has now put these benefits in jeopardy as many employers are curtailing or eliminating retiree health insurance coverage. This analysis looks at the underlying dynamics of providing these benefits and how employers are changing their plans. It assesses the extent to which colleges and universities offer these benefits to retiring faculty members and the prospects of continuing provision of the benefits in the future. It concludes that the current provision of these benefits, as now offered and financed, is economically irrational in many cases. It suggests that the new Medicare legislation that will provide pharmaceutical for retirees starting in 2006 may be a better alternative for providing retiree health insurance for many employers.

I. Introduction

Many employers in the United States today are grappling with what to do about the retiree health benefit plans they have been sponsoring. In some cases this matter has arisen because the character of these benefits and the regulatory environment in which they operate has raised concerns about the rationale for employer sponsorship of retiree health insurance. Cost inflation for health benefits generally, and particularly for prescription drug benefits that are a major part of retiree health benefit costs, has accentuated the concerns that some employers have about sponsoring these programs. The demographic composition of the workforce and the prospect of burgeoning retiree populations is another consideration that employers are taking into account. Finally, the recent adoption of legislation expanding Medicare's coverage to include drug benefits for eligible retirees after 2006 naturally raises questions about what employers now sponsoring their own retiree health insurance programs ought to do relative to the new coverage.

This paper explores the myriad issues that employers are now considering as they decide their future role in providing retiree health insurance. The ultimate focus of the paper is on what is happening in the world of higher education and how employers in this sector of the economy are currently treating retired faculty and how the health insurance now being provided might change in the future. For a variety of reasons, however, many employers in the private sector are substantially ahead of those in the public and nonprofit sectors in considering what they should do with their retiree health benefit programs. Because of this, the initial discussion presented here is in broader context than just focusing on the situation in higher education.

In some regards, the employer sponsorship of retiree health benefits in the United States may seem entirely irrational. The initial part of the discussion in the next section briefly describes the role that employer-sponsorship of these benefits has played and why we find ourselves in the situation that we do at this time. In the third section of this paper, the general trends in retiree health benefits are explored. In the fourth section, the analysis turns specifically to the situation in higher education in the provision of retiree health benefits for faculty members. The final section provides some general conclusions.

II. Background

The United States is unique in the developed world in the way in which it finances the delivery of health care goods and services. The majority of the U.S. population receives health insurance coverage through a patchwork of public and private programs with varying levels of benefits. In other countries, the public receive their health goods and services through comprehensive mandated health insurance coverage or national health service delivery systems.

In 2002, total health expenditures in the United States were $1,553 billion representing 14.9 percent of gross domestic product (GDP) in the U.S. economy that year. Of all health care expenditures in the United States that year, 50.4 percent were privately financed (CMS, 2004). By comparison, among the other G-7, about 76 percent of their annual expenditures on health care are financed through public mechanisms (OECD, 2001).

While a larger share of health expenditures in the United States tends to come from private sources than in most countries, the direct outlay of cash at the point of

consumption in the United States only amounted to 13.7 percent of total outlays in 2002. The rest of the private expenditures on health care goods and services was paid through insurance programs or other third-party payment mechanisms. Of the public expenditures, 70.7 percent were financed by the federal government. Of federal expenditures, 52.9 percent was through Medicare. Medicaid accounted for 29.2 percent of federal health expenditures and 49.3 percent of state and local expenditures (CMS, 2004).

Medicare and Medicaid were established during the 1960s because many of the elderly were not covered by private health insurance of any sort and they were believed to be in poorer health and had significant unmet medical needs because of their lack of such insurance (Rice, 1962). The enabling legislation creating Medicare was established in 1965 covering only people who had attained the age of 65 and who qualified for benefits based on periods of coverage under the national Social Security program. Coverage was expanded in 1972 to include the disabled. During 1999, 85.4 percent of Medicare payments to program beneficiaries went to people 65 years of age and older (CMS, 2001, Table 14). That year, 97.2 percent of the non-institutionalized population over the age of 65 in the United States was covered by Medicare (DHHS, 1999). Some of those not covered by Medicare never worked in covered employment long enough to qualify for the benefits or did not qualify for spousal coverage because they were never married long enough to someone who earned coverage.

While Medicare was structured to provide a broad base of health care protection for the elderly and disabled, it did not cover a substantial portion of their health care expenditures. In 1999, Medicare paid for 53 percent of the medical care consumed by

program beneficiaries (CMS, 2002). Mindful of the share of medical care consumption that would be covered under Medicare and of the implications this would have for low-income people qualifying for program benefits, federal law provided Medicaid supplemental benefits to provide a more comprehensive level of coverage to such individuals. In addition to being covered by Medicare, 13 percent of all people over the age of 65 in 2000 were also covered by Medicaid (CMS, 2000). In 1999, total Medicaid payments were $153.5 billion. Of these, $42.5 billion was for aged persons age 65 and above (CMS, 2001, Tables 101 and 104). During 1999, Medicaid covered 12 percent of the Medicare beneficiaries' total cost of medical care consumption (CMS, 2002).

For the elderly who did not qualify for Medicaid coverage as a supplement to Medicare, the voids in the package of benefits provided through Medicare resulted in provision of overlapping coverage by private insurance. In 2000, 22 percent of the elderly covered by Medicare purchased medigap insurance on their own. Another 29 percent were covered by employer-sponsored retiree health benefit plans that provided supplemental coverage. Four percent of the elderly under Medicare had a medigap plan that they purchased on their own plus employer-sponsored coverage. An additional 18 percent were in Medicare HMOs, which cover many services in full, thereby making supplemental policies unnecessary. Two percent were covered by some sort of other publicly health insurance program. This left only 12 percent of all Medicare-covered elderly who had no supplemental coverage at all (CMS, 2000).

During 1999, private insurance covered 12 percent of total health consumption for those covered by Medicare. In addition, Medicare enrollees paid for 19 percent of their medical care consumption directly out-of-pocket. The latter amount does not include

their premiums for Medicare Part B, supplemental private insurance, or HMO premiums (CMS, 2002). The implications of having supplemental health insurance to augment Medicare coverage will vary somewhat from plan to plan. For a typical retiree covered by an employer-sponsored health plan today and eligible for Medicare, an average of about 65 percent of medical care costs will be covered by Medicare, 25 percent by the employer plan and 10 percent out of pocket.

Evolving World of Employer-Sponsored Health Insurance

Part of the reason to be concerned about the future of employer-sponsored retiree health benefits is related to a larger context in which employers find themselves sponsoring any sort of health benefit programs. U.S. employers stumbled into the role they play in financing these benefits somewhat by accident. During World War II wage controls limited employers' ability to compete for workers on the basis of higher pay but employers were allowed to add benefits that had not been previously provided. Among other things, employers offered workers attractive health insurance coverage to attract and keep them during this period. Health benefits that employers offered as a way to beat wage controls in the 1940s had grown to be 6 percent of total compensation by the end of the twentieth century and for some employers were two or three times that level. Early in the twenty-first century, the cost of these benefits has grown rapidly.

Over the years there has been some debate over who pays for employer-sponsored health benefits—whether it is the employer through higher compensation costs or the worker through reductions to cash wages or some other elements of compensation. Since the end of World War II, total compensation of U.S. workers, including the self employed, has hovered around two-thirds of our annual gross domestic product (GDP).

This has been the case during periods when health costs were very small at the beginning of the period and when they have been many times higher in recent years. It has been the case when health benefit costs were growing much more rapidly than total compensation costs and when they grew slower than total compensation. As employer-sponsored health benefits have increased over the decades relative to total output produced by workers, the relative share paid in other forms of compensation has declined. Until now, health benefits have likely not played a major role in affecting total compensation of workers or its broad distribution. The evolution of health benefits over the years, the magnitude of their costs, and who benefits from them may change that in the future.

Changing Characteristics of Benefits

In the 1950s, the nature of the health benefits that employers provided was very different than what most people are familiar with today. Consumption of medical goods or services under the typical employer-sponsored benefit plans was reimbursed on the basis of defined schedules of payments for specific services covered. In the early 1950s, private health insurance benefits were typically limited to inpatient care. A common plan might reimburse hospital room and board charges between $3 and $10 per day (roughly $25 to $75 per day in current terms) for a limit of up to one month per year. Surgical procedures were reimbursed on a fixed schedule of payments and it was not uncommon that the maximum reimbursement for any surgical procedure would be $150 (roughly $1,150 in current terms). Ancillary benefits such as anesthesia, laboratory services, operating or delivery room services were generally limited to $1,000 or less (roughly $6,225 in current terms). Doctor's visits for a single illness might be limited to $50 to $75 (roughly $400 to $600 in current terms) (Strong, pp. 175-185).

By the late 1950s or early 1960s, employers began to add major medical coverage to their basic hospital plans. Under these plans, expenses not covered under the basic plan beyond some threshold of out-of-pocket expenditure by the covered individual would be reimbursed. These plans covered practically all types of necessary medical expenses both in and outside of hospital care although the plans typically included maximum benefit limits of $10,000 to $20,000. The combination of basic insurance and major medical plans underwent further metamorphosis into single comprehensive plans (Pickrell, pp. 36-44).

As Congress developed the Medicare and Medicaid programs in the 1960s, both the medical community and the general public expressed grave concern about the intrusion of the government into the doctor-patient relationship. Section 1801 of the Social Security Amendments that set up the Medicare program was quite explicit that the government would not exercise "any supervision or control over the practice of medicine or the manner in which medical services are provided." The implementation of the legislation followed the practice then prevalent among Blue Cross plans and reimbursed hospitals on the basis of their costs, including capital costs. Under Medicare, physicians were reimbursed on the basis of "reasonable and customary" charges for the costs of services that were provided under the program. Many employer-provided health programs followed the lead of the government in paying for services provided under their plans on the basis of reasonable and customary charges.

By the end of the 1970s, a survey of slightly more than 800 employer-sponsored benefit programs found that 69 percent of them ran a combined basic plan supplemented with a major medical plan. The remainder all provided comprehensive major medical

coverage. Among the basic medical plans, the survey found that 85 percent of plans paid the full cost of a semi-private room while a patient was in the hospital and more than 95 percent of the plans covered stays of longer than a month in the hospital. Charges for services delivered under these plans were covered on the basis of reasonable and customary rates for ancillary benefits in the hospital by 77 percent of the plans. Fifty-two percent covered surgical charges, 44 percent covered in-hospital physician fees, and 35 percent covered outpatient diagnostic expenses on a reasonable and customary basis. For major medical and comprehensive coverage, the typical deductible in the plans was $100 or less for a covered individual and the plan typically covered up to 80 percent of costs of services provided under the plan. In 86 percent of the plans, retirees under the age of 65 were provided some continued coverage under the plan for active workers and 71 percent provided some level of coverage for retirees beyond the age of 65 (Watson Wyatt, 1984).

During the 1980s, employers began to adopt a number of plan provisions aimed at controlling costs of their health benefit programs. Among other things, many of them began to offer flexible benefit plans with several different options of health coverage from which people eligible for their benefit programs could choose. Typically, the options would include a couple of choices of indemnity plans plus an HMO option. The differences in the indemnity plans offered would be in the levels of copayments and deductibles covered members would face and in the share of the premium that the members would pay out of their own funds. The typical HMO plan at this juncture provided a relatively comprehensive package of benefits and generally provided coverage of services delivered on a first-dollar basis. In terms of the package of benefits offered, on paper at least, the HMO offering generally looked superior to what was offered in the

other choices provided under employer plans. Employers managed the share of people who took the HMO options through alternative pricing of the choices. Higher pricing of the HMO options and the perception that HMOs restricted physician choice and the delivery of services encouraged many of those covered by employer plans to stay with their traditional coverage.

As the efforts to control health costs continued to evolve during the late 1980s and into the 1990s, there was a growing sense that many of the characteristics of HMOs were desirable. Employers reengineered their traditional plans with benefit provisions that mimicked HMOs but where the services were delivered through networks of independent providers organized by third-party vendors. These new systems of managed care attempted to control the price of services delivered to covered populations through negotiated price schedules with the providers within the networks. They tried to control the volume of services delivered using gatekeepers to direct consumers to use appropriate care within the networks. There was a considerable backlash on the part of consumers to being limited in choice of providers and in the levels of services delivered under this version of managed care. The providers helped to fan this dissatisfaction because they disliked the limits that the system was attempting to impose upon the delivery of services.

By the end of the 1990s, in response to the overall dissatisfaction with managed care, the sponsors of health insurance plans began to relax many of the controlling features in the managed care systems. Covered members of plans were being given options to utilize services delivered by providers outside of the networks and the gate keeping elements of plans were largely eliminated. In the whole process, however, the package of benefits that was provided from the shift out of the traditional indemnity plan

environment to the post-managed care point-of-service environment had become much more generous. The cost of benefits provided under this new generation of plans far outstripped the share of costs paid by participants in the plans through copayments and coinsurance contributions.

The Cost of Health Care Services

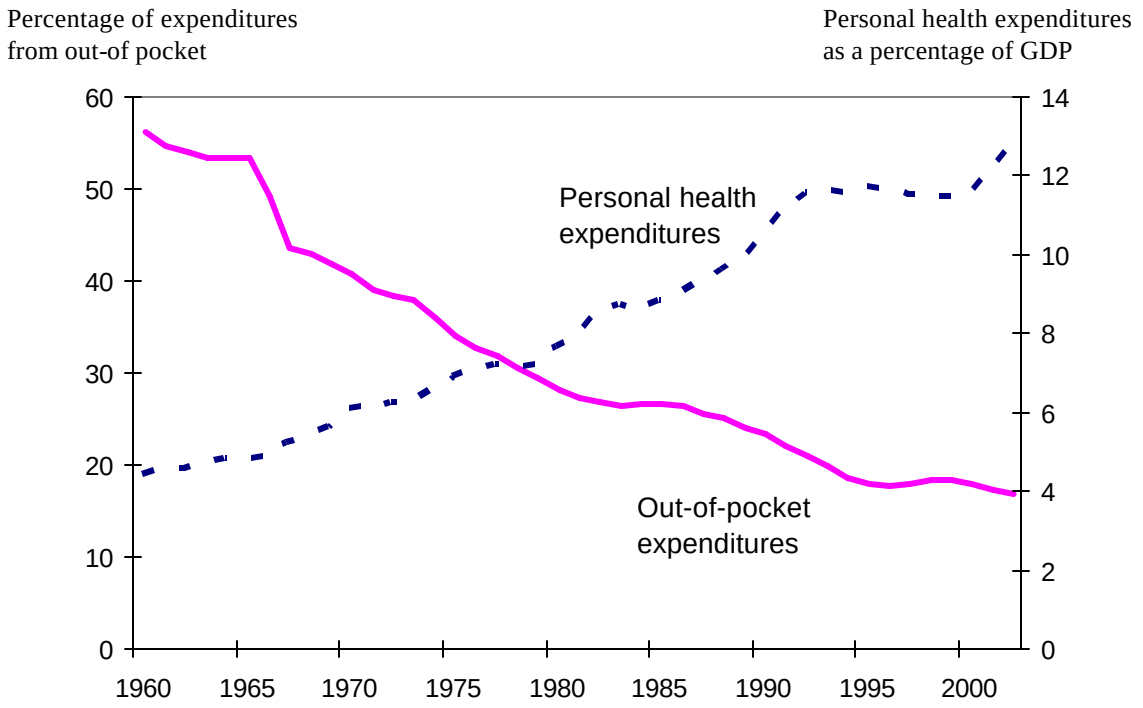
In the early 1950s, about 40 percent of the civilian population was covered by some sort of health insurance (Strong, p. 175). Twenty years later, an estimated 80 percent of the civilian population under the age of 65 and 51 percent of that 65 and above was covered by some form of private health insurance (Mueller, p. 4). By 2000, 84 percent of the non-elderly population was covered by public or private insurance and nearly all of the post-65 population had at least one source of third-party coverage (Fronstin). This expansion of health insurance coverage meant that millions of health care consumers faced much lower price barriers to medical care consumption than they would have without such insurance.

In 1960, total health care expenditures in the United States were about 5.1 percent of gross domestic product (GDP) and the delivery of health goods and services at the personal level consumed about 4.5 percent of GDP. At that time, individual patients and their families paid 55.2 percent of personal health care spending out-of-pocket. From that baseline, two distinctive patterns emerged that are reflected in Figure 1.

The growth in insurance coverage and the changing characteristics of the benefits provided by it led to a substantial decline in out-of-pocket spending for personal health care consumption, from 55.2 percent to 15.9 percent of all spending on personal health care goods and services, over the 43 years covered in Figure 1. For consumers, out-of-

pocket expenditures on personal health care consumption fell from 2.5 percent of GDP in 1960 to 2.0 percent in 2002. Over the same period, total personal health care spending grew from 4.4 percent to 12.8 percent of GDP. Total health care expenditures in the United States grew from 5.1 percent of GDP in 1960 to 14.9 percent in 2002.

Figure 1: Percentage of Total Personal Health Care Expenditures Paid Out-of Pocket and Percentage of GDP Spent on Personal Health Care, 1960 through 2002*



Source: Center for Medicare and Medicaid Services, Office of the Actuary.

*Note that out-of-pocket expenditures do not include personal premium contributions for insurance coverage.

There were several factors behind this extraordinary growth in health care spending. Figure 2 shows the annualized rates of growth in GDP per capita and personal health expenditures per capita for each of the decades from 1960 through 2000 and separately for the period 2000 through 2002. The growth rate for per capita personal

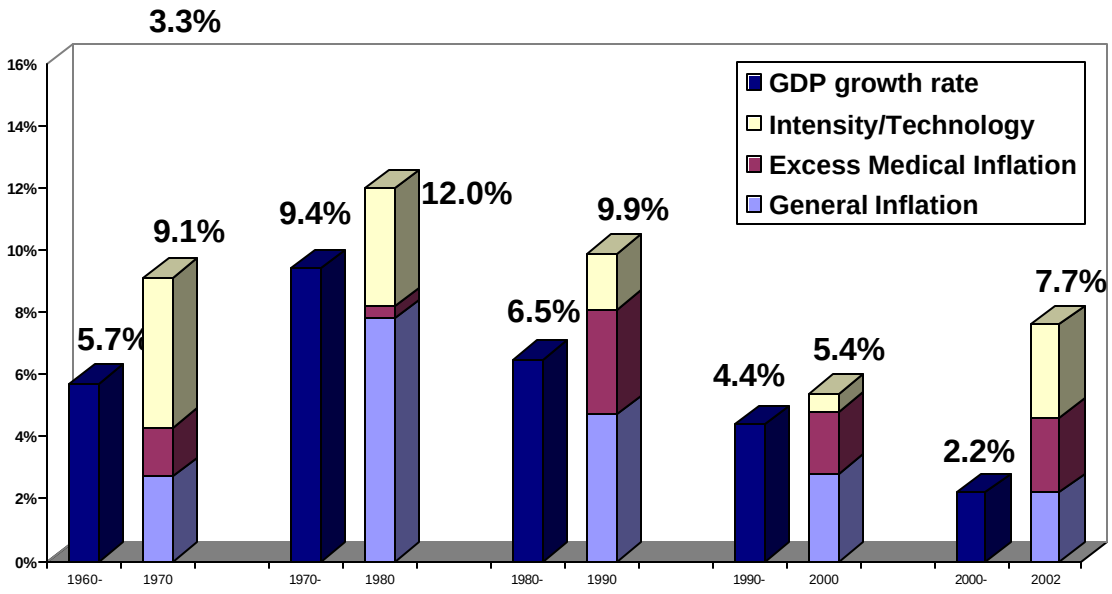
health care expenditures has consistently exceeded the growth in per capita GDP over each of the periods shown in the figure. In Figure 2, the personal medical inflation rates for each of the periods have been decomposed into three components: general price inflation, medical price inflation in excess of general inflation, and growth attributable to more intensive delivery of services due to either changing practice patterns or technology. General inflation and medical care inflation are calculated from the price indices published by the Bureau of Labor Statistics. The intensity/technology component is the residual that remains after the two elements of price inflation are removed.[1]

Price inflation reflected in Figure 2 is broken into two components. The first of these is general price inflation in the overall economy as calculated from the Bureau of Labor Statistics' consumer price index for all urban consumers (CPI-U). General price inflation accounted for about half of all of rate of growth in per capita health costs during the 1980s and 1990s but dropped to less than 30 percent for the 2000-2002 period. The second component of health cost increases reflected in Figure 2 is the extent to which health care prices as reported as a subcomponent of the larger index exceed the CPI-U. The health care sector of the U.S. economy by the CPI measures developed by the BLS has historically been prone to excessive price inflation. The extent of this excessive inflation was minor during the 1970s, a period of generally high inflation in the overall

[1] This latter measure actually understates the role of technology because some portion of excess medical price inflation reflects technology enhancements to existing products and services provided in the health sector. While the Bureau of Labor Statistics attempts to measure the price changes for a fixed market basket of goods over time, it is not uncommon for elements of the market basket to experience technological improvements, much as new automobiles are improved over time. To the extent that technology enhances the quality of a product in a way that increases its price, the price increase for the product reflects the imbedded improvement rather than price inflation.

economy but has been significant over most of the remaining period reflected in Figure 2. Since the beginning of the 1980s, excessive price inflation in the health sector accounts for about a third of all of rate of growth in per capita health costs.

Figure 2: Compound Annual Growth Rates by Decade in GDP Per Capita and Medical Expenditures Per Capita for the U.S. Population from 1960 to 2002



Source: Watson Wyatt calculations based on data from 2001 OASDI Trustees report, National Health Expenditures data from www.hcfa.gov, and inflation indices from www.bls.gov.

The third component of health cost increases reflected in Figure 2 is the extent to which per capita health care utilization grew over and above the rates that can be attributed to general or health specific price inflation. This reflects the extent to which people are consuming more services either because service patterns or technology are changing. During the ramp up in insurance coverage during the 1960s this factor accounted for 53 percent of the total growth in per capita costs of health care. During the 1970s, it still accounted for 31 percent of health cost growth. The periods of the 1980s and 1990s as managed care was evolving and being implemented, the increasing intensity

of the delivery of services dropped to accounting for only 19 and 10 percent of the total run up in personal per capita health spending respectively. But corresponding with the relaxation of some of the more aggressive health management techniques in recent years, the increasing intensity of service delivery accounted for 40 percent of the increase in health costs for the period 2000 to 2002. This latter period is quite brief compared to the other periods reflected in the table and one has to be careful about making comparisons with such a short period to the earlier decade-long rates. However, many of the sponsors of health insurance programs have continued to see the costs of their plans grow significantly more rapidly throughout 2003 and into 2004 than inflation or other underlying economic growth rates. Many plan sponsors are quite concerned that we may be entering a period when both the intensity of services and excess health inflation are exploding uncontrollably. For employers sponsoring health benefits this is becoming particularly worrisome.

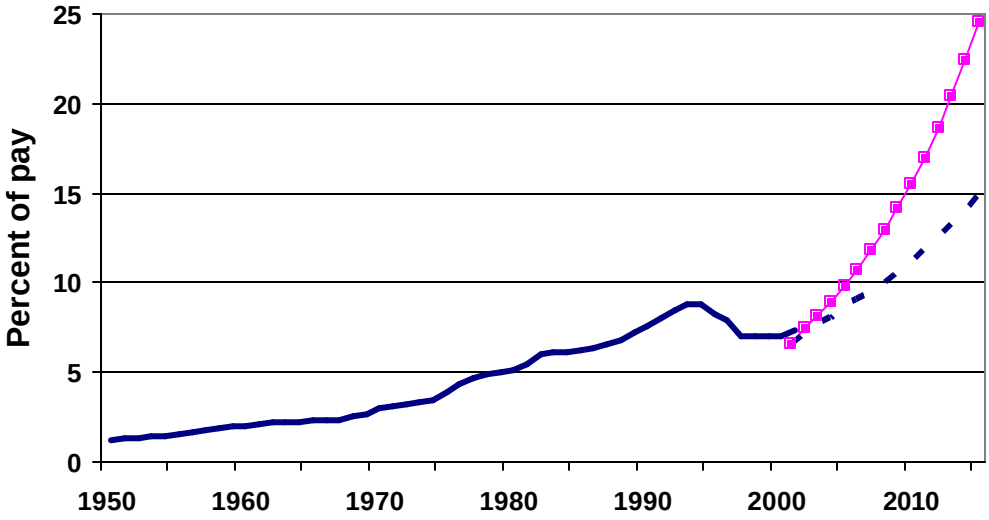
Health Benefits as Compensation

Many economists look at the employer sponsorship of health benefits and conclude that employers should be relatively indifferent as to whether workers want more or less health care or how it is financed. Health care is part of the compensation package and as long as total compensation paid to a worker does not exceed his or her marginal contribution to the enterprise, it should make little difference to the employer how the compensation is split. This may have been the case at some earlier times but is likely becoming less so.

Figure 3 shows the historical levels of employer contributions to private health insurance plans stated as a percentage of cash wages paid to employed workers in the

United States. The historical data run through 2001. In that year, the Social Security Administration estimates that the average cash wage level in the United States was $32,922 (SSA, 2004). In that year, employer contributions for health insurance equaled 6.6 percent of cash wages according to the National Income and Produce Accounts data reflected in Figure 3. In 2001, premiums for employer-sponsored health benefit plans in a sample of firms studied by the Kaiser Family Foundation increased 10.9 percent. In 2002, they increased 12.9 percent and in 2003, 13.9 percent. In this sample of firms, health premiums increased by 6.8 percentage points more than workers' earnings increased in 2001, by 9.7 percentage points more in 2002, and by 10.8 percentage points more than wages grew in 2002 (Kaiser-HRET, 2003, Exhibits 1.1 and 1.2).

Figure 3: Employer Contributions to Private Health Benefit Plans as a Percentage of Cash Wages Paid to Employed Workers for Selected Years



Sources: Historical data were derived from the Bureau of Economic Affairs, U.S. Department of Commerce, *National Income and Product Account* series. The projections were derived by the author as outlined in the text.

Based on the recent history, we projected the implications that health premiums continue to increase more rapidly than wages through 2015 under two alternative scenarios that are reflected in Figure 3. In both scenarios, we assumed that average wages grow at a rate of 4 percent per year. In the lower of the two health premium increase scenarios, reflected by the dashed line beyond 2001 in the figure, we assumed that health premiums would increase at a rate of 10 percent per year, or 6 percentage points per year faster than wages were assumed to grow. In the higher of the two, we assumed employer health costs would increase at a rate of 14 percent per year, 10 percentage points more than the rate of increase in assumed wages.

The point of Figure 3 is that employers have gone through health cost increases the last two or three years that, if played out over the next decade or so, could drive total health costs to equal something between 15 and 25 percent of cash wages paid to workers. Since this is an average and many employers are already starting at a base somewhat higher than that implied by Figure 3, some employers are potentially looking at a situation where health costs stated as a percentage of their cash wages are even higher than those suggested here.

Just because health insurance premiums have been outstripping wages or other components of compensation does not mean that they can continue to do so indefinitely. The long-time, venerable Washington economist, Herb Stein, used to say, "If something cannot go on forever, it will stop." A lesser known observation of this same wise man was that, "Economists are very good at saying that something cannot go on forever, but not so good at saying when it will stop" (Fisher, 2001). Given the recent history of developments in the provision of health insurance many employers are concerned that we

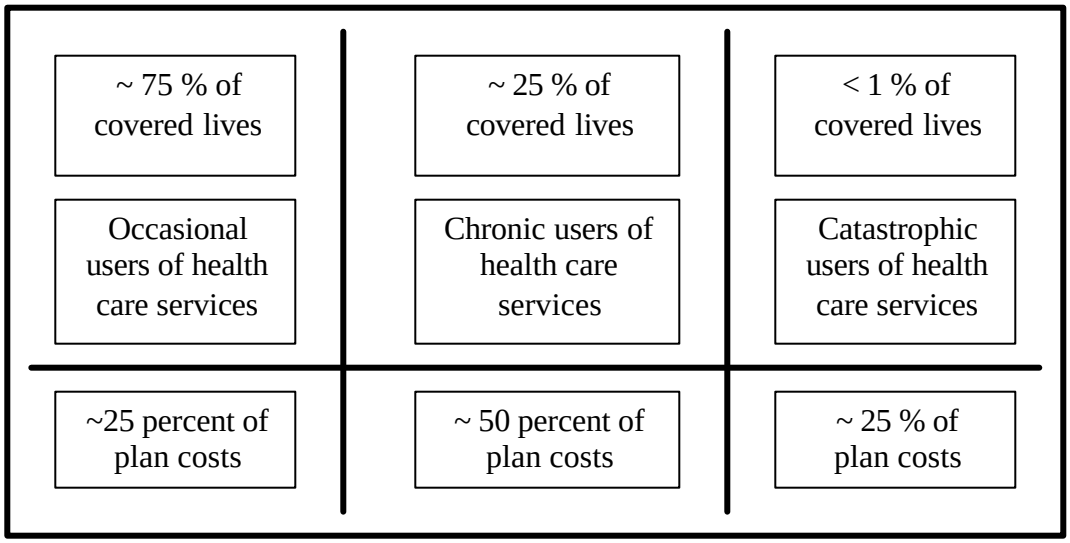
might be in for another stretch of high increases in the costs of health services delivered under their plans. If that happens, it could have significant implications on employers' ability to compensate workers based on their productivity.

Health care consumption patterns fall along a continuum of need, repetition, and intensity with varying cost implications at the respective points in the continuum. To help in explaining this, consider Figure 4. The solid horizontal line in the box represents the utilization continuum. The two vertical lines cutting across the continuum represent conceptual boundaries that distinguish between utilization patterns consumers present to a typical health benefit plan sponsored by an employer. In the figure, people are grouped into one of three categories by the nature of health care services that they use in a typical year. Of course, it is possible that a single individual might fall into more than one category in a year, but most will only fall in only one. The first category includes people who can be characterized as occasional users of health care services. The second category captures people who are chronic users of health care services including people who are treated for such ongoing diseases as hypertension, diabetes, and the like. The final category includes people who incur a catastrophic event that requires intensive care over a variable duration.

Most people covered under a typical employer plan are generally healthy and only occasional users of the plan during any given year. This group may encompass as many as 75 or 80 percent of all people covered under the plan, although the plan outlays for them are probably less than 25 percent of total outlays in most cases. The segment of the health utilization spectrum that includes chronic conditions suggests that this segment of the covered population encompasses roughly 25 percent of covered lives under a typical

plan and accounts for as much as 50 percent of total plan costs. The third segment of the health care utilization spectrum relates to consumption of health care services in catastrophic cases. While the portion of the covered population that might fall into this category of care in any given year might be less than 0.5 percent of the total covered population, this group can easily account for up to 25 to 35 percent of total plan costs in any given year.

Figure 4: Rough Characterization of Health Care Utilization under a Typical Employer-Sponsored Health Plan in the United States in 2003



Source: Developed by the author.

In an environment where health care costs are expected to increase more rapidly than wages and are expected to become an increasingly important part of compensation, the pattern of health utilization under employer-sponsored plans takes on increased significance. Within the typical employee population, some share of the benefits delivered under a health benefit plan goes to dependents of workers but much of the benefit is concentrated on the workers themselves. There is reason to believe that, on

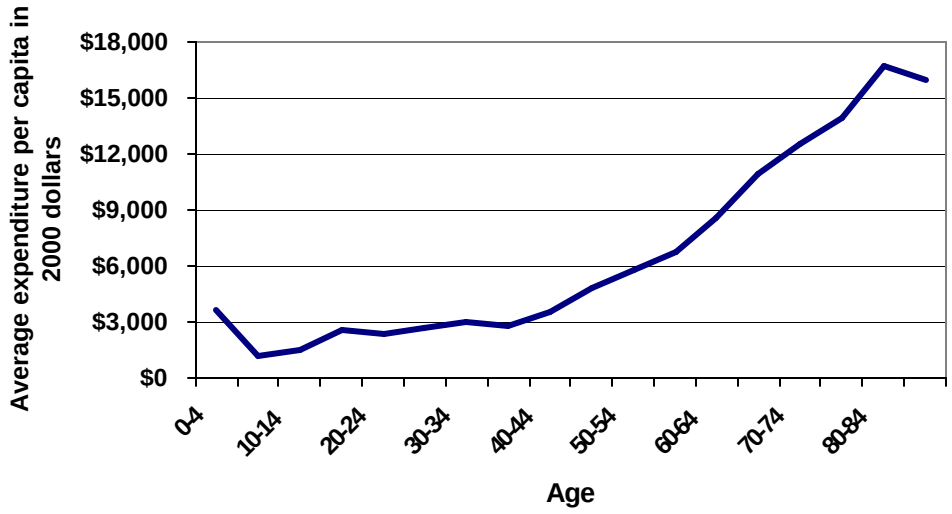
average, the health status of workers may be related to their productivity at work. Those in critical care, by definition, cannot be very productive. While many of those with chronic conditions might lead relatively normal lives, they almost certainly require more time to attend to their medical needs than those without such ailments and are also more likely to have problems associated with their chronic problems that might affect their productivity at work.

This line of reasoning is not to suggest that employers should seek to get rid of workers at the sign of any significant illness. It does suggest that, given the way we finance employer-sponsored health care in the United States, we may be headed down a path where a significant and increasing portion of compensation is being specifically targeted toward some of our least productive workers. In a market based economic environment, such a pattern of compensation does not make sense and many employers can be expected to attempt to prevent this situation from coming to fruition. For many retirees covered under employer-sponsored health benefit plans this has particular implications.

One other piece of evidence is important before turning specifically to the situation that retirees face; this is the pattern of health care consumption reflected in Figure 5 based on analysis of utilization patterns under employer-sponsored medical plans and Medicare and Medicaid. On average, older people consume considerably more health care than younger ones. The pattern reflected here is not unique to the United States but reflects the patterns across many developed societies with a variety of organizational structures for financing and delivering health care services (Costello and Bains, p. 24). From the perspective of health plan sponsors, retirees not yet eligible to

receive Medicare pose a significant cost risk to their health plans. Even those covered by Medicare would often present higher cost risks than younger workers if they are covered by a relatively generous retiree health benefit plan.

Figure 5: Age Profile of Average Expenditures on Health Care in the United States during 2000



Source: Watson Wyatt Worldwide.

III. Trends in Retiree Health Benefit Provision

Lawrence Atkins (p. 108) suggests that employer-provided health benefits for retirees evolved mostly without "design or intent" as a result of collective bargaining over benefits during the 1950s and 1960s. Relatively few retirees were receiving benefits from these plans, and the low cost of providing the benefits on a pay-as-you-go basis made them virtually a "throwaway" in negotiations. By 1962, 21 percent of the post-65 population was enrolled in an employer-sponsored plan and another 31 percent purchased some level of coverage privately (Rice, p. 9).

The enactment of Medicare in 1965 produced savings for these employer-sponsored plans, because Medicare became the primary payer for retirees once they

reached age 65. Employer-sponsored plans paid only for the costs not reimbursed by Medicare, and more employers began to offer these plans. Atkins argues that employers adopted these benefits "because they needed them to make their retirement packages work, because they helped in collective bargaining, because they were attractive to labor in competitive labor markets, and because the costs were rarely significant." He notes that there were so few retirees at the time that often they were simply kept on the active employee plan. The supplemental packages furnished by employers produced insurance coverage with very low out-of-pocket costs for retirees. From these humble beginnings, retiree health benefits have been buffeted by the same design and cost considerations as employer-sponsored health benefits for active workers in addition to other problems.

Retiree health benefits are different than health benefits that employers provide to active employers in that they are provided to people who no longer work for the entity providing them. In this regard, they are like a defined benefit pension which raises a set of issues beyond the cost and incidence issues associated health benefits provided to active workers. In the case of active workers' benefits they are earned at the time the worker perform their duties for the employer. In the case of retirees' benefits, they are earned long before they are actually provided.

The implications of accruing obligations for employer-sponsored retirement plans and how to deal with them have been understood for many decades. Steven Sass, who has written a history of the evolution of employer pensions in the United States, has written about the "science of reform" that swept the pension movement in this country in the 1920s. He says the scientific experts of the time understood the importance of eliminating the uncertainty of risk for both employee and plan sponsors. They concluded

that the benefits paid under retirement plans had to be expensed "in conjunction with the employer's receipt of productive labor services." But the second condition for the soundness of a plan was that monies have to be laid aside to cover obligations as they are earned (Sass, p. 62).

Accounting and Paying for Retirement Benefits in the Corporate World

In 1984, the Financial Accounting Standards Board (FASB) issued Financial Accounting Standard 81 (FAS 81) requiring employers to report on their financial statements either the current cost of retiree welfare benefits or the unfunded liability if the amounts were distinguishable from the benefit costs for active employees. FAS 81 raised employer awareness about unfunded liabilities associated with their retiree health benefit plans and their magnitude was illuminated by a number of well-publicized studies. In 1988, GAO estimated that retiree health benefit liabilities represented 8 percent of the value of companies' stock (Thompson, 1988). Another study estimated that the annual costs to amortize these retiree medical liabilities might run as high as 12 percent of payroll, or 10 times the current rate of pay-as-you-go spending (Investors Daily, 1989). By this time, many corporate employers were aware that unfunded retiree medical liabilities had the potential to be quite large relative to the value of assets in their companies or the market values of their stock. While non-corporate entities were not required to comply with the FASB standards, many non-corporate sponsors of retiree health benefit plans became more fully aware of the obligations they faced because of the publicity that was raised in regard to corporate obligations.

With the subsequent promulgation of FAS 106, FASB required that employers estimate and report future obligations associated with retiree health benefit programs on

their financial statements for fiscal years beginning after December 15, 1992. The rationale was that retiree medical benefits are a form of deferred compensation for current employees, and the future benefits should be reported as they are earned. The underlying theory was that if an employer is going to hold out these benefits to employees in trade for their work, the obligation of paying for them down the line has to be recognized at the time the work earning the benefit is done and the obligation incurred.

As the Financial Accounting Standards Board moved to require accounting for retiree health obligations they put in place the first principle underlying secure retirement benefits that Sass tells us have been well known since at least the 1920s. But while the accounting rules for retiree health plans were being tightened, the U.S. Congress enacted significant restrictions on employers' ability to fund welfare benefit plans. The funding restrictions in the Deficit Reduction Act of 1984 (DEFRA) were prompted by concerns that funded plans could be used to shelter significant income from taxation. The legislative history also noted articles that discussed potential abuses that might occur in the use of welfare plan assets, such as the acquisition of ski chalets or yachts.

DEFRA prohibited employers from taking medical cost inflation and utilization trends into account when funding retiree medical benefits, and limited funding to current retirees. At the time, health care inflation was nearly double the rate of general inflation and utilization rates were trending upwards. FAS 106, on the other hand, required plan sponsors to account for all their future liabilities, including those associated with future medical inflation, increased utilization, and future retirees. DEFRA also limited the employer's deductible contribution, and imposed a 100 percent excise tax on any assets

reverting to the employer from a funded welfare benefit plan.[2] The first condition for securing retiree health benefits was put in place by accounting regulations but the second condition, funding them as they were being earned, was trumped by legal restrictions on the funding of benefits as they were accrued during a covered person's active work life.

The Omnibus Budget and Reconciliation Act of 1989 (OBRA 89) further restricted retiree medical funding opportunities. Prior to OBRA 89 the IRS had allowed 401(h) contributions up to 25 percent of the pension plan's cost, including the normal or actuarial cost of providing pension benefits to participants.[3] OBRA 89 limited employer 401(h) contributions to 25 percent of all employer contributions to the pension plan. This meant that employers with well-funded pension plans could no longer contribute to the 401(h) account.

OBRA 90 Section 420 permitted limited transfers of excess defined benefit plan assets into 401(h) accounts. The transferred assets must be used only to pay qualified current retiree health liabilities for the tax year of the transfer. The effect of these legal restrictions has been to eliminate any tax-preferred means to fund health care liabilities of future retirees. The vehicles that do exist are largely for current retirees, and they limit contributions and do not account for growing utilization and medical inflation.[4]

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[2] The contribution limits had a slightly delayed effective date, applying to contributions after 1985, with a special four-year transition rule for plans with excess reserves. Special rules did allow additional contributions for plans covering collectively bargained employees or plans sponsored by tax-exempt employers.

[3] A 401(h) account is an account in a pension plan, and is used to provide retiree medical benefits.

[4] In addition to the use of 401(h) accounts, there has been increased use of life insurance products such as Corporate Owned Life Insurance (COLI) and Trust Owned Life Insurance (TOLI). These are more informal vehicles for funding and allow firms to invest in cash-value life insurance on a relatively large group of active and retired employees. The proceeds from these polices are used to pay post retirement

FAS 106 accounting for retiree medical benefits has provided better information to corporate investors and other interested parties concerning the extent of future obligations. More importantly, it prompted corporate executives to closely examine the magnitude of their commitments in sponsoring retiree health benefit plans. For many employers, it became clear that the generous plan designs and premium subsidies offered in an earlier era were now producing unacceptable financial obligations. This was particularly true in view of the high rates of medical inflation in the 1980s and the fact that plan sponsors were limited in their ability to fund these obligations as they accrued.

In a survey of medium and large firms in 1980, 85.6 percent of them reported that they provided some form of retiree health benefits. By 2000, the percentage reporting these benefits had dropped to 37.1 percent. For the most part, the larger employers continued to sponsor plans, but even there, substantial curtailments in what was offered were the general rule (McDevitt, Mulvey, and Schieber [MM&S], p. 14). There are a number of common ways that plans have been curtailed without being eliminated by larger employers in the for-profit sector. These include increasing periods of service under the plan in order to qualify for benefits at retirement age, implementing a sliding schedule of premium payments based on service under the plan, capping the dollar amount the employer will contribute for retiree health premiums, and shifting to a notional defined contribution plan where a balance is accumulated over the period of

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medical benefits. But because COLI is not held in a trust for the purpose of providing post retirement medical benefits and the proceeds can be used for any purpose it is not a plan asset for FAS 106 purposes and cannot be used to directly offset FAS 106 liabilities. TOLI proceeds, however, are in a trust and can be considered as an offset to the FAS 106 liabilities. But once again, TOLI only covers funding for current retirees.

work for an employer and that balance can be used to pay part of the premium for retiree health insurance during retirement. All of these methods are being used extensively to curtail retiree health liabilities in the private sector today.

One 1984 survey of employer plans found that 43 percent of plans had no service requirement in order for people age 65 and above to qualify for retiree health benefits and that another 46 percent required five years of service or less to qualify (Dopkeen, 1987). By 2001, 72 percent of plans were requiring 10 or more years of service to qualify for benefits for people then eligible to retire and 87 percent would require 10 or more years of service for young workers to qualify for such benefits in the future (MM&S, p.17). For people eligible to retire prior to age 65 in 2001, 80 percent of plans had service requirements of 10 years or more in order to qualify for benefits and 91 percent had such requirements for younger workers (MM&S, p. 18). For workers retiring in 2001, the average employer contribution for a pre-65 retiree with 10 years of service was 43 percent of the total premium for coverage, 53 percent for a retiree with 15 years of service, 63 percent for a retiree with 20 years of service, and 71 percent for a retiree with 25 years of service (MM&S, p.19).

Another common device for limiting retiree health obligations is to implement a dollar cap on the annual premium contribution that employers will make for retiree health benefits. In 2001, 26 percent of large plans had such caps in place for current retirees, 39 percent had them in place for people nearing retirement, and 45 percent had them in place for new hires. For pre-65 retirees in 2001, the average cap for current retirees was $4,450 and $3,900 for future retirees. The average employer contribution at that time was $3,074. For post-65 retirees, the average employer contribution caps were $2,000 for

current retirees and $1,740 for future retirees with current average employer contributions at $1,304 (MM&S, p. 20).

Given the recent premium hikes that employers are reporting for their health benefit plans, this suggests that retirees in the average plan will be hitting the employer-contribution caps within the next year or so. It is important to keep in mind that once these premium caps are hit, that all additional premium increases fall onto the retiree. If an employer has a plan with a $3,000 cap where the employee has been paying 40 percent of the premium when the total premium hits $5,000, the cost sharing will change dramatically. If the cost of this plan increases by 10 percent in the year after reaching the cap, in the next year, the total cost of the plan will rise to $5,500 but the cap will mean the retiree will have to pay a premium of $2,500, an increase of 25 percent over the prior year and the retirees share of the total premium will rise to 45 percent.

The establishment of notional retiree medical accounts is a relatively recent development in the private sector employer community. In 2001, among large employers still sponsoring retiree health benefit plans, only 2 percent had such accounts for current retirees. Seven percent had set up such accounts for current workers close to retirement eligibility and 13 percent had established such accounts for new hires (MM&S, p. 24).

IV. Retiree Health Benefits for Faculty in Higher Education

The rules that apply to corporate sponsors of retiree health benefits in regard to how they account for the financial obligations or fund the benefits in these plans do not apply to most employers in the higher education sector. Virtually all the institutions of higher learning in the United States are either public sector or nonprofit entities. The Financial Accounting Standards Board does not have domain over either class of entities

and the income tax penalties applied to private-sector sponsors for funding retiree health benefits as they accrue do not apply. Because of these differences, it is quite possible that characteristics of retiree health benefits in higher education are evolving along a different path than in the for-profit sector.

The imposition of disclosure requirements regarding the financial obligations posed by retiree health plans in conjunction with the limitations on benefit funding on for-profit sponsors corresponded directly with the changing pattern of benefit provisions under the plans. The provision of a retiree benefit on a pay-as-you go basis is not economically rational for single employers or workers in the for-profit sector. To put the viability of an unfunded retirement benefit promised to an employee in perspective, we went back to the 1972 Fortune 50 list of industrial companies in the United States. Of the 50 largest companies on that list, 21 of them remained intact and operating under the same corporate structure in 2002 as they did 30 years earlier. Another 21 of them had been purchased or subsumed into some other corporate organization, four had been split into multiple parts, and four had gone through at least one bankruptcy but were still operating. At least three of the 21 that were acquired by another entity had also undergone bankruptcy in the subsequent 30 years since being on the Fortune top 50 list in 1972. No matter how well intentioned the management of a company might be in committing to provide future retirees with health insurance, it is impossible to guarantee that benefit over a normal working career and retirement on a pay-as-you-go basis.

It is not just the survival probabilities of the entities sponsoring these benefits that put them at risk. In some cases where employers might be able to provide retiree health benefits on a pay-as-you-go basis across a period of several decades, they may not be

willing to do so because of the pressures imposed upon them by the financial markets. In many regards, private sector employers are like people. Some people insist on paying for things when they buy them. Others are willing to buy things on credit and pay for them later. Just like individuals, employers have different limits on their ability or willingness to take on debt. Some employers with very stable, predictable cash flows may have higher debt capacity than others where revenues and profits are highly cyclical. For plan sponsors, accumulating retiree health liabilities that cannot be funded until later is the equivalent of buying on credit. For employers that are able to handle heavy debt obligations, unfunded retiree benefits may not be a problem as long as they remain economically viable and under relatively consistent management. But the track record of the Fortune top 50 industrial companies from 1972 suggests that is a dicey proposition.

In the case of institutions of higher learning, the signaling effects of the FAS disclosure requirements imposed on corporate employers have not applied up until now although that situation is likely to change for public entities in the relatively near future. In February 2003, the Governmental Accounting Standards Board (GASB) issued an exposure draft of a new standard for *Accounting and Financial Reporting by Employers for Postemployment Benefits Other than Pensions*. Based on comments on that exposure draft of new rules for state and local government accounting for retirement benefits including retiree health care, a revised exposure draft was issued on January 30, 2004 to be open for comment until April 30, 2004. After the comment period, it is anticipated that GASB will issue final accounting standards for retiree health benefits that will take effect in 2006. These new standards are expected to require that public employers recognize the cost of accruing benefits in periods when the related services are rendered

by workers, that they calculate and report actuarial accrued liabilities for promised benefits associated with past service of workers and the extent to which such benefits have been funded, and that they indicate future cash flows required to meet these obligations (GASB, 2004).

Since virtually all colleges and universities are non-profit institutions, the funding limitations imposed on corporate employers sponsoring retiree health benefits did not apply for colleges and universities so there would have been a greater opportunity to match the securing of retiree health benefits with the accrual of liabilities during workers' careers. For most colleges and universities, the vagaries of market demand for specific goods and services that can lead to the rise and fall of corporate employers also are not applicable.

In order to see what colleges and universities are doing in providing health benefits for retired faculty members, Watson Wyatt undertook a survey on the subject in February 2004. The survey questionnaire was sent to 263 institutions and garnered complete responses from 67 of them. Of the responding institutions, 18 percent reported they did not provide retiree health benefits. There were 46 private schools who responded to the survey, of which 12 did not have a plan. Among the latter, the average enrollment was approximately 2,300 undergraduate students. Among those reporting a health benefits plan for retired faculty, the average enrollment was around 4,300 undergraduate students. There were 22 public schools that responded to the survey and 21 reported providing health insurance to retired faculty. The average enrollment in the latter group of institutions was 19,300 undergraduates.

Table 1 indicates the extent to which health insurance is being offered to retired faculty among the schools that were offering such coverage at the beginning of 2004. Among the 34 private institutions that offered retiree health benefits, all of them offered the benefits to retired faculty under the age of 65 who were already retired or eligible to retire. For new hires, however, only 27 offered the prospect of providing retiree health benefits in the future. A number of the private schools that provided retiree health benefits prior to age 65, did not continue to provide such benefits beyond age 65 when the retirees would typically qualify for Medicare. For new hires, only 62 percent of all the private institutions that offered some benefits currently would provide them beyond age 65 for faculty members now joining the staff. In the case of the public institutions, there is much less indication so far that the provision of coverage is being curtailed to the same extent it is in the private schools.

Table 1: Number of Institutions of Higher Learning in Survey Sample Providing Retiree Health Benefits to Retired Faculty by Indication of Coverage

	Private institutions			Public institutions		
	Current retirees	Eligible to retire	New hires	Current retirees	Eligible to retire	New hires
Pre-65 coverage						
Retiree	34	34	27	21	21	20
Spouse	34	34	27	21	21	19
Post-65 coverage						
Retiree	30	29	21	21	20	19
Spouse	30	29	21	21	20	19

Source: Watson Wyatt Worldwide.

The provision of retiree health insurance to retired faculty across the set of institutions reflected in Table 1 is important in that it gives a clear indication that the

retired faculty members involved have access to continuing health insurance coverage. The value of what they have access to varies considerably from one institution to the next. Table 2 shows the extent of cost sharing of premiums between the retirees and the sponsoring institutions for the faculty members, but not necessarily their spouses, for those who are currently retired or eligible to retire.

Table 2: Cost and Cost Sharing of Retiree Health Benefits Provided by Private and Public Colleges and Universities in 2004

	Current retirees				Now eligible to retire			
	Private schools		Public schools		Private schools		Public schools	
Pre-65 plan								
Total reporting	31		18		32		18	
	Percent of total	Average spending	Percent of total	Average spending	Percent of total	Average spending	Percent of total	Average spending
Retiree pays all	16.1	$5,030	27.8	$5,030	18.8	$4,890	27.8	$5,030
Share expenses	54.8		38.9		65.6		44.4	
Retiree share		$2,023		$950		$1,958		$1,432
Employer share		$2,717		$3,480		$2,574		$3,345
Employer pays all	29.0	$4,006	33.3	$4,134	15.6	$4,508	27.8	$4,274
Post-65 plan								
Total reporting	29		20		29		19	
	Percent of total	Average spending	Percent of total	Average spending	Percent of total	Average spending	Percent of total	Average spending
Retiree pays all	13.8	$3,725	20.0	$3,562	13.8	$3,725	21.1	$3,562
Share expenses	51.7		45.0		65.5		47.4	
Retiree share		$1,817		$679		$1,866		$679
Employer share		$1,781		$3,062		$1,735		$3,062
Employer pays all	34.5	$3,625	35.0	$3,513	20.7	$3,625	31.6	$3,644

Source: Watson Wyatt Worldwide.

The public schools are more likely to require that the retiree pay the full premium for the retiree health insurance coverage than are private schools. But the public schools are also more likely to pay the whole cost of the benefit than the private schools. Where premiums are shared, the private institutions generally share the cost on something approaching a 50-50 basis whereas the public employers typically pick up a significantly larger share of the total premium.

As noted earlier, many private companies that continue to sponsor retiree health benefits have undertaken a variety of measures to limit the liabilities that these benefits pose in the future. A number of colleges and universities have adopted limitations similar to those being utilized in the corporate sector but the pattern of adoption of these methods is much less widespread by the academic employers, at least those in the public sector. In a 2001 survey of corporate sponsors of retiree health benefits, roughly 60 percent of the respondents indicated they had service requirements of 10 years to qualify for retiree health benefits plus another 30 percent required more than 10 years for future retirees (MM&s, p. 18). In Table 3, the private academic employers in the current survey are showing around 90 percent indicating that they have implemented service requirements of 10 years or more for retiring faculty to qualify for retiree health benefits. For the public institutions, on the other hand, 35 percent or more still have service requirements of 5 years or less to qualify for benefits.

Among the responding academic institutions to the current survey, only 11 percent of the private and 19 percent of the public schools indicated they varied the share of premiums paid by current retirees based on service prior to retirement. For faculty members now eligible to retire but still working, the 16 and 29 percent of the respondents

respectively varied premiums based on service. For new hires still being offered benefits in the future benefits in the future, 18 and 29 percent of the respondents had such variable premium schedules. By comparison, 63 percent of private plan sponsors in 2001 reported that they would vary premiums based on service for pre-65 benefits and 72 percent reported they would do so for post-65 coverage (MM&S, p. 18).

Table 3: Utilization of Minimum Service Requirements to Qualify for Health Benefits Provided to Retired Faculty by Institutions of Higher Learning in 2004

	Private institutions			Public institutions		
Minimum service requirement	Currently retired	Eligible to retire	New Hire	Currently retired	Eligible to retire	New Hire
Number reporting	29	29	21	21	21	20
	Percent reporting service requirement of:					
None	4	3	5	5	5	5
5 years or less	7	3	5	33	29	30
10 years	48	48	48	38	29	30
More than 10 years	41	45	43	24	38	35

Source: Watson Wyatt Worldwide.

For the schools responding to the survey in 2004, only 9 percent of the private institutions and 24 percent of the public ones indicated they had implemented employer contribution caps for health benefits provided to current retirees under age 65. For those already over the age of 65, 13 percent of private and 24 percent of the public institutions had adopted such caps. In the case of private employers in 2001, 26 percent had adopted caps for current retirees under age 65 and 24 percent had them for retirees age 65 and over. For those now eligible to retire but still working, 12 percent of private and 24 percent of public schools had adopted premium caps for faculty retiring before age 65. For those retiring after age 65, 17 and 24 percent had such caps. The similar private

sector rates in 2001 were 39 percent for both pre- and post-65 retirees (MM&S, p.20). Only a handful of the respondents to the current survey, across both the public and private institutions, had hit their premium caps already. By comparison, among the private firms surveyed in 2001, 42 percent had already hit their pre-65 caps and 50 percent had reached their caps for post-65 retirees (MM&S, p. 21).

One response that private employers have adopted to limit retiree health liabilities but to continue to provide some level of benefits for future retirees is the adoption of "retiree medical accounts" that accumulate during a worker's career and can be used to help pay health insurance premiums during retirement. Rather than paying a percentage of the premium for a defined insurance benefit, the employer makes a fixed contribution to an account, and the retiree is able to use the employer contribution in the account to purchase health insurance.

Like traditional retiree medical plans, retiree medical accounts are not taxable to the employee, they are not prefunded, and employees do not necessarily accrue a vested right to the benefit. Employers can retain the right to modify or eliminate the plan altogether as long at this is clearly communicated to employees and retirees. Employers may continue to offer a choice of one or more group-rated medical plans, but the retiree pays the full premium either from the retiree health account or directly.

Most of the employers reporting retiree medical accounts limit participation in these accounts to employees who have met age and service requirements, for example, age 40 and one year of service. This concentrates benefits on older employees and limits the cost of the benefits. Contribution formulas differ, but participants are typically credited a fixed dollar amount for each year of participation in the plan, and the account

may earn interest both before and after retirement. Retiree health accounts are typically "notional accounts," meaning that funds are not deposited into these accounts as credits are earned. Rather, these accounts are simply a bookkeeping device that allows the employer and employee to keep track of the dollar amounts that will be made available for retiree medical benefits sometime in the future.

The retirement incentives associated with a retiree medical account are different from those of a traditional retiree medical plan. Where the traditional plan offers the highest present value to employees who retire early, the retiree health account continues to accumulate credits for each additional year of service. By working longer, the employee also reduces the number of costly pre-Medicare years for which retiree medical coverage must be funded. Finally, the traditional plan usually makes additional contributions for spousal coverage, but the retiree health account does not.

Although retiree medical accounts typically provide more limited employer contributions than those associated with traditional medical plans, they represent one way for employers to offer a benefit that is predictable, manageable, and consistent with prevailing strategies to attract and retain employees. Much like savings plans and cash balance plans designed to provide retirement income, retiree health accounts clearly communicate the dollar value of the benefit and encourage the employee to take on greater individual responsibility for retirement planning. In the 2001 survey of private employers, 13 percent had set up these accounts as a way to control retiree health liabilities but still maintain a plan. In the 2004 survey of academic institutions, only one private school had established such a plan.

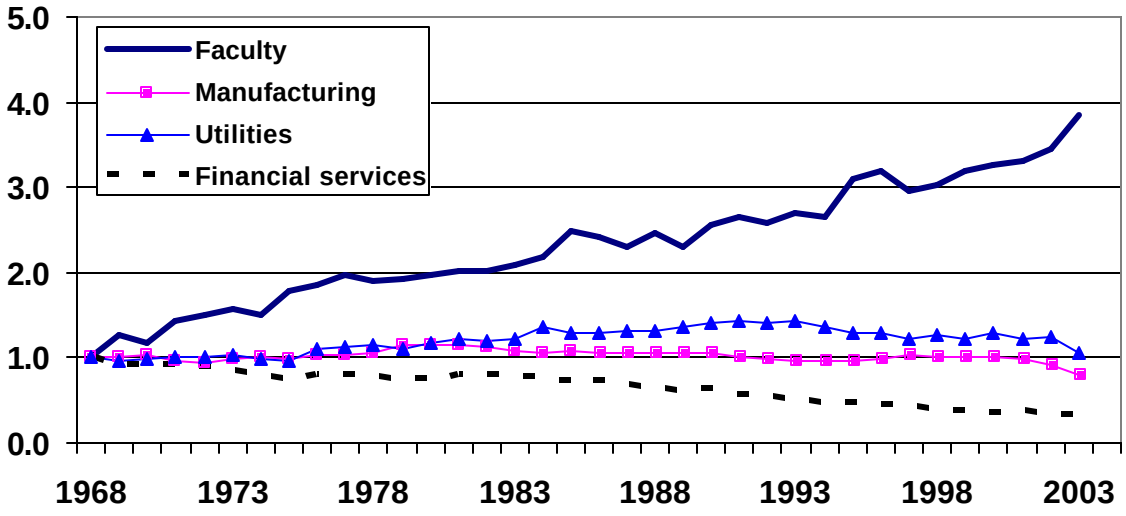
Among the respondents to the current survey, 47 percent of the private institutions and 71 percent of the public ones indicated that they were at least partially funding retiree health obligations. These response rates were surprisingly high and we asked many follow-up questions of respondents to verify this information. We found a variety of things the schools were doing. For example, one university reported that they allow retiring employees to convert unused sick leave into an account at retirement to help pay the retiree's premiums which they considered to be partial funding. In almost every case, we concluded there was very little funding taking place. At least in the case of public colleges and universities, our conclusion is consistent with the GASB's assessment of how most public employers have been operating their retiree health benefit plans.

Future Provision of Health Benefits for Retired Faculty

To a considerable degree the retiree situation that has occurred in higher education in the United States, especially among faculty, has been remarkably different than that for private employers that have sponsored retiree health benefit plans. In many of the latter, the companies that have sponsored retiree health benefits and continue to do so are in the manufacturing, utilities, and financial services sectors of the economy. The employment experience in these sectors has been remarkably different than in the higher education sector over the period since the baby boom generation has entered the workforce. Figure 6 shows employment levels compared to 1968 for firms in the manufacturing, utilities and financial services sector from 1968 through 2003. It also shows the employment of faculty in higher education over the same period. Labor force growth in the three industrial sectors has been relatively flat or declining over most of the period but the employment of faculty in higher education has shown steady growth over

most of the period. Where there is little or no employment growth over time, sponsors of retirement plans invariably find that their retiree dependency levels rise driving up costs of retirement plans, especially those financed on a pay-as-you go basis.

Figure 6: Ratio of Current Employees to Number of Employees in 1968 for Selected Industries Compared to Faculty in Higher Education by Year

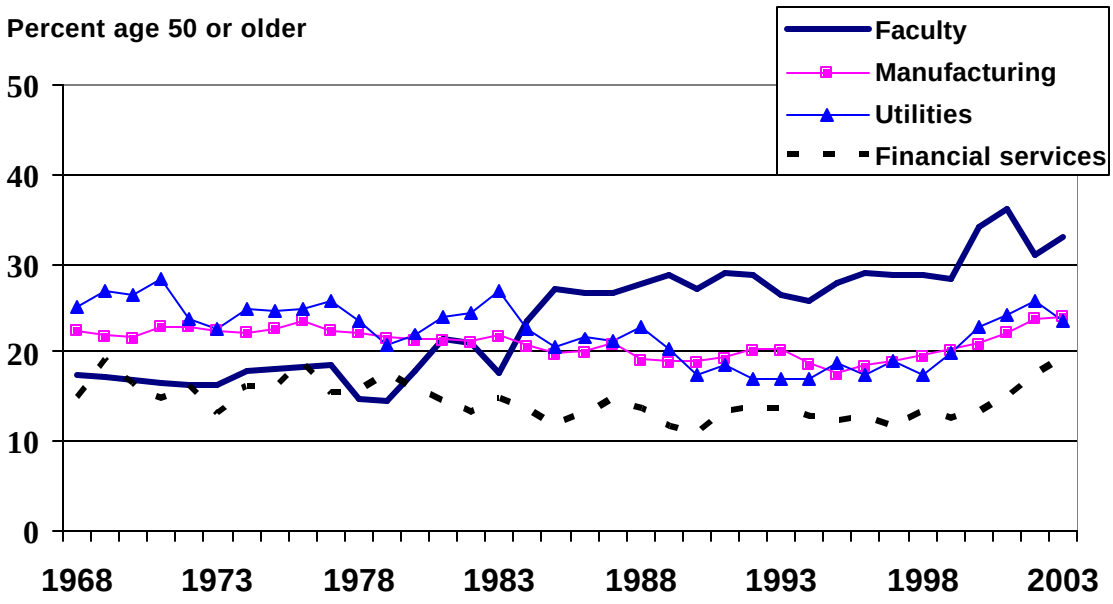


Source: Author's tabulations of the *Current Population Survey*, various years.

As we look to the future, there are some indications that employers in the higher education sector may have built up a larger reservoir of future retirees, in relative terms, than many private industrial firms. Partly this is the result of different work and retirement characteristics in the various sectors. Many of the private employers have traditionally had defined benefit plans and have utilized early retirement incentives that encourage workers to retire when they reached their late 50s or early 60s. Academic institutions, which have more generally relied on defined contribution plans, especially for faculty members, have not had similar retirement incentives built into their retirement

packages. The incentives built into retirement plans have been shown to effect the timing of retirement by the workers who participate in them (McGill et al, 2004). In any event, Figure 7 shows that the percentage of faculty over the age of 50 during the late 1960s in institutions of higher learning tended to be below that of workers of similar ages in them private sector industries where retirement plans have been most prevalent. In the last 20 years, however, the situation has completely reversed and higher education now has a much larger concentration of faculty over 50 than among the employed in the major industries where retirement plans prevail.

Figure 7: Percentage of Faculty in Higher Education and Employees Age 50 or Older in Selected Industries by Year



Source: Author's tabulations of the *Current Population Survey*, various years.

The combination of domestic economic reorganization, changing regulations, and transferring various sorts of activities to foreign countries has resulted in remarkable

increases in the ratio of retirees to active workers in virtually all of the firms in the manufacturing, utility, and financial services industries. Retiree health benefits have become a particular problem in this environment because they have been operated on a pay-as-you-go basis from a funding perspective. The costs of any retirement plan operated on this basis are directly proportional to the ratio of retirees benefiting from it compared to the workers who have to support it. In the case of retiree health benefits, the problem has been greatly exacerbated by the abnormally high rates of inflation in the health sector.

Despite the fact that employment patterns in higher education have evolved differently than those in many of the industries already troubled by the retiree health obligations they face, the same issues apply in this case as in the others. Retirement may come somewhat later in higher education than in other industries but the larger share of current workers that are now at advanced ages suggests that retiree dependency ratios among faculty could rise fairly quickly in future years. A disproportionate share of existing faculty are members of the baby boom generation or older. This generation of workers is now approaching the age at which they will begin to retire either because of health considerations or because of normal expectations to do so. Even if they are all replaced by young faculty members, the future ratio of retirees to active workers will increase in the vast majority of cases. And the pressures on health costs that apply to other sponsors of health insurance will continue to apply to academic institutions.

Of course, there is always the prospect that the higher education sector will continue to grow more rapidly than the remainder of the economy and that the added employment will allow employers in this sector to continue to escape the aged

dependency problems that have plagued other sectors. Much of the growth in the education sector over the past 40 years has been demand driven and it is not clear that the fundamental market factors that have persisted over this history will continue in coming decades. The baby boom generation and even its echo with subsequent birth cohorts have been accentuated with increasing demand for a college education. This growing demand has been supported by public and private funds that may be constrained by alternative claims in the future. The baby boomer generation's retirement will likely place an unprecedented claim on public budgets unless there are remarkable changes to public pensions and medical programs. To the extent there is retrenching on these programs, it may be concentrated on the middle and upper middle classes, including older workers and retirees who have been major contributors to higher education in the past.

In the case of public institutions of higher learning, the new GASB accounting standard is going to introduce some of the same sorts of pressures on retiree health benefits that they have introduced in the private sector. Given that changes that will be adopted to respond to these pressures will be undertaken in a public policy environment, the changes may not be as rapid as those taken in the private sector or as radical. But even in the public sector, the recognition of costs associated with retirement plans often leads to changes. If nothing else, the recognition of costs associated with these sorts of programs can lead to reallocation of budgets within organizations and may ultimately result in actual reallocation of resources.

For private institutions of higher learning, there is currently no regulatory authority that has the purview to force the accounting for retiree obligations. Given the concerns about public budgets, there seems little appetite on the part of Washington

policymakers to require that sponsoring entities fund these benefits as they accrue. Failure to do so, however, raises the prospect that future management of institutions that continue to sponsor these benefits will become hamstrung with obligations than are not properly anticipated and that have the potential to become so large that they pose a threat to the long-term viability of the institutions.

Whether an academic institution is in the public or the private sector there are fundamental cross generational issues that the provision of these benefits raise. The basic principles on which GASB is basing its new standard for accounting for retiree health benefits are the same as those that Steven Sass, the pension historian, has told us plan sponsors learned more than 80 years ago. To secure a retiree benefit over time, the obligation it poses must be accrued as it is being earned and must be funded at the time it is accrued.

It is likely that full accounting and a shift toward funding of retiree health benefits will lead many academic sponsors to reconsider the benefits that they have provided up until the present time. It is clear that some of this reassessment is now underway and that the net result is that benefits are being curtailed or costs shifted to retirees. The implementation of the prescription drug benefit recently adopted under Medicare may allow some sponsors to go further in terms of reducing retiree health obligations than they would have gone in the past. This opportunity arises for several reasons.

First, a typical employer-sponsored plan covering retirees also eligible for Medicare now spends something approaching two-thirds of its outlays on prescription drugs. The lack of drug coverage in Medicare has been its major inadequacy as a stand-alone insurance plan. Second, for a substantial number of plans documented in this

analysis, 14 percent of the private school plans and 20 percent of the public plans, retirees are already paying the full premiums for their retiree health insurance and the Medicare coverage may be no more costly than the existing coverage and may be nearly as comprehensive as current plans up to and including the catastrophic coverage levels. Third, in many cases, the employer cost of the current benefits is roughly as expensive as the Medicare coverage will be up to and including the catastrophic coverage levels. If employers want to continue to provide this level of benefits on a defined benefit basis, they would be better off establishing an actual defined benefit pension plan to provide future retirees a stream of income to cover their Medicare costs for prescription coverage. For the remaining employers that are in a cost sharing relationship with their retirees the financial picture may not be as clear but the logic that applies to cashing out current health obligations for the other employers applies here as well. Defining a limited commitment and funding it as it is accrued will be a much sounder guarantee over the long term than what is being provided today.

It is clear that many current employers in this sector have a strong aversion to defined benefit pensions. Yet, in sponsoring retiree health benefits it is clear these same institutions have committed themselves to an alternative form of defined benefit plan where they have virtually no control over the escalation of costs over time, where inflation has historically been extremely high and persistent, and where there is little precedent for funding the obligations as they accrue. This is not a logical situation for either the sponsoring organizations or the potential beneficiaries of current plans to sustain.

References

Atkins, G. Lawrence, "The Employer Role in Financing Health Care for Retirees," in Judith F. Mazo, Anna M. Rappaport, and Sylvester J. Schieber, eds., *Providing Health Care Benefits in Retirement* (Philadelphia: University of Pennsylvania Press and the Pension Research Council, 1994), pp. 100-124.

Centers for Medicare and Medicaid Services, *Medicare Current Beneficiary Survey, 2000* found at: http://www.cms.hhs.gov/mcbs/CMSsrc/2000/Summary1.pdf.

Centers for Medicare and Medicaid Services, The 2001 Medicare and Medicaid Statistical Supplement to the *Health Care Financing Revie*, (2001).

McGill, Dan M., Kyle N. Brown, John J. Haley, Sylvester J. Schieber, *Fundamentals of Private Pensions*, eighth edition (Oxford: Oxford University Press, 2004).

Centers for Medicare and Medicaid Services, Office of Research, data from the Medicare Current Beneficiary Survey 1999, Cost and Use File, (2002).

Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group, 2004, http://www.cms.hhs.gov/statistics/nhe/#download.

Declan Costello and Mandeep Bains, *Budgetary Challenges Posed by Aging Populations*, (Brussels: Economic Policy Committee, European Economic Commission, October 2001).

Department of Health and Human Services, Agency for Health Care Research and Quality, *1999 Medical Expenditure Panel Survey* tabulations by Watson Wyatt.

Dopkeen, Jonathan C., "Postretirement Health Benefits," *Health Services Research* (February 1987), vol. 21.

Fischer, Stanley, "Remembering Herb Stein: His Contributions as an Economist," Prepared for delivery in a session commemorating Herb Stein, at the American Economic Association meetings, New Orleans, Louisiana, January 6, 2001 found at: http://www.imf.org/external/np/speeches/2001/010601.htm.

Fronstin, Paul, "Sources of Health Insurance and Characteristics of the Uninsured: Analysis of the March 2001 Current Population Survey," EBRI Issue Brief No. 240, December 2001.

Governmental Accounting Standards Board, *Accounting and Financial Reporting by Employers for Postemployment Benefits Other Than Pensions* (January 30, 2004).

Investor's Daily, "Retiree Health Benefits Total 12 % of Payroll" (February 2, 1988), p. 9.

Kaiser Family Foundation and Health Research and Education Trust, *Employer Health Benefits: 2003 Annual Survey* (Menlo Park, California and Chicago, Illinois respectively, 2003).

McDevitt, Roland D., Janemarie Mulvey, and Sylvester J. Schieber, *Retiree Health Benefits: Time to Resuscitate?* (Washington, DC: Watson Wyatt Worldwide, 2002).

Meuller, Marjorie Smith, "Private Health Insurance in 1971: Health Care Services, Enrollment, and Finances," *Social Security Bulletin* (February 1973), vol. 36, no. 2, pp. 3-22.

Pikrell, Jesse F., *Group Health Insurance* (Homewood, Illinois: Richard D. Irwin, Inc., 1961), revised edition.

Organization for Economic and Cooperative Development, *OECD Health Data 2001*, (Paris, 2001).

Rice, Dorothy P., "Health Insurance of the Aged and their Hospital Utilization in 1962: Findings of the 1963 Survey of the Aged," *Social Security Bulletin* (July 1964), vol. 27, no. 7, p. 9.

Sass, Steven A., *The Promise of Private Pensions* (Cambridge, Mass.: Harvard University Press, 1997).

Strong, Jay V., *Employee Benefit Plans in Operation* (Washington, DC, BNA Incorporated, 1951).

Thompson, Lawrence H., Statement of Assistant Comptroller General, Human Resources Division before the Subcommittee on Oversight, Committee on Ways and Means, House of Representatives, .

Watson Wyatt Worldwide, *1984 Group Benefits Survey* (Washington, DC: Watson Wyatt Worldwide, 1984).